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 waiver's 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:
All Assisted Living waiver providers must have a policy and process in place that guides the providers practice in assuring safeguards are in place to protect the safety, health and well-being of all waiver participants. This policy and process must provide education for employees and provide guidance for facility staff to enable identification, prevention and action regarding allegations of abuse, neglect and exploitation.
Assisted Living Waiver providers must conduct checks of the Mississippi Nurse Aide abuse registry of all employees providing care to waiver participants. The types of positions for which abuse registry screenings must be conducted include any individual providing direct care or supervision to the residents, owners, operators, and transportation drivers. The facility must assure that the Mississippi Nurse Aide Abuse Registry is checked prior to employment of the above mentioned employees. The facility must maintain documented evidence in the personnel files of each employee to demonstrate to the Division of Medicaid that such checks have been made.

Facilities must provide a licensed nurse at the facility at least eight hours a day (including weekends and holidays) to assess and assist the waiver participants with medication administration or oversight. The nurse must have an active and unencumbered license. If the facility employs a licensed practical nurse (LPN), the LPN must have supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facilities must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate the Mississippi Nursing Practice Law or Administrative Code in any manner.
Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

Assisted Living providers must began identifying and maintain records of medication allergies of waiver participants as of October 1, 2013.

Assisted Living Waiver Providers must provide all staff with training upon hire and annually thereafter in the following areas:
a) Vulnerable Persons Act: Prevention of abuse, neglect and exploitation
b) Resident Rights and Dignity
c) Care of an Alzheimer's Resident
d) Care of residents with Mental Illness
e) How to Deal with Difficult Residents

The Assisted Living Waiver provider will maintain evidence of this training on file and easily accessible per request of the Division of Medicaid staff.
The Assisted Living Waiver provider must assure that each direct care staff successfully completes 40 hours of course curriculum as identified by the State as a requirement prior to providing care to waiver participants. Documentation of completion of this course work must be maintained at the facility and be made available to the Division of Medicaid upon request.
Failure of the Assisted Living waiver provider to comply with training requirements will require an acceptable plan of correction by the provider. Continued noncompliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.

The Assisted Living Waiver provider must supply normal, daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. The waiver participant may choose to bring in his or her own personal products or brand name products.

Assisted Residential Care service was added to this waiver. This waiver sets aside five (5) waiver slots for participants with acquired traumatic brain injuries who are in a family/participant crisis or have behavioral issues that require twenty-four (24) hour supervision and assistance to successfully thrive in a community or residential setting. If not for services provided in this waiver, these individuals would require institutionalization. The object for offering this service is to strengthen and support informal and formal services to meet the unique needs, cognitively and behaviorally, for these waiver participants in a specialized residential setting. Traumatic brain injury is defined as a traumatically acquired non-degenerative structural brain damage. This term does not apply to brain injuries that are congenital or due to injuries induced by birth trauma. There are specifc training requirements for this service provider.

Waiver provider agreements must be more detailed and accountable as to avoid price gouging of Medicaid waiver participants. The agreements must include a detailed account of costs differentiating between room and board verses care services. All agreements must be approved by the Division of Medicaid prior to waiver admission and prior to any update or change.

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*):
Assisted Living Waiver

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.0355
Waiver Number:MS.0355.R03.00
Draft ID: MS.08.03.00

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

Regular Waiver

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

10/01/13

Approved Effective Date: 10/01/13

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:
Individuals must be 21 and over.

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 Assisted Living Waiver is a statewide program designed to allow Medicaid eligible beneficiaries requiring nursing facility level of care the choice to receive personal care, supervision, therapeutic care and social services in a home and community based setting as opposed to an institutional setting. This waiver also promotes rebalancing resources between institutional and community services by facilitating community transition of institutionalized persons.

Waiver participants reside in a Personal Care Home-Assisted Living facility that is licensed by the Mississippi State Department of Health or other licensed adult residential care home/community living setting as deemed acceptable by the Division of Medicaid. Waiver participants must be 21 years or older, aged, disabled and require one or more waiver services in order to function in the community. The participant exercises freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. Services provided in this waiver compliment the State plan services already provided for Medicaid eligible beneficiaries.

A waiver participant may select any willing provider, provided they meet the Division of Medicaid's provider requirements, to furnish waiver services included in the service plan. This waiver provides a variety of services including personal care services, homemaker services, medication oversight, medication administration (to the extent permitted under state law), social and recreational care, intermittent skilled nursing services, transportation and therapeutic needs as specified in the plan of care.

Services are provided in a home-like, residential or community living environment. Personal assistance and supervision is provided twenty-four (24) hours a day to meet scheduled or unpredictable needs in a manner that promotes maximum dignity and independence while meeting the safety and welfare needs of the waiver participants. Other individuals or agencies may also furnish care directly, or under agreement with the facility but may not provide services in lieu of those furnished under this waiver. The waiver does not include the costs of room and board expenses for waiver participants. Room and board expenses must be met from participant resources or through other venues.
The Assisted Living Waiver is administered and operated by the Long Term Care Bureau of The Division of Medicaid (DOM). DOM exercises full responsibility of developing policies, procedures, rules and regulations for the administration of the program.
Case Management is an administrative function provided by DOM to assist the waiver participant and/ or their designee by thoroughly assessing the waiver participant to determine the participant's preferences, needs, and goals. Once the assessment is completed, the case manager works with the waiver participant and/or his designee to develop a plan of care that best meets their needs and preferences using waiver and non-waiver services regardless of the funding. The main objective of the case management service is to assure the waiver participant receives consistent quality of care while avoiding unnecessary or premature institutionalization.

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:
Public input about the Assisted Living Waiver and its operation is constantly sought and obtained by the Division of Medicaid (DOM). Staff from DOM attend and present at workshops and training venues which allows and encourages a means of generating input from a variety of sources. In fiscal year 2012, DOM developed a learning collaborative group consisting of representatives from all areas of health care that come together to work on various issues and topics related to our elderly and disabled populations. A large component of this learning collaborative consists of a group of stakeholders with a depth of knowledge and expertise that assist with and make recommendations for waiver renewals. A focus group comprised of providers and other interested parties was solicited and gathered to seek input regarding the scope and nature of services offered during the development of this renewal document. Direct input from waiver participants and their representative parties was solicited throughout the development of this waiver renewal proposal. Input received directly guided the development of waiver changes. Input regarding the overall costs of facility operation was solicited from various providers and was used as a basis for determining a fair reimbursement rate for services provided by this waiver.
Group meetings consisting of representatives from the Mississippi Department of Human Services, Mississippi Department of Health, Alzheimer's Association, Mississippi Health Care Association, various Assisted Living owners and operators and waiver case managers was held frequently to discuss proposed changes for the waiver as well as to seek their input.

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:	Ricks, RN, MSN
First Name:	Ann
Title:	Bureau Director/LTC
Agency:	Office of the Governor, Division of Medicaid
Address:	Walter Sillers Building, Suite 1000
Address 2:	550 High Street
City:	Jackson
State:	**Mississippi**
Zip:	39201
Phone:	(601) 359-6697 **Ext:** ☐ **TTY**
Fax:	(601) 359-9521
E-mail:	ann.ricks@medicaid.ms.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

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: Kristi Plotner

State Medicaid Director or Designee

Submission Date: Aug 23, 2013

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

Last Name: Dzielak

First Name: David

Title: Executive Director

Agency: Division of Medicaid

Address: 550 High Street

Address 2: Sillers Building #1000

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-9562 **Ext:** **TTY**

Fax: (601) 359-6294

E-mail: david.dzielak@medicaid.ms.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The transition plan includes allowing existing Assisted Living (AL) waiver providers ample time to allow their existing direct care worker staff the ability to receive the 40 hours of training as specified. Direct care staff hired prior to October 1, 2013 will have until December 30, 2013 to complete the 40 hours. All direct care workers hired on or after October 1, 2013 must receive the 40 hours of training and certification prior to providing care to waiver participants.
Facilities will have until January 1, 2014 to have trained ALL staff regarding, (a) Vulnerable Adults Act: Prevention of abuse, neglect and exploitation, (b) Resident Rights and Dignity, (c) Care of an Alzheimer's Resident, (d) Care of residents with Mental Illness and, (e) How to Deal with Difficult Residents. Any new staff hired on or after October 1, 2013 must receive this training at the time of hire.

Effective October 1, 2013, facilities are expected to supply normal daily personal hygiene items including at a minimum, deoderant, soap, shampoo, toilet paper, facial tissues, laundry soap and dental hygiene products.

Nurse aide abuse registry checks must be completed on all required staff hired before October 1, 2013 by January 1, 2014. All new employees hired on or after October 1, 2013, must have the Nurse Aide abuse registry checked at the time of employment.

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
   Bureau of Long Term Care
   (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:

   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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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
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 State's quality improvement strategy, provide information in the following fields to detail the State's 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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.

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 State's 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.
The State is the Administrative and Operating agency.

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	65		☑
	☑	Disabled (Physical)	21	64	
	☑	Disabled (Other)	21	64	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

For the five (5) slots specifically set aside for acquired traumatic brain injury participants, participants must be in a crisis/high stress situation at risk for institutionalization. These participants require 24 hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury. Acquired Traumatic Brain Injury is defined as a traumatically acquired non-degenerative structural brain damage. This term does not apply to brain injuries that are congenital or to brain injuries induced by birth trauma.

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:

The State does not employ a maximum age limit on the waiver participants. The web application did not allow us to check 'non applicable'.

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:

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:

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	900
Year 2	900
Year 3	1000
Year 4	1000
Year 5	1100

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	
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 participants from Nursing Home to Community
Residential Care for waiver participants with acquired traumatic brain injuries

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 participants from Nursing Home to Community

Purpose *(describe):*

Nursing home residents desiring to transition to the community/home setting have 25 Assisted Living slots per fiscal year available for that purpose. The State has an expectation that more waiver slots will be funded by the legislature and that potential waiver participants who reside in nursing homes will be able to be accommodated by the increased funding and corresponding increase in waiver capacity.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was based on transition practices for recent years.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4 (renewal only)	25
Year 5 (renewal only)	25

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):*

Residential Care for waiver participants with acquired traumatic brain injuries

Purpose *(describe):*

A limited number of slots (5) will be reserved for caring for those individuals with an acquired traumatic brain injury who are in a crisis/high stress environment with behavioral issues requiring services that if not for the supervision and care provided by this waiver, would require institutional care.

Describe how the amount of reserved capacity was determined:

The number of reserved capacity is based upon the identified number of individuals made known to the Medicaid Agency in need of such care. The reserved capacity is a baseline for initiating this service and may be reevaluated as the need for this service increases.

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

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4 (renewal only)	5
Year 5 (renewal only)	5

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:

Mississippi Administrative Code, Title 23: Medicaid, Part 208, Chapter 3: Home and Community Based Services Assisted Living Waiver Rule 3.1-3.11.

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**
- [x] **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:

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:

- [x] **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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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 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 4)

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 4)

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-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 an entity 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:

A licensed social worker performs the initial evaluation also known as the Pre-Admission Screening (PAS). The State has determined that a licensed social worker's qualifications and credentials are appropriate for the waiver's target population.
Qualifications for the social worker include:
1) Maintain an active, unencumbered and current license to practice social work in Mississippi
2) A bachelor's degree in social work from an accredited university and,
3) Two (2) years of full time experience in direct services to aged and disabled clients.

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.

An evaluation of level of care is provided to all waiver applicants for whom there is a reasonable indication that services may be needed in the future. The level of care of enrolled participants is reevaluated at least annually.

A comprehensive preadmission screening process is used to ensure the needs of the applicant/participant are fully captured. The process involves a collection of objective clinical eligibility criteria that is to be applied uniformly regardless of the current or future placement. The process allows applicants/participants found clinically eligible for long term care to make an informed choice between institutional and community-based services. It also supports transitions from an institutional setting into the community.

The State uses a Pre-Admission Screening (PAS) tool that encompasses activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. PAS data is entered into a scoring algorithm to generate a numerical score. The score is compared to a numerical threshold for eligibility, with those at or above the threshold deemed clinically eligible. Applicants/participants scoring below the

threshold may qualify for a secondary review by a DOM/LTC clinician before eligibility is denied. Applicant/participants also retain their customary appeal/Fair Hearing rights in accordance with Medicaid policy.

If an applicant/participant is denied waiver services based on failure to meet level of care eligibility, he/she will be notified of the reason for denial along with information and assistance if needed, to request and arrange for a fair hearing.

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 level of care of enrolled participants is reevaluated at least annually.
The comprehensive preadmission screening process is used in order to ensure that the needs of the applicants/participants are fully captured. The process involves a collection of objective clinical eligibility criteria that is to be applied uniformly regardless of the current or future placement. The process allows applicants/participants found clinically eligible for nursing facility level of care to make an informed choice between institutional and community-based services. It will also support discharges from the nursing facility, if the applicant/participant desires to move into the community. Additionally, the level of care is certified by a physician.
A scoring algorithm has been designed using an eligibility threshold per DOM policy. Applicants/participants scoring within the threshold will be deemed clinically eligible.

Applicant/participants also retain their customary Fair Hearing/appeal rights in accordance with Medicaid policy.

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:

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):*

The Division of Medicaid has manual and automated monitoring systems to ensure that a re-certification is completed timely. These procedures include:
1. Tickler files and
2. Edits in the computer system
The goal is 100% of participants are re-certified in a timely manner to avoid a lapse in service.

A re-certification is scheduled at least two months in advance to prevent any lapse in service due to overlooked recerts.

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 original participant's records are housed in the Division of Medicaid HCBS Bureau. If the PAS has been submitted electronically a copy will be housed in the case tracking subsystem of the Medicaid computer system. If the PAS is submitted via hard copy it is entered in the system and housed in case tracking. Each Division of Medicaid case manager is required to keep a copy of the entire document for the period of time specified under current federal guidelines.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
1) Number and percent of waiver applicants who receive a Preadmission Screening prior to the receipt of waiver services. Numerator: Number of waiver applicants who receive a Preadmission Screening prior to the receipt of services. Denominator: Total Number of applicants.

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

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**	☐ **Weekly**	☑ **100% Review**

Agency		
☐ **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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
2) Number and percent of waiver participants who receive a recertification screening within 365 days. Numerator: Number of participants who received a recertification screening within 365 days. Denominator: Total number of participants who received a recertification screening.

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

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: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
3) Number and percent of participants certified by a physician in less than 90 days prior to the expiration of the current certification. Numerator: Number of participants certified by a physician in less than 90 days; Denominator: Total number of participant recertifications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OmniTrack and MMIS (HCBS Certification Compared to End Date of Current Lock-In)

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:
4) Number and percent of participant's initial and recertification preadmission screenings where the criteria are accurately applied. Numerator: Number of participant's initial and recertification preadmission screenings where the criteria are accurately applied. Denominator: Total number of initial and recertification preadmission screenings reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Facility visits with specific questions from the preadmission screening tool that we will use to compare to the criteria applied by the case managers.

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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 State's 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.
Performance Measure (PM) 1): Upon discovery of non-compliance, correct documentation is obtained. The case manager conducts preadmission screening; Disenrollment is performed. If the individual is determined ineligible, the individual is dis-enrolled with a notice of appeal rights. Services will continue until appeal is completed. (Case managers would explore other State plan services as a possibility for care); Retract provider payment,

PM 2): 1.Upon discovery of a non-compliance, a PAS will be completed; 2. The case manager will submit a discharge notice but services will continue according to the plan of care until such time that the PAS is received, and/or explore other State plan services as an alternate means of care until re-enrollment is complete. The participant will receive a proper notice of discharge with instructions and assistance to request a hearing. The case will be worked by DOM as a new case. DOM will evaluate the recertification tracking process and modify as needed. DOM conducts training on recertification process.

PM 3): 1. Upon discovery of non-compliance, Re-certification cases are closed (the case manager must submit a new PAS); 2. DOM conducts Case Manager training on PAS process.

PM 4): 1. For non-compliance with the initial PAS, DOM will either pend the case or request a new PAS. (DOM reviews all initials) For recertification, the participant would be issued a notice of discharge along with notice of the right to appeal. Other State plan services would be explored for alternate services); 2. Speak with Supervisor to identify the issue and address with the Case Manager to determine redirection or training needs; 3. Provide one-on-one training on conducting the PAS.

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 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).

During the preadmission screening process, long term care program options, including institutuional care, waiver services and other State plan services, are explained by the case manager. The case manager assists in providing information to match the participant's care needs, strengths, and desires with DOM-covered long term care programs, to ensure the participants, and participant's family, are able to make an informed choice from the available DOM-covered options prior to the enrollment into the waiver program. The preadmission screening process requires the participant or their legal representative to sign and attest to their choice of long term care option on a Freedom of Choice document.

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 Case Managers maintain copies of the Freedom of Choice (Informed Choice) attestation and the signed listing of enrolled services providers in the original Assisted Living Waiver case management files at DOM. The records are retained for a period of six (6) years. They are available upon DOM request.

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. The subscribed interpretation service provides access in minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code.
A Limited English Proficient (LEP) Policy has been established. All essential staff has received training on the use of the Language Line Service. All necessary steps have been taken to ensure that 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 the LEP persons and to ensure that the language assistance provided results in accurate and effective communication between the Division of Medicaid and applicants/beneficiaries about the type of services and/or benefits available and about the applicants and/or beneficiaries 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
Other Service	Adult Residential for Care for Acquired Traumatic Brain Injury Participants
Other Service	Assisted Living

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:

Adult Residential for Care for Acquired Traumatic Brain Injury Participants

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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):*

These are bundled services provided in a residential environment to individuals with an acquired traumatic brain injury in the need of long term care services to avoid institutionalization. Services may include personal assistance or supervision for a period of twenty-four (24) hours continuously per day in a residential and community setting. This environment provides for a range of choices with personal preference, self-determination and dignity of risks receiving full respect and consideration. Services provide for an environment of peer support that is conducive to enhancing the functional abilities of the individual with a brain injury. The physical environment must be conducive to enhancing the functional abilities of the waiver participant. Necessary therapeutic services must be available as needed including, social work, behavioral services, speech therapy, physical therapy, occupational therapy, vocational services, cognitive activities, medication oversight or administration, transportation escort service, essential shopping, housekeeping service, laundry service, dining service and therapeutic recreational services. All therapeutic providers must be licensed under the state and if applicable, national boards. When provided to the participant, the above services are included in the comprehensive rate paid to the provider and the Medicaid agency will not be billed

separately. The provider agrees not to bill the waiver participant or their responsible party beyond what Medicaid has agreed to pay.
Nursing or skilled services are incidental rather than an integral to the provision of these services. A nurse must be available minimally 8 hours per day and must practice in accordance with the applicable nurse practice law and in accordance with acceptable standards of practice.
Escort service is defined as providing assistance accompanying or physically assisting a waiver participant who is unable to travel or wait alone for medical appointments.
An Acquired Traumatic Brain Injury means an insult to the brain, not of a degenerative or congenital nature, that may produce a diminished or altered state of consciousness, which results in an impairment of cognition abilities or physical functioning. It can also result in the disturbance of behaviors or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functioning disability, or psychosocial maladjustment.

Waiver participants in the Assisted Living waiver who are receiving services in the TBI-residential care facilities are eligible for Medicaid coverage of physical therapy, occupational services, speech therapy and behavioral services provided as part of the bundle of services included in a comprehensive rate. They will not be eligible for Medicaid coverage for physical therapy, occupational services and behavioral services outside of the waiver.
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	Adult Residential Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential for Care for Acquired Traumatic Brain Injury Participants

Provider Category:
Agency
Provider Type:
Adult Residential Care
Provider Qualifications

License *(specify):*
The entity providing services to the Acquired Traumatic Brain Injury (TBI) waiver participants must be a licensed entity deemed acceptable by the Division of Medicaid to meet minimum requirements specific for care of individuals with an acquired TBI. Each facility located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each licensed facility shall comply with all applicable state and federal laws including, but not limited to, Nursing Practice Laws and the laws governed by the Board of Pharmacy. Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the

applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law pursuant to 25 U.S.C. 1647(a)(2).

Training requiremnts
Certificate *(specify):*

Other Standard *(specify):*
.
Providers must provide:
1) A private living quarter with bath consisting of a toilet and sink,
2) Normal daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial paper, tissue, laundry soap and dental hygiene products,

Additional requirements:
1. The setting muse be integrated in, and facilitate the individual's full access to the greater community, including opportunities to seek employment and working competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities;
2. The setting is selected by the individual from among all available alternatives and is identified in the person-centered plan of care;
3. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
4. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;
5. Individual choice regarding services and supports, and who provides them, is facilitated;
6. Safety needs of an individual with dementia must be supported by a specific assessed need and addressed in the plan of care;
7. The waiver participant's unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement;
8. Each waiver participant has privacy in their sleeping or living unit:
a. Units have lockable entrance doors with appropriate staff having keys to doors;
b. Waiver participants share units only at the participant's choice; and
c. Participants have the freedom to furnish and decorate their sleeping or living units;
9. Waiver participants have the freedom and support to control their own schedules and activities and have access to food at any time;
10. Participants are able to have visitors of their choosing at any time;
11. The setting is physically assessable to the participant; and
12. The setting does not include:
a. A nursing facility;
b. An institution for mental diseases;
c. An intermediate care facility for the mentally retarded;
d. A hospital providing long-term care services; or
e. Any other location that have qualities of an institutional setting.

The Waiver provider must comply with the following standards:
1) Maintain a current, signed and dated copy of an admission agreement for each waiver participant. At a minimum, the agreement shall contain:
a) Basic charges agreed upon separating costs for room & board and personal care services,
b) Period to be covered,
c) List of itemized charges
d) Agreement regarding refunds for payments
The admission agreement must explain in detail the costs associated with and agreed upon for care services provided to the waiver participant. The costs for room and board must be clearly reflected in the agreement. At no time, should the facility charge the waiver participant for the costs of care services over and beyond the reimbursable amount paid by Medicaid.
The admission agreement must be approved by the Division of Medicaid prior to the provision of waiver services. Any new or amended admission agreement must be submitted and approved by Medicaid prior to implementation.
2) Must provide a licensed nurse at the facility at minimum, eight hours a day to assist the

participants with medication administration or oversight. The nurse must have an active and unencumbered license. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facilities must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate the Nursing Practice Law or Administrative Code in any manner.
3) Waiver providers must provide all staff with training upon hire in the following areas, but not limited to:
a) Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation
b) Rights and Dignity
c) Crisis Prevention and Intervention
d) Caring for Individuals with Dementia
e) Assisting with Activities of Daily Living
f) HIPPA Compliance
g) Stress Reduction
h) Behavior Programs
I) Recognition and Care of Individuals with Seizures
j) Rational/Behavioral Therapy
k) Elopement Risks
L) Safe Operation and Care of Individuals with Assistive Devices
m) Caring for Individuals with Disabilities
n) Safety
Care providers must have training in CPR and First Aid.
All program managers must be nationally certified as Brain Injury Specialist.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOM will verify the provider qualifications of each provider initially and ongoing.

Frequency of Verification:
Licensure verification will be accomplished on an annual basis.

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:
Assisted Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
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):*
Assisted Living services include personal care services, chore services, attendant care, medication oversight and administration (to the extent permitted under State Law), therapeutic, social and recreational programming, in an environment that is home like and provides the participant full access to the typical facilities in a home while providing for privacy and easy access to resources and unscheduled activities in the community. The setting allows for participants to have the opportunity for visitors at times of preference and convenience to them. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.
Nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled nursing care or supervision. Medicaid will neither reimburse the waiver participant nor the care facility for the cost of room and board.
Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units must have lockable doors with appropriate staff having keys. (This requirement does not apply where it conflicts with fire code). Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) which may also serve as living or dining rooms.
The waiver participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.
Attendant Call Systems are emergency response systems for participants who are at risk of falling, becoming disoriented or experiencing some disorder that puts them in physical, mental or emotional jeopardy requiring immediate assistance. The participant either wears an electronic device (e.g., a medallion or a bracelet) or is in proximity to a button that enables him or her to summon emergency help from an assisted living attendant. This component may also alert the attendant if the participant wanders from the facility.
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**
- [x] **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	Assisted Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Assisted Living
Provider Qualifications

License *(specify):*
Each Assisted Living waiver provider must be licensed in accordance with the regulations of the Mississippi Department of Health-Health Facilities Licensure and Certification-Minimum Standards for Personal Care Homes Assisted Living or other licensing entity as deemed acceptable by the Division of Medicaid. Every licensed facility located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each licensed facility shall comply with all applicable state and federal laws including, but not limited to, the Mississippi Nursing Practice Law and the Laws governed by the Mississippi Board of Pharmacy. Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law pursuant to 25 U.S.C. 1647(a)(2).

Based on the Mississippi Board of Nursing Administrative Code, Part 2830 Chapter 2: Functions of the Licensed Practical Nurse
Rule 2.1 LPN Supervision: The LPN gives nursing care under the direction of the RN, advanced practice registered nurse (APRN), licensed physician.

Certificate *(specify):*

Other Standard *(specify):*
The Assisted Living Waiver provider must comply with the following standards:
1) Maintain a current, signed and dated copy of an admission agreement for each waiver participant. At a minimum, the agreement shall contain:
a) Basic charges agreed upon separating costs for room & board and personal care services,
b) Period to be covered,
c) List of itemized charges
d) Agreement regarding refunds for payments
The admission agreement must explain in detail the costs associated with and agreed upon for care services provided to the waiver participant. The costs for room and board must be clearly reflected in the agreement. At no time, should the facility charge the waiver participant for the costs of care services over and beyond the reimbursable amount paid by Medicaid.
The admission agreement must be approved by the Division of Medicaid prior to the provision of waiver services. Any new or amended admission agreement must be submitted and approved by Medicaid prior to implementation.
2) Must provide a licensed nurse at the facility at least eight hours a day to assist the residents with medication administration or oversight. The nurse must have an active and unencumbered license. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facility must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate the Mississippi Nursing Practice Law or Administrative Code in any manner.
3) Assisted Living Waiver providers must provide all staff with training upon hire and annually thereafter in the following areas:
a) Vulnerable Persons Act: Prevention of abuse, neglect and exploitation
b) Resident Rights and Dignity
c) Care of an Alzheimer's Resident
d) Care of residents with Mental Illness
e) How to Deal with Difficult Residents
The Assisted Living waiver provider will maintain evidence of this training on file and easily

accessible per request of the Division of Medicaid staff.
4) Must assure that each direct care staff successfully completes 40 hours of course curriculum as identified by the State as a requirement prior to providing care to waiver participants. Documentation of completion of this course work must be maintained at the facility and be made available to the Division of Medicaid upon request.
Failure of the facility to comply with training requirements will require an acceptable plan of correction by the facility. Continued noncompliance will result in suspension of referrals until successful completion of training requirements are met.
5) Must keep accurate documentation that reflects the care and services provided to the participant while in the facility. The record should clearly demonstrate when the resident leaves the facility for an overnight stay, whether it be for a hospitalization, visit with the family or any other occasion. This documentation is vital for Medicaid to reimburse for care. Failure to maintain the documentation may result in recoupment of funds by the Division of Medicaid.
6) Must maintain compliance with all requirements, regulatory rules and regulations and administrative codes as specified by the licensing agency. If a facility fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the facility demonstrates compliance with the regulatory agency. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the DOM.
7) Must supply at a minimum, normal, daily personal hygiene items including a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. The waiver participant may choose to bring in his or her own personal products or band name products.

Verification of Provider Qualifications

Entity Responsible for Verification:
Mississippi Department of Health Facilities Licensure and Certification
Minimum Standards for Personal Care Homes Assisted Living and other licensing entity as deemed acceptable by DOM. The license shall be posted in a conspicuous place on the licensed premises and shall be available for interested persons. The license is not transferable or assignable to any other person except by written approval of the licensing agency.

Frequency of Verification:
Each licensed facility shall be inspected by the licensing agency or by persons delegated with authority by said licensing agency at such intervals as the licensing agency may direct. The Division of Medicaid reviews the licensure status of the facilities on an annual basis or more often if necessary to assure maintenance of a current, active license.
The facility must submit to DOM a current copy of the renewed license annually.

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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Licensed social workers employed by the Division of Medicaid.

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):

SOURCE: Mississippi Code of 1972, Section §43-11-13

Pursuant to Section § 43-11-13, Mississippi Code of 1971, the Assisted Living providers are required to perform a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary actions have been taken against the employee by the agency, and a criminal history record check on:
(a) Every new employee of a covered entity who provides direct care or services and who is employed on or after July 01, 2003, and
(b) Every employee of a covered entity employed prior to July 1, 2003, who has documented disciplinary action by his or her present employer;
No employee hired on or after July 1, 2003, shall be permitted to provide direct care until the results of the national criminal background check have revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.
If such criminal history record check discloses a felony conviction, a guilty plea, and/or a plea of nolo contendere to a felony for one or more of the following crimes which have not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be eligible to be employed by the facility.
a) possession or sale of drugs
b) murder
c) manslaughter
d) armed robbery
e) rape
f) sexual battery
g) sex offense listed in Section 45-33-23 (g), Mississippi Code of 1972
h) child abuse
i) arson
j) grand larceny
k) burglary
l) gratification of lust
m) aggravated assault
n) felonious abuse and/or battery of vulnerable adult

Pursuant to Section § 43-11-13, Mississippi Code of 19972, a criminal background is waived for those employees of an assisted living provider employed prior to July 1, 2003. For these employees, the provider must have a signed affidavit stating that he or she does not have a criminal history as specified above. Proof of this affidavit must be kept on file in the employee's personnel file as proof of compliance.
Waiver providers are responsible for ensuring that mandatory disciplinary investigations, affidavits and criminal background checks are completed accordingly as part of the licensing process. The provider assures that fingerprints are submitted to the licensing agency whereby they are electronically submitted to the Federal Bureau of Investigations and the Mississippi Criminal Information Center. If there is a potential conviction, the licensing agency sends a letter of notification to the provider. A copy of the record of arrest and prosecution (RAP) is sent to the potential employee. The provider reconciles the RAP sheet with the employee to determine if employment is permit able. Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of the national criminal background

check must be on file and maintained by the provider. The state licensing agency conducts annual reviews as part of an onsite inspection to assure compliance with this mandatory requirement. Additionally, the Division of Medicaid conducts annual compliance audits to confirm compliance.
The assisted living provider may, in its discretion, allow any employee unable to sign the affidavit as required above or any employee applicant aggrieved by the employment decision under this section to appear before the provider to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed. The provider may grant waivers for those mitigating circumstances, which shall include, but not limited to: (1) age at which the crime was committed: (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the waiver participants in the facility.
The entity must comply with the above and all other regulatory requirements as specified related to criminal history record checks as specified in the Minimum Standards For Personal Care Homes Assisted Living, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification.
Additionally, the Assisted Living waiver providers must check the Office of Inspector General Exclusion list prior to employing the individual to assure that no employee of the provider is named on this list and is prohibited from employment in a Medicare or Medicaid funded entity.
Assisted Living waiver providers must have a policy that fully states the agency's practice in assuring that safeguards are in place to protect the well-being of waiver participants.

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):

The entity responsible for maintaining the Mississippi Nurse Aide abuse registry is the Mississippi Department of Health, Division of Licensure and Certification. The types of positions for which abuse registry screenings must be conducted include any individual providing direct care or supervision to the residents, owners, operators, and transportation drivers. The facility must assure that the Mississippi Nurse Aide Abuse Registry is checked prior to employment of the above mentioned employees. The facility must maintain documented evidence in the personnel files of each employee to demonstrate to the Division of Medicaid that such checks have been made. The Division of Medicaid ensures that mandatory screenings have been conducted by verification of documented evidence found during the on-site annual compliance review. Part of the on-site monitoring process includes reviewing personnel records of staff providing services. One of the elements reviewed is whether the abuse registry screening was conducted and returned indicating no history of abuse before the staff person began providing services. If it is found that an abuse registry screening was not conducted for a particular staff member or member(s), the staff member(s) are prohibited from providing services and the provider is required to develop a corrective action plan. The maximum length of time for the submission of a corrective action plan is 30 days, which may be altered by the Division of Medicaid given the nature and severity of the concern. Plans must demonstrate how the provider will correct the negative finding as well as address any systematic issues with timelines for each remedial activity. The Division of Medicaid (DOM) staff reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DOM requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Personal Care Home - Assisted Living	
Adult Residential Care Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

A home-like character is maintained in the assisted living or adult residential facilities that can be owned, rented or occupied under a legally enforceable agreement by the waiver participant, and the participant has, at a minimum, the same resposnibilities and protections from eviction that tenant have under the landlord/tenant law of the State, county, city or other designated entity.
The facility must maintain a living environment which is supportive of the participant to exercise their rights to:
1) attend religious and other activities of their choice;
2) the right to manage own personal financial affairs, or receive a quarterly accounting of financial transactions made on their behalf;
3) not be required to perform services for the facility;
4) communicate with persons of their choice, and may receive mail unopened or in compliance with policies of the facility;
5) be treated with consideration, kindness, respect and full recognition of their dignity and individuality;
6) may retain and use personal clothing and possessions as space permits;
7) voice grievances and recommend changes in licensed facility policies and services;
8) not be confined to the licensed facility against their will, and shall be allowed to move about in the community at liberty. Physical and/or chemical restraints are prohibited; and
9) not be limited in their choice of a pharmacy or pharmacist provider in accordance with State law;
10) decide when to go to bed and get up in the morning;
11) privacy in their sleeping or living unit (Participants may share units only at the participant's discretion);
12) furnish and decorate their sleeping or living space;
13) freedom and support to control their own schedules and activities;
14) have access to food at any time;
15) have visitors of their choosing at any time;
16) have meals available over long periods of time or allows the participant to decide when to eat his or her meal; and
17) have lockable entrance doors, with appropriate staff having keys to the doors.

The facility setting is physically accessible to the waiver participants.

The facility must supply normal, daily personal hygiene items including at minimum, deodorant, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. The waiver participant may choose to bring in his or her own personal products or brand name products. Waiver participants are encouraged to use their own personal belongings and furniture in the personal care home.
Nutritious snacks must be available at all times. The dining room must be available for congregate meals and socialization. Participants choose their own physician.
This waiver service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Personalized care is furnished to participants who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. Waiver participants may lock their rooms unless a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. This requirement does not apply where it conflicts with fire code. Each living unit is separate and distinct from each other. The participant retains the right to assume risk,

tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and must treat each person with dignity and respect. Assisted Living waiver services also include medication administration, transportation specified in the plan of care and attendant call systems. Attendant call systems are emergency response systems for waiver participants who are at risk of falling, becoming disoriented or experiencing some disorder that puts them in physical, mental or emotional jeopardy requiring immediate assistance. The waiver participant either wears an electronic device (e.g. a medallion or a bracelet) or is in proximity to a button that enables him or her to summon emergency help from an assisted living attendant.
Assisted living services may also include intermittent skilled nursing services. However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision.
Prior to, or at the time of admission, the operator and the waiver participant or the participant's responsible party shall execute in writing a financial agreement. This agreement shall be prepared and signed in two or more copies, one copy given to the participant or the responsible party, and one copy placed on file in the facility. At a minimum, the agreement shall contain specifically:
1) Basic charges agreed upon separating costs for room and board and personal care.
2) Period to be covered in the charges
3) Services for which charges are made
4) Agreement regarding refunds for any payments made in advance,

In addition to an admission agreement, Specific to Subchapter 12, Rule 47.12.1, of the Mississippi Administrative Code, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification, the Assisted Living Facilities must have admission and discharge criteria that must be applied and maintained for the protection of rights for waiver participant placement and continued residence in a licensed facility.

Based on Title 23, Part 200: General Provider Information, Chapter 3, Rule 3.8 (a) of the Mississippi Division of Medicaid Administrative Code, facilities that have agreed to be a Medicaid provider for this waiver, are expected to bill Medicaid for covered services and accept Medicaid payment in full for said services. Medicaid participants in assisted living facilities may not be held liable for billed charges above the Medicaid maximum allowable for care services. Rule 4.2(A) (9), Conditions of Participation, further states that, “The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary’s service limits…” participants should not be required to make payments on charges for services covered by Medicaid. Regardless of what is agreed upon between the facility and the waiver participant or their representative, the facility cannot bill waiver participants additional fees for care services over and above the current reimbursable rate. Waiver participant room and board rates must not fluctuate on a monthly basis due to less Medicaid reimbursable service days. The admission agreement must clearly distinguish between the room and board rate and the care service costs.

ANY CHANGE in the fee agreement must be approved by the Division of Medicaid before executed with the waiver participant.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home - Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	☐
Assisted Living	

	☑

Facility Capacity Limit:

Mississippi Department of Health - Minimum Standards for Personal Care Homes Assisted Living. The maximum number of beds for which the facility is licensed shall not be exceeded.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	☑
Assisted Living	☑

Facility Capacity Limit:

The maximum number of beds for which the facility is licensed shall not be exceeded.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

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:

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:

With respect to the waiver participant's free choice provisions, the Division of Medicaid (DOM) allows for a continuous, open enrollment period for Assisted Living waiver providers. The DOM website has information regarding the requirements and procedures for becoming a DOM approved provider allowing for continuous availability. The DOM, Bureau of Long Term Care has a designated staff member available to provide assistance and guidance regarding the Assisted Living waiver provider application process. Provider proposal packets are available upon request

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: 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/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
1)Number & percent of new provider applications for which the provider obtained appropriate licensure in accordance with waiver provider qualifications prior to service provision. N: Number of new provider applications for which the provider obtained appropriate licensure in accordance with waiver provider qualifications prior to service provision. D: Total number of new provider applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS/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:
2) Number and percent of providers continuing to meet applicable licensure following initial enrollment. Numerator: Number of providers continuing to meet applicable licensure following initial enrollment. Denominator: total number of enrolled licensed providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
3) Number and percent of enrolled Assisted Living waiver providers meeting provider training requirements. Numerator: Number of enrolled providers meeting provider training requirements. Denominator: Total number of enrolled

providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 State's 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.

PM 1 a) Medicaid provider numbers are not issued without verification of licensure; b) The State obtains a copy of the current and active license prior to issuing a Medicaid provider number; c)If the provider cannot supply a copy of current licensure, the provider is notified their application is denied.

PM 2) a) Request a correction application plan; b) Monitor the implementation of the corrective action plan to determine correction of problems; c) If the correction action plan is not followed, the provider will receive notice of revocation of the provider number; d) if closure is necessary, transition residing waiver participants to other approved providers of their choice

PM3) when training requirements are not met, DOM will require the AL facility to establish and implement a corrective action plan. Until such time the correction action plan is completed satisfactorily, DOM will suspend referrals to the facility. With continued noncompliance with training requirements, DOM may suspend or revoke a provider number.

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 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-3: 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

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:

- ☑ **Social Worker.**

  Specify qualifications:

  The Division of Medicaid Case Manager is a BS prepared social worker who is licensed to practice in the State of Mississippi and has at least two (2) years of full-time experience in direct services to elderly and disabled clients.
- ☐ **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.

The Division of Medicaid (DOM) provides case management to the waiver participants in this waiver. The case manager strives to get the waiver participant, and if desired, a chosen representative meaningfully and actively engaged in the development of the plan of care. Prior to admission to the waiver, the case manager provides the participant or his or her representative, information regarding all services and waiver providers. The participant or his or her representative makes an informed choice between receiving long term care services in an institutional setting or waiver services in the home and community residential setting. They also choose the assisted living facility where they want to reside. Once the participant has made an informed choice for waiver services, the case manager assesses for functional eligibility. When it is determined that the participant meets both functional and financial eligibility, the case manager works with the waiver participant and if so desired, his or her representative to develop a plan of care that best meets the participant's needs, goals and personal preferences. The participant is actively involved in developing the plan of care and also has the authority to engage responsible parties or others to help as desired.

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 State uses a comprehensive preadmission screening process to ensure that the plan of care is participant-centered and that it fully captures the waiver participant's needs, strengths, preferences, goals and risk factors. The preadmission screening tool is a collection of objective clinical eligibility criteria that is applied uniformly. Incorporated in the preadmission screening process is a mechanism to assure the waiver participant makes an informed choice between institutional and community-based services. The preadmission screening process supports nursing facility transition into the community.

A DOM case manager, who is a licensed social worker, the waiver participant, their caregivers and or others chosen by the participant, collectively work to identify the participant's personal goals, health care needs and preferences. The case manager is responsible for informing the waiver participant and others chosen by the participant, about State Plan services and other programs furnished through other State and Federal programs. The case manager coordinates waiver services and non-waiver services to meet the needs of the waiver participant.

The case manager is responsible for continued and ongoing monitoring of the waiver participant's needs and effectiveness of the plan of care. The plan of care is reevaluated on a regular basis with monthly contacts. However, a quarterly review of the plan of care is required. If a change in the plan of care is warranted or desired by the waiver participant, the waiver participant and other persons of their choice will confer with the case manager to identify potential changes. The plan of care is updated annually or more frequently based on the individual needs, desires and

goals of the waiver participant. Informed Choice is assured by the case manager by informing the waiver participant and/or person of their choice of the available Medicaid-covered long term care options, including alternatives to Nursing Facility placement. The waiver participant acknowledges their participation in the care planning process by signature or initials and attests to having the long term care program options explained to him/her.

The care plan development meetings are scheduled at times and locations that are convenient for the waiver applicant/participant and or their representative. Upon initial enrollment into the waiver, the case manager contacts the applicant and or their designated representative via telephone to schedule a convenient time and meeting location. This contact is made immediately upon notice of an available waiver slot. At the time of recertification, the case manager notifies the waiver participant and or their designated representative at least a month prior to the recertification deadline to schedule a convenient time and meeting location.

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.

Risks are assessed based upon the following processes:
Upon initial enrollment into the waiver, the Case Manager meets with the participant and/or designated responsible parties and representatives to identify and/or confirm the presence of or potential for risks. A risk assessment tool is used to capture the specific risks as related to the community living, health, work and, leisure. The risk assessment tool captures:
a) What is the teams (Case Manager, provider and designated parties) evaluation of the risks?
b) What can be done differently to prevent these risks?
c) What strengths/assets does the participant have toward prevention?
d) Who can help with prevention measures?
e) What supports would minimize the risks?
f) Who can provide the supports?
A person centered approach is developed with particular regard to the waiver participant's needs, goals and preferences. Following enrollment into the waiver, the manager continues assessing for risks during the monthly and quarterly visits.
The identified risks are addressed through the coordination with the Assisted Living waiver provider, the participant and others, as designated, being fully involved in developing measures to resolve and manage apparent risks and to reduce their future risk development. Participant-specific risk plans proactively and reactively address the risk issue. Annually, the person centered plan of care is reevaluated during the recertification process and updated accordingly to needs identified during the risk assessment.
It is the Case Managers responsibility to monitor participant's' risk. Case Managers are evaluated based on their documentation on their participants. This includes evaluations of how case managers followed up on incident reports, and review of information gathered from case managers' routine visits, where they will have reviewed and how providers are implementing a participant's risk management plans.

Risk factors to be considered are:
1. Abuse, neglect and exploitation.
2. Deviant behavior from that which is commonly regarded as acceptable by societal norms. These specific behaviors are wandering, inappropriate sexual behavior, assaultive behavior, and resistance to physical care. This also includes "thought impairment" such as hallucination, delusion, or suicidal ideation that is not related to a severe and persistent mental illness.
3. The inability to communicate information in a manner that is understandable.
4. Incontinence that is, unable to control his/her body to empty the bladder and/or bowel with the inability to self-manage related needs.
5. Falling or has fallen at least twice in the past 60 days resulting in injury which required physician treatment or hospitalization.
6. Inability to manage hydration or nutritional needs.
7. A history of the waiver participant having placed him/herself at risk through an action or inaction which resulted in Adult Protective Services or law enforcement referral, hospitalization, increased service need, or decrease in physical or mental capability.
8. The participant lacks a network of caring friends/relatives/neighbors/staff or non-waiver providers who are

physically, mentally, and psychologically able and willing to provide any care or support.
Strategies to mitigate risk are incorporated into the plan of care, subject to participant needs, goals and preferences.

Back up plans are developed on an individual participant basis. Back up risk mitigation must include staffing requirements for 24 hour coverage as outlined in state Administration Code, Minimum Standards for Personal Care Homes, Assisted Living, Title 15: Mississippi State Department of Health , Part 3: Office of Health Protection, Subpart1: Health Facilities and Certification:

The following staff ration shall apply:
One (1) resident attendant per fifteen (15) or fewer residents for the hours of 7:00 a.m. until 7:00 p.m.
One (1) resident attendant per twenty-five (25) or fewer residents for the hours of 7:00 p.m. until 7:00 a.m.. There shall be designated, in writing and posted in a conspicuous place, on call personnel in the event of an emergency, during this shift.
There shall be, at minimum, a licensed nurse on the premises for eight (8) hours a day. Licensed nurses, cannot be included in the resident attendant ration. Licensed practical nurses must furnish care in accordance with the Mississippi Nurse Practice Law in regards to required supervision.

The assisted living waiver provider must also have disaster preparedness and management procedures to ensure that waiver participant's care, safety, and well- being is maintained during and following instances of natural disasters, disease outbreaks, or similar situations.

In the event of closure of an Assisted Living waiver provider, the Division of Medicaid, the participants and their designated representatives, and the licensing agency will work collaboratively to arrange for appropriate transfer of waiver participants to other Medicaid approved providers.

Upon admission to the waiver and during the annual re assessment, the case manager documents who should be notified in the case of an emergency, disaster or when there is an unforeseen need for back up arrangements. Additionally, the case managers keep a list of other available Medicaid approved providers easily assessable and of preference to the waiver participant. This information is included in the overall plan of care to have available in the need for back up and this information is added to the plan of care.

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.

The waiver participant and/or others as chosen by the waiver participant, are given a list of qualified providers. They, along with the case manager, review the list to determine which provider would best meet the needs, goals and desires of the waiver participant. The waiver participant and/or their other chosen party is given an opportunity to meet the provider prior to the selection in order to make a more informed choice. Once all the options are taken into consideration the waiver participant and/or chosen party selects the provider they feel best meets the needs of the participant. On an ongoing basis, the case manager provides ready access to information about qualified providers. When a participant selects a company that is owned and/or operated by a family member, the services may be delivered if the family member who owns and/or operates the company is not normally considered a caregiver nor is legally responsible for the participant.

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):

Prior to submitting the proposed plan of care to the Division of Medicaid for review and approval, the participant and or their chosen parties, the Assisted Living waiver provider staff and the case manager, discuss all of the available options, the specific needs, goals and desires of the participant, and how the needs can be addressed and met. Once this collaboration occurs, the plan of care is forwarded to the Division of Medicaid electronically for the review and approval process. Once the plan of care is approved by DOM qualified staff, a letter of approval is forwarded to the case manager. The case manager is required to make monthly contacts with the participant and/or responsible party

and quarterly face-to-face visits to the participant in the Assisted Living facility.
Each participant is given contact information of the case manager for the participant or his or her designee if they have any questions or concerns regarding their services or care.

The Division of Medicaid exercises oversight of plans of care on a routine basis through the monthly and quarterly review process conducted by the case managers.

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):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

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 plan of care is the fundamental tool by which the State assures the health and welfare of waiver participants in the Assisted Living waiver. The State's process for developing a waiver participant's plan of care requires the plan to be based on a comprehensive preadmission screening process which identifies the needs, preferences and goals for the participant. The approved waiver specifies that a licensed social worker in conjunction with the waiver participant and others as requested by the participant are jointly responsible for plan of care development. Plans of care are reviewed and approved by a licensed registered Medicaid Program Nurse at the Division of Medicaid.
Monthly contacts with the waiver participants by the case manager are conducted to determine the appropriateness and effectiveness of the waiver services and to ensure that the services furnished are consistent with the participant's needs, goals and preferences. A monthly contact with the waiver participant provides oversight for utilization review to determine if services are provided in accordance with the plan of care. The minimum time frame for conducting the face-to-face interview is every 3 months. The quarterly visit is to ensure that services are on-going and also to identify any problems or changes that may be required.
If implementation of the plan of care is in question during the monitoring process, the DOM reviewer will follow up

with the appropriate case manager and/or supervisor to resolve issues. If a systematic problem is identified, DOM will review the policies and procedures to determine how best to intervene and rectify the problem. Resolution may require a change in policy or possibly can be corrected through training and education.

On an ongoing, continuous basis, the case managers are evaluating and monitoring the implementation of the plan of care as well as service delivery. Case managers are sensitive to waiver participant's right to exercise their free choice of providers and will counsel and assist the participant when or if they choose to change assisted living providers. Likewise, case managers monitor the back up plans and access to non-waiver services in the state plan on an ongoing basis to assure the participant's welfare is maintained and their needs are met. When non waiver service needs are identified, such as, the need for diapers or medical equipment, it is the case manager's responsibility to assist the participant in meeting these needs through the State Plan coverage or other available resources. The case manager assures the participant is knowledge of services that are available through the State Plan or other resources.

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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 participants whose plans of care address their needs, including health & safety risk factors, based on the preadmission screening or recertification. Numerator: Number of participants who have plans of care that address their needs. Denominator: Total number of participants' plans of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OmniTrack for the PAS and then DOM Nurses compare the plan of care to the PAS as part of the "up front" 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 =
☐ **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:

2): Number and percent of participants whose plans of care that addresses personal goals. Numerator: Number of participants whose plan of care addresses personal goals Denominator: Total number of participant's' plans of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OmniTrack for the PAS and then DOM Nurses compare the POC to the PAS as part of the "up front" 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 =
☐ **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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
3): The number and percent of participant's plans of care where the individual's signature indicates involvement in the POC development. Numerator: Number of participant's plans of care with signature indicating involvement in POC development; Denominator: Number of participant's POCs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OmniTrack for the PAS then DOM Nurses compare the POC to the PAS as part of the "up front" 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 =
☐ **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:
4)The number and percent of plan of care quarterly updates are performed in according to the waiver application. Numerator: Number of plan of care quarterly updates that are performed according to the waiver application. Denominator: Total number of plan of care quarterly updates reviewed.

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

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 participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
5) Number and percent of participant's plans of care that are updated annually.
Numerator: Number of participant's plans of care that are updated annually;
Denominator: Number of participant's plans of care reviewed.

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

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:
6) Number and percent of participant's plans of care that are revised when individual's needs change. Numerator: Number of participant's plans of care revised when individual's need change; Denominator: Total number of participant's plans of care reviewed with a change in need.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Reviewed by DOM staff

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
7) Number and percent of participant who received services in accordance with the plan of care including in the type, scope, amount, duration and frequency.
Numerator: Number of participants who received services in accordance with the plan of care; Denominator: Number of participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
CM monthly and quarterly visits

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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
8) Number and percent of participant's informed choice forms with signature indicating choice between institutional care and the waiver. Numerator: Number of participant's informed choice forms with signatures indicating choice between institutional care and the waiver. Denominator: Number of participant's plan of care reviewed

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

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:
9)Number and percent of participant's freedom of choice forms with signature indicating choice of providers. Numerator: Number of participant's freedom of choice forms with signature indicating choice of providers; Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Compliance audit and internal 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 =
☐ **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 State's 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.

PM 1) The case will be pended until such time the CM can accurately and completely develop the plan of care. DOM will ask the CM to complete the POC accurately. Once the POC is complete, DOM Nurses will review the POC for approval; DOM will determine if the negative finding is an isolated problem or if it is more systemic in nature. If the issue is isolated to one case manager, one on one training will occur. If a systemic issue is identified, DOM will reevaluate the policies and make changes as necessary. Additionally, wide spread training will be conducted for all case managers and supervisors.

2) The case will be pended until such time the CM can accurately and completely develop the plan of care. DOM will ask the CM to complete the POC accurately. Once the POC is complete, DOM Nurses will review the POC for approval; DOM will determine if the negative finding is an isolated problem or if it is more systemic in nature. If the issue is isolated to one case manager, one on one training will occur. If a systemic issue is identified, DOM will reevaluate the policies and make changes as necessary. Additionally, wide spread training will be conducted for all case managers and supervisors.

3) The case will be pended until such time the CM can accurately and completely develop the plan of care; DOM will determine the scope and severity of the negative and address accordingly with training, either one on one or with all case managers.

4) If a negative finding demonstrates a quarterly review was omitted, the case manager will immediately complete the update. DOM will evaluate the finding to determine if it is an isolated event or system wide problem. One on one training or all will be trained depending on the scope and severity of the problem.

5) Case managers will be held accountable for failure to complete plan of care timely. If the lack of timely updating is determined to be a fault of the case manager failing to perform this function timely, the waiver participant's services will not be interrupted. DOM processes will be reviewed to determine if there is a need to revamp the procedures surrounding assurance of timely updating plans of care.

6) Case manager will accurately revise the plan of care to reflect that the participant's needs are being met. The case manager will receive training on a one to one basis.

7) DOM will intervene immediately to assure the participant's needs are met and services are delivered in accordance with the plan of care. DOM will evaluate to determine the cause of the failure to deliver services. Case managers will be trained on the importance of assuring the services on the plan of care are delivered as directed.
8) DOM will determine if the CM failed to provide the information to the participant or if the CM just failed to have the appropriate form completed. If the CM failed to provide the participant with the appropriate information for the informed choice, the CM will be held accountable and reprimanded accordingly. DOM will provide counseling and training necessary to avoid the reoccurrence of this negative finding. If the CM just failed to have the form completed, but there is evidence the participant was indeed given appropriate information to make a sound choice, DOM will have the CM have the appropriate form completed as required.

9) DOM will require the same steps of remediation for this negative finding as documented in #8.

Systemically, if the quality assurance reviews reveal negative findings in the area of Service Plan, DOM will evaluate to determine if the finding is isolated, a pattern or systemic. Based on the scope and severity of the finding, DOM will take action to reevaluate the agency's procedures and adjust accordingly. Training will be provided based on how widespread the issue reaches. Training may be on a one to one basis or if warranted, all case managers will be trained. DOM will constantly reevaluate the system to assure the waiver participants receive a plan of care that assuredly meets their needs, preferences and goals.

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.

The opportunity to request a fair hearing is fundamentally protected by the Division of Medicaid in all of the following instances:
(1) When participants are not provided the choice of home and community based services as an alternative to institutional care,
(2) When waiver participants are denied the service(s) of their choice or the provider(s) of their choice, and
(3) When the waiver participant's services are denied, suspended, reduced or terminated.
Waiver applicants or participants will be informed in writing of the procedures for requesting a fair hearing as part of the waiver enrollment process. Fair Hearing procedures are based on the Mississippi Division of Medicaid's Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process A case manager sends a Notice of Action (NOA) to the waiver participant by certified mail (Signature return requested).
Contents of Notice of Action include:
(1) Description of the action the provider has taken or intends to take
(2) Explanation for the action
(3) Notification that the participant has the right to file an appeal
(4) Procedures for filing an appeal
(5) Notification of participant’s right to request a Fair Hearing, and
(6) Notice that the participant has the right to have benefits continued pending the resolution of the appeal
(7) The specific regulations that support, or the change in Federal or State law that requires the action
The participant or his 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 participants to request a local hearing first. The request for a state or local hearing must be made in writing by the participant or his legal representative. The participant may be represented by anyone he/she designates. If the participant elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the participant has designated them as the participant’s representative and the participant has not provided written verification to this effect, written designation from the participant regarding the designation must be obtained.

The participant 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 participant can show good cause for not filing within 30 days.
A hearing will not be scheduled until a written request is received by either the case manager or 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.
The participant or their 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 participant'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 participant or service providers. Upon receipt of the request for a state hearing, the DOM's Bureau of Administrative Appeals will assign a hearing officer.
Waiver participants may be discharged from the waiver for the following reasons:
(1) The participant and/or their legal representative requests termination;
(2) After intervention is provided, the participant refuses to be served;
(3) The participant has been found to no longer meet the program eligibility criteria;
(4) The participant is not available for services at the Assisted Living waiver provider facility for more than thirty (30) days. This is usually the case when a participant enters a Medicaid covered institution or when a participant leaves the assisted living provider for more than thirty days at a time;
(5) The participant is a threat to him/herself or others;
(6) The participant is in a hazardous environment that is found to be unsafe for the participant and or caregivers. When it is found to be an unsafe environment for the participant, the State notifies the Mississippi State Department of Health Facilities Licensure and Certification Division, the State Attorney General's Office and the Department of Human Services to assist with an investigation and to seek a safer environment for the participant. The case manager is the first line of contact with the participant and these cases are reported to Division of Medicaid and consideration of a decision to terminate services is ultimately the responsibility of DOM.

Any participant considered for termination from the waiver is provided written notification of the decision, the right to appeal and the procedures for requesting an appeal through the state Medicaid program.
If the participant/representative disagrees with the decision of the local level, they must submit a written request to appeal the decision to Division of Medicaid at the state level. The request must be received by Division of Medicaid within 30 days of the mailing date of the notice of action. If no request to appeal the notice of action is submitted in writing to the Division of Medicaid within 30 days of the notice of action date, the decision for denial or termination will be final and binding.
If the participant/representative requests to appeal the notice of action decision, the case manager Supervisor will forward copies of all documentation used to reach the decision to the Executive Bureau at the Division of Medicaid.
Services must remain in place during any appeal process.
Upon receipt of the request for a state hearing, the Bureau of Executive Appeals at DOM will assign a hearing officer.
The hearing officer will notify the participant/representative, by certified mail, of the date, time and place of the hearing. (Hearing may be conducted with all parties involved present, or conference phone hearing with all parties, dependent upon participant's request, and the hearing will be recorded.)
After the hearing, the hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director.
The Executive Director will make the final determination of the case, and the participant/representative will be notified, in writing, of the final decision of the appeal. DOM must take final administrative action on a hearing, whether state or local, within ninety (90) days from the date of the initial request for a hearing.
Upon the determination of the Executive Director, the case manager will be notified by the Division to either initiate, continue, or terminate services.

All records that pertain to adverse actions, the opportunity to request a fair hearing, appeal documentation and final determinations are filed in the electronic in the Long Term Care Bureau in the Division of Medicaid.

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.

The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants are encouraged to attempt to resolve disputes with the Assisted Living waiver provider. When participants are unable to resolve disputes with the provider, they are advised and encouraged to report the issue to their case manager(CM), who is a licensed social worker. The CM responds to the participant within 24 hours. If a resolution is not reached within 72 hours the CM reports the issue to the CM Supervisor. The CM Supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to the Director of the Bureau of LTC/DOM. The Bureau Director along with the CM Supervisor and the CM will consult with each other and work towards a resolution within seven days. In the event the dispute is with the CM then the CM Supervisor works with the participant to assign a new CM. Once a new CM is assigned the CM Supervisor evaluates the participant's satisfaction with the new CM within the following month and notifies Bureau Director of the final resolution. The Bureau Director and the CM Supervisor are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the CM at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.

At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process. The participant is informed that dispute resolution mechanisms as well as filing a grievance or making a complaint are not prerequisites or a substitute for Fair Hearing.

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 CM Supervisor 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).

The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants are encouraged to attempt to resolve disputes with the Assisted Living waiver provider. When participants are unable to resolve disputes with the provider, they are advised and encoraged to report the issue to their case manager(CM), who is a licensed social worker. The CM responds to the participant within 24 hours. If a resolution is not reached within 72 hours the CM reports the issue to the CM Supervisor. The CM Supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to the Director of the Bureau of LTC/DOM. The Bureau Director along with the CM Supervisor and the CM will consult with each other and work towards a resolution within seven days. In the event the dispute is with the CM then the CM Supervisor works with the participant to assign a new CM. Once a new CM is assigned the CM Supervisor evaluates the participant's satisfaction with the new CM within the following month and notifies Bureau Director of the final resolution. The Bureau Director and the CM Supervisor are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the CM at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances

and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.

At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process. The participant is informed that dispute resolution mechanisms as well as filing a grievance or making a complaint are not prerequisites or a substitute for Fair Hearing.

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).

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.
Complaints of abuse, neglect or exploitation of a participant such as in an Assisted Living Waiver provider are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of assisted living waiver providers.
Abuse is defined as:
• The willful or non-accidental infliction of physical pain, injury or mental anguish
• The unreasonable confinement of a vulnerable adult
• The willful deprivation by a caretaker of services which are necessary to maintain the mental and physical health of a vulnerable adult.
• Includes sexual abuse
• Does not mean conduct which is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility
• Includes, but is not limited to, a single incident
Neglect is defined as:
• The inability of a vulnerable adult who is living alone to provide for themselves the food, clothing, shelter, health care or other services which are necessary to maintain their mental and physical health
• The failure of a caretaker to supply the vulnerable adult with the food, clothing, shelter, health care, supervision or other services which a reasonably prudent person would do to maintain the vulnerable adult's mental and physical health
• Includes a single incident
Exploitation is defined as:
The illegal or improper use of a vulnerable adult or his resources for another's profit or advantage with or without

consent of the vulnerable adult, and includes acts committed pursuant to a power of attorney.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:

(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any care facility that complies in good faith with the requirements of this section to report the abuse or exploitation of a waiver participant in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both such fine and imprisonment.
(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all

The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.

The Attorney General’s (AG) office is legislatively mandated to investigate and enforce the law regarding alleged abuse, neglect and exploitation in licensed health care facilities. Specific enforcement guidelines are depicted in the Mississippi Vulnerable Persons Act of 1986, §43-47-1 of the Mississippi Code of 1972, as amended. The AGs office receives allegations both electronically and orally via a toll free long distance number. Once allegations are received, the chief investigator reviews each complaint to determine if the allegation falls within their jurisdiction or purview to investigate. The facility has seventy-two (72)hours to provide the Mississippi Attorney General’s (MFCU) and the Mississippi State Department of Health with a written report regarding their investigation of the alleged incident. Once the review is completed the allegation is assigned to an investigator according to its scope and severity of the issue. The Chief Investigator or the Investigator assigned to the case will follow up with the facility to ensure that the facility has provided the Mississippi Attorney General’s Office (MFCU) with the written report. The investigator assigned to the case has 72 hours to contact the provider or individual reporting the alleged incident which prompts a written report of facility findings. Investigations consist of a variety of information gathering techniques including, but not limited to, interviewing, observation, medical record review, and record analysis. At the request of the DOM, the Mississippi Attorney General’s Office (Medicaid Fraud and Control Unit) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the

investigation.
DOM and the AGs office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.

The Mississippi Department of Health has a complaint hotline that allows for individuals to file complaints against assisted living facilities. An individual staffs this telephonic hotline Monday - Friday during normal business hours, an answering machine is activated for coverage allowing complainants to record their concerns/complaint, thus triggering follow up or a call back from the hotline coordinator with a target response of 24 hours. This hotline allows facilities to self-report critical incidents and or complaints of alleged abuse, neglect and exploitation. Critical incidents and complaints are triaged via an intake triage committee which consists of a nurse and representatives for long term care and other staff members. Based on the scope and severity of the allegations, the complaint will be scheduled accordingly. There are seven action levels of triage as follows:
a) Immediate Jeopardy (Investigations begin within 2 working days of the notification)
b) Non-Immediate Jeopardy (Investigations begin within 10 working days of the notification)
c) High, Non Immediate Jeopardy (Investigations begin within 45 working days of the notification)
d) Medium, Non Immediate Jeopardy (Investigations begin within 45 working days of the notification)
e) Low, Administrative Review/Off Site Investigation (Investigations begin within 45 working days of the notification)
f) Referral
g) No Action Necessary
Assisted Living facilities are required to report incidents of alleged abuse, neglect or exploitation orally or telephonically within 24 hours of discovery, excluding Saturdays, Sundays and legal holidays and in writing within 72 hours of discovery. If the facility fails to report in accordance with this regulation, the investigator will investigate for potential noncompliance with this regulatory requirement.

Incidents are evaluated to determine the degree of harm to the waiver participant, the thoroughness of the facility to investigate the circumstances related to the event, the facilities implemented corrective action and the effectiveness of the corrective actions. If the investigator determines the facility has not taken appropriate action and a serious situation is ongoing, an investigation will occur.
Investigations are conducted by making an onsite visit, record review (charts, policies, procedures, minutes, etc...), interviews with staff, family, waiver participants, and personal observations. Within 10 days of exiting the facility, the investigator must provide a written report to the facility that includes the investigative findings. These findings are presented as a legal document with a cover letter. When negative findings are cited, the facility must submit an acceptable plan of correction. Once the facility has had a chance to implement changes necessary to rectify the negative findings, the investigator will return to the facility to determine if the facility is back in compliance.
The Mississippi State Department of Health works closely with the Division of Medicaid to assure the process of protecting the health and welfare of our waiver participants is maintained. Each agency shares information freely regarding critical incidents including the types of complaints, investigations and outcomes. This free flow of communication allows the state to develop a system in which all allegations are tracked as well as allows the DOM to determine if trends exist. Working collaboratively, the two agencies address ways to improve detection and prevent abuse, neglect and exploitation of our waiver participants.
The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.

When participants are initially assessed for the Assisted Living Waiver program, they are informed of the contact information of the case manager. The CM maintains monthly contact with each participant and/or responsible party by telephone or visit to the Assisted Living facility. Face to face visits are made to the participant at their residence in the Assisted Living waiver provider or other home and community based setting on a quarterly basis. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or responsible party has notified the CM of their concern, a visit to the facility is made as soon as can be arranged. The purpose of the visit to the facility is to assess the participant and the environment, document an account of the occurrences and notify the proper authorities. The CM determines if the environment is free of harm or perceived threat for the waiver participant.

The facility must develop and maintain policies and procedures to guide staff in the early detection and prevention of abuse, neglect and exploitation. These policies and procedures must be implemented to assure the safety and welfare of the waiver participants. When an allegation of abuse has occurred, the facility must provide evidence that the safety and welfare of all waiver participants is protected by removal of the accused perpetrator from the facility until such time that a thorough investigation has been completed.

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.

Assisted Living waiver providers are required by this waiver to assure that all staff are trained at the time of hire and annually thereafter on the following subjects:
a) Vulnerable Persons Act: Prevention of abuse, neglect and exploitation
b) Resident Rights and Dignity
c) Care of an Alzheimer's Resident
d) Care of residents with Mental Illness
e) How to Deal with Difficult Residents
The Assisted Living waiver providers will maintain evidence of this training on file and easily accessible per request of the Division of Medicaid staff.

Assisted Living waiver providers must assure that each direct care provider successfully completes 40 hours of course curriculum as identified by the State as a requirement prior to providing care to waiver participants. Documentation of completion of this course work must be maintained at the Assisted Living waiver provider and be made available to the Division of Medicaid upon request.
Failure of the Assisted Living waiver provider to comply with training requirements will require an acceptable plan of correction by the provider. Continued noncompliance will result in indefinite suspension of Medicaid waiver referrals until successful completion of training requirements are met.

The State assures that training is provided to the waiver participants and others ,as designated by the participant, concerning the State's protection from abuse, neglect, and exploitation, including how these individuals can notify appropriate authorities or entities when the alleged abuse has occurred. Case managers will be responsible for providing this training and information upon admission to the waiver and then annually thereafter. This information is provided verbally and in written form to the participant and other involved individuals.

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.

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.
Complaints of abuse, neglect or exploitation of a participant such as in an assisted living facility are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of Assisted Living waiver providers.
Abuse is defined as:
• The willful or non-accidental infliction of physical pain, injury or mental anguish
• The unreasonable confinement of a vulnerable adult
• The willful deprivation by a caretaker of services which are necessary to maintain the mental and physical health of a vulnerable adult.
• Includes sexual abuse
• Does not mean conduct which is a part of the treatment and care of, and in furtherance of the health and safety of a waiveer participant
• Includes, but is not limited to, a single incident
Neglect is defined as:
• The inability of a vulnerable adult who is living alone to provide for themselves the food, clothing, shelter, health care or other services which are necessary to maintain their mental and physical health
• The failure of a caretaker to supply the vulnerable adult with the food, clothing, shelter, health care, supervision or other services which a reasonably prudent person would do to maintain the vulnerable adult's mental and physical health
• Includes a single incident
Exploitation is defined as:
The illegal or improper use of a vulnerable adult or his resources for another's profit or advantage with or without

consent of the vulnerable adult, and includes acts committed pursuant to a power of attorney.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:

(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any Assisted Living provider that complies in good faith with the requirements of this section to report the abuse or exploitation of a patient or resident in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both such fine and imprisonment.
(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all

The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.

For allegations deemed potentially immediate jeopardy situations, an Investigation will be initiated with two (2) working days of receipt of the complaint. The purpose of the onsite visit is to assure that all participants who could be affected by the reported situation are adequately protected from harm and to verify the provider’s ability to correct the circumstances creating the immediate jeopardy.
For allegations that are considered non-immediate jeopardy- high risk, an investigation will be initiated within ten (10) working days of receipt of the complaint.
For allegations that are considered non-immediate jeopardy –medium risk, an investigation will be initiated within 45 working days of the receipt of the complaint.
For allegations that are considered Non-Immediate jeopardy—low risks, an onsite investigation may not be scheduled, but the allegation will be reviewed at the next onsite visit.

The assigned complaint investigator will contact the participant during the course of the on-site investigation to advise them that the investigation is in progress and to validate details of the reported allegation. Following completion of the investigation and the processing of required documents, the participant will be notified. Timeframes of notification vary depending on the amount of time it takes to complete an investigation but notification occurs once

the investigation is completed

The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.

When an allegation of abuse, neglect or exploitation occurs, the Assisted Living waiver provider staff is required to report to the Department of Health and the Attorney General's office.

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.

DOM has procedures in place to assure that all Assisted Living waiver providers, waiver participants and care givers are trained in the reporting of critical incidents. A data base is maintained by DOM to collect, record, and trend critical events. This information is used to identify opportunities for improvement involving early detection and prevention.
The Mississippi Attorney General's office, Mississippi Department of Health and the Department of Human Services work with the Mississippi Division of Medicaid to communicate information and oversight activities of critical events and incidents. Each agency provides a free flow of information to the Division of Medicaid including the specific names of individuals involved in reported incidents, the status of investigations along with outcomes. Each agency works with the Division of Medicaid to identify strategies to reduce the occurrence of critical events.

The Mississippi Department of Human Services entered into an interagency agreement allowing the sharing of critical incident information that includes types of incidents reported, participant characteristics, providers, how quickly reports are reviewed and investigated, follow up, results of investigations and whether waiver participants are informed of the investigative results.

The case managers and the case manager supervisors work closely with the investigators from the Mississippi Attorney General's office to follow up on reports of abuse, neglect or exploitation. The Mississippi Attorney General’s Office (MFCU) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation. DOM and the AGs office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.

The Mississippi Department of Health has an interagency agreement with the Division of Medicaid which allows for free flow of information regarding all allegations and their findings. Their investigation results include a review of the facilities over all compliance with the overall licensure regulations as related to the occurrence of critical incidents. DOM’s oversight of the incident management system occurs on an ongoing and continuous basis. When investigations are in progress, DOM is notified and assists as requested and there is free flow of communication between agencies.

Information compiled from the oversight agencies allows the DOM to analyze the incidents to determine trends/patterns to assist in the development of strategies to reduce future occurrences of critical incident events. An excellent example of how information is used from analyzing critical incident reports resulted in the Division of Medicaid identifying the need for additional training for care staff related to dealing with difficult residents and resident rights. The review determined that confirmed abuse occurred in a facility and that staff were not fully trained and competent to deal with residents with acting our behavior. The facility had to provide an acceptable corrective action plan to resolve the issues.

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 or seclusion during the course of the delivery of waiver services. DOM and Mississippi State Department of Health Licensure and Certification Division are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The CM is responsible for monthly contact with the waiver participant and/or caregiver to ensure safety. The CM is also responsible for conducting a quarterly face-to-face visit with the participant to ensure quality of services.

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 does not permit the use of restrictive interventions. DOM and Mississippi State Department of Health Licensure and Certification Division are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The CM is responsible for monthly contact with the waiver participant and/or caregiver to ensure safety. The CM is also responsible for quarterly face-to-face visits with the participant to ensure quality of service.

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 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 Licensing agency of the Assisted Living provider is responsible for oversight of medication management

and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for participants in this waiver is vested in a licensed physician. Each Assisted Living provider must employ appropriately trained or professionally qualified staff to administer medications if an individual requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to service recipients 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 DOM requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DOM on-site compliance reviews.
First line responsibility for monitoring an individual's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Assisted Living setting. Staff monitoring focuses on areas identified by the physician and /or pharmacist which may be of concern. Each waiver provider must have policies and procedures that identify the frequency of monitoring. Individuals 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 Division of Medicaid makes available an eScript information system so that prescribing physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries. The system integrates prescription drug formularies to alert providers to adverse drug reactions.

All participants' medications must be stored in a secure area and not accessible to anyone other than whom the medication is prescribed. A refrigerator must be provided for storage of medications requiring refrigeration.
A non-resident employee, appointed by the operator of the facility, must be responsible for the following:
1. Storage of medication
2. Maintenance of a current prescription medication list, the including frequency and dosage of medications and known allergies, which shall be updated at least every 30 days or when there is a change in the medication. Managing this prescription is used to guard against medication errors.
3. Disposal of outdated or other unused medications in accordance with the regulations of the Mississippi Board of Pharmacy.
Scheduled drugs may only be allowed in an Assisted Living provider if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.
The Assisted Living provider must keep accurate records to demonstrate that waiver participants have adequate amounts of medication on hand and that necessary oversight is provided for medication administration. The nurse must review the medication list for each participant to assure that waiver participants are neither over nor inappropriately medicated.

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.

Mississippi State Department of Health Licensure and Certification is responsible for follow up and oversight.

The Mississippi State Department of Health conducts annual onsite visits reviewing the overall operation of the facilities to assure compliance to regulatory requirements. This agency visits more frequently in the event of a complaint or report of a negative finding. The agency communicates information and findings regularly to the Department of Medicaid after the annual visits and after any complaint investigation. Annually, the agency provides DOM with a copy of the provider’s current license verifying the facility is in compliance with the licensing rules and regulations. In the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies.

Waiver case managers provide monthly contacts, either by phone or face to face, with the waiver participant to assure services are being provided in accordance with the plan of care. Face to face visits are made quarterly. During these visits, the State gathers information concerning potentially harmful practices and uses the information to develop quality improvement measures to address the issue.

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).

HCBS/Assisted Living Waiver administrative code states that
Assisted Living Services may include Medication Oversight/Medication administration (to the extent permitted under State Law).

Medication administration is limited to the decisions, made by someone other than the person for whom the medication has been prescribed, regarding (1) which medication is to be taken, (2) the dosage of the medication, or (3) the time at which the medication is to be taken.

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.

Nursing activities must comply with Mississippi Board of Nursing Administrative Code, Part 2830, Chapter 1, Section 1.3 Supervision and Delegation, Part 2830 Chapter 1: Assign duties for giving patient treatments to licensed nurses and/or auxiliary workers based upon knowledge of their educational preparation and experience. Thus, medication administration may only be delegated to another registered nurse or licensed practical nurse and not to an unlicensed person.

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:

  Mississippi State Department of Health Licensure and Certification.
  Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.

  (b) Specify the types of medication errors that providers are required to *record:*

  All avoidable, serious or life-threatening errors shall be reported by telephone to Mississippi State Department of Health Licensure and Certification Branch of the licensing agency by the next working day after the occurence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.

  (c) Specify the types of medication errors that providers must *report* to the State:

  All avoidable, serious or life threatening errors shall be reported to Mississippi State Department of Health Licensure and Certification branch of the licensing agency by the next working day after the occurence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.

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.

Mississippi Department of Health Licensure and Certification branch of the licensing agency is the state agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Monitoring is performed according to the Minimum Standards for Personal Care Homes Assisted Living. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.

The agency communicates information and findings regularly to the Division of Medicaid after the annual visit which includes an evaluation of medication administration. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. 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 agency provides DOM with copies of cited deficiencies.

The Division of Medicaid conducts annual onsite compliance audit of waiver providers as part of the oversight responsibility. The findings from this compliance audit along with reports from the Department of Health are evaluated to determine if negative findings are such that remediation is required. Data collected during annual visit by the Department of Health and the Division of Medicaid is analyzed to identify evidence of trends and patterns which require a need for policy, procedure and systems changes.

Data are collected during the annual visits by the Department of Health and Division of Medicaid. Additionally, case managers acquire data during the monthly, quarterly and annual visits regarding medication errors. All of this data collectively is reviewed to determine the occurrence of trends and patters or the possibility of isolated incidents. After the data is analyzed, the information is synthesized to determine is 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
1) Number and percent of reported critical incidents that adhere to the timeframes for follow-up as specified in the approved waiver application. Numerator: Number of reported critical incidents that adhere to the timeframes for follow-up as specified in the approved waiver application. Denominator: Total number of reported critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from the Department of Human Services, Mississippi Attorney General's Office and Department of Health

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:
2) Number and percent of waiver participants who have an emergency preparedness plan (EPP). Numerator: Number of waiver participants who have an EPP. Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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:
3) Number and percent of waiver participants who receive information on how to report suspected cases of abuse, neglect or exploitation. Numerator: Number of waiver participants who receive information on how to report suspected cases of abuse, neglect or exploitation. Denominator: Total number of participant's reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 State's 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.

Performance Measure 1): 1. For those reported critical incidents with no follow-up by MS Department of Health or the Attorney General's office, DOM will request immediate follow-up of the reported critical incident; 2. For those reported critical incidents with late follow-up DOM will request documentation within 30 days.

Performance Measure 2): 1. DOM will require case managers to develop EPP with the waiver participant within 7 days of discovery and submit the EPP document upon completion; 2. DOM will do one-on-one training with case manager upon discovery.

Performance Measure 3): 1. DOM will require the case manager to provide the necessary information to the participant and others as designated by the participant within 30 days of discovery. 2. The case manager supervisor will determine if this is an isolated offense or whether a pattern of offenses has occurred and take necessary action to address individually or as a systems issue. 3. One on One training with the case manager will be provided by the case manager supervisor.

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 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 2)

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 QMS 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;
- 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

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.

Mississippi has taken a global approach towards the development of a Quality Improvement strategy that encompasses all waivers. Continuous quality improvement is based on the processes of discovery and remediation and the aggregated data produced by those activities. Quality improvement takes place on the participant, provider and system wide levels.
Quality improvement at the participant level is focused on monitoring and improving care and outcomes for the participant. The participant's case manager is primarily responsible oversight of the quality improvement at the participant level. Participant level discovery takes place through the monthly and quarterly contacts that a case manager makes with the participant and his/her providers. When a case manager discovers an issue related to the participant's Plan of Care, he/she is responsible for addressing the issue with the participant's provider and developing remedial actions to address the issue. If a provider is not responsive to participant level remediation, a case manager is responsible for reporting the issue to the case manager supervisor with the Division of Medicaid who intervenes as necessary to achieve remediation.
Quality improvement at the provider level is focused on monitoring and improving services delivered by providers. The Department of Health, Division of Licensure and Certification is responsible for oversight and development of provider regulations and licensing. All providers are surveyed annually. Additionally, the Division of Medicaid conducts annual on-site compliance audits to assure compliance with Medicaid rules and requirements and waiver assurances. DOM conducts initial visits to new applicant providers to ensure compliance with DOM operational Standards. As issues are identified through on-site monitoring, providers are required to submit Plans of Corrections for remediation. Provider level data is collected through the discovery processes of on-site monitoring, reporting of serious incidents, and reporting of grievances.
Quality improvement at the systemic level is designed to improve the overall system's delivery of care. System level discovery incorporates data from multiple sources to develop a comprehensive view of service provision. Data from the discovery processes at the participant and provider levels is utilized for system level quality improvement activities.
As part of the administrative oversight of the Division of Medicaid, DOM conducts on-site compliance reviews. The compliance reviews examines adherence to the sub-assurances of the waiver. DOM issues a report of findings that identifies issues found during the compliance audit. Through regular meetings between DOH and DOM, the two agencies share decision making concerning corrective action. As a mitigation strategy, DOM informs all providers that might be affected by warranted corrective action so that all providers can examine the issue and put mitigation strategies in place to prevent a future occurrence.

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: Continuously and ongoing.

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.

System improvements and design changes are targeted at three levels – participant, provider and systemic. In order for system improvements and evaluation of those improvements to take place, many parties are involved.
The responsibility for participant level improvements is vested with the participant's case manager through the plan of care. Revisions to the plan of care occur as participant needs change. Through monthly and quarterly contacts, case managers assess the health and welfare of the participant and whether or not the plan of care is meeting the needs of the participant. Changes to the plan of care are communicated to the appropriate providers.
At the provider level, providers are responsible for the reporting of serious incidents. Providers are responsible for reviewing serious incidents and putting action(s) in place to prevent future occurrence. The Division of Medicaid is responsible for tracking data related to the type of incident, participants involved in the incident and remedial action taken. Serious incident tracking data is utilized to determine whether or not remedial actions put in place at the provider level are effective in mitigating future incidents. Should serious incidents be identified that are suspected to jeopardize the health and/or welfare of a waiver participant necessary intervention is enacted immediately to protect the health and safety of the participants. This may include engaging the support of other entities charged with protecting vulnerable persons, such as the MS Attorney General's Office or the MS Department of Human Services.
At the systemic level, as administrator and operator of the assisted living waiver, DOM is responsible for reviewing and analyzing aggregate data in order to put in place comprehensive quality improvement activities. As activities are designed, evaluation of the outcomes and effectiveness of the activities is built into the planning process. .
System design changes are communicated through a variety of methods. Since most system design changes require changes to DOM waiver operational standards those changes are communicated through the state's administrative procedures rules that include the public posting of changes with required public comment periods

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy is continuously evaluated to ensure the strategy is accomplishing the intended goal of improving outcomes for waiver participants. Annually, the Division of Medicaid reviews the performance measures to ensure data collection is occurring as planned and intended outcomes are being achieved.

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).

The Mississippi Division of Medicaid operates two audit units to assure provider integrity and proper payment for Medicaid services rendered. The Program Integrity Bureau investigates any suspicion of fraud or abuse reported or identified through the surveillance and utilization reporting (SURS) program. The Compliance and Financial Review Bureau conducts routine monitoring of cost reports and contracts with other agencies. In addition, these waiver services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the

expected parameters for payments are subject to review. It is also possible to set up filters specifically for the waiver programs to identify areas of misuse.

Claims for Federal financial participation in the costs of waiver services are based on state payment for waiver services that have been rendered to individuals enrolled in the waiver, authorized in the Plan of Services and Supports, and properly billed by certified waiver providers in accordance with the approved waiver.

The Mississippi Division of Medicaid maintains responsibility for ensuring financial audits of Assisted Living Waiver providers is conducted. The Division will also generate all required financial reporting for each Assisted Living Waiver service provided. The audit will verify the maintenance of appropriate financial records and review claims to verify coding and accuracy of the payments made. Immediate action will be taken when necessary to address any financial irregularities identified in the review.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
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. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Performance Measure: Number and percent of claims that were coded correctly in accordance with the reimbursement methodology specified in the approved waiver. Numerator: Number of claims paid that were coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver Denominator: Total number of claims

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: Semi Annually	

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: Semi Annually

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 State's 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.

DOM will recoup money paid to providers within 30 days of notification; 2) Submit computer systems requests (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; 3) Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow-up within 48 hours of discovery.

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 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).

To set the context for developing the Assisted Living waiver service rates, the State carefully considered the service description and provider handbook information for the waiver service. Costs analysis surveys were sent to various assisted Living providers to obtain a realistic view of actual costs and expenditures for a baseline of comparison of rates. Additionally, a review of each provider service rates was performed for comparison. For the Assisted Living waiver rate development, the following items were considered:
> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hours practitioners are at work
> Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, Assisted Living facility surveys, and DOM and Milliman experience.
Once the initial service rates were calculated, a comparison was made to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. Projected service rate increases for waiver years following the initial year were based on an expected two (2) percent increase in accordance with the Bureau of Labor Statistics and the Consumer Price Index.

Information about payment rates is made available to waiver participants through the DOM website. Additionally,

case managers discuss the waiver payment rates with the Assisted Living participants upon enrollment into the waiver and at any change.

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:

Assisted Living Waiver providers bill their claims directly to the State's claims payment system. This system is housed and managed by the State's fiscal agent.

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:

The State fiscal agent houses claims data and information and can be produced upon request. The fiscal agent has audit functions to deny payment for services when an individual is not Medicaid eligible on the date of service. The fiscal agent also has an audit function to deny any individual who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the fiscal agent system requires an individual to be an approved, eligible Medicaid waiver beneficiary, documented in the MMIS system, in order for the claim to pay. The lock-in function is housed in the fiscal agent system under the recipient(participant) file and is performed by Medicaid HCBS or the Medicaid fiscal agent. All payments for waiver and state plan services furnished to the program

participant will be made via the process of provider claims through MMIS. Waiver services will be assigned specific procedure codes.

The State conducts post utilization reviews to ensure the services were delivered on the dates reflected on the beneficiary's approved service plan and billing documentation.

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.**
- [x] **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: *Complete item I-3-e.*

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:*

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

- **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. *Select one:*

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.

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:

☐ **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 is for participants residing in residential, home and community based care facilities. The Assisted Living waiver services rendered in this waiver do not include coverage for room and board. Certain waiver participant records to demonstrate the facility is not charging for room and board are required to be maintained within Assisted living waiver providers and are available to representatives of the Medicaid agency. Such records include admission agreements which must contain provisions specifically setting forth services and accommodations to be provided by the Assisted Living provider. The admission agreements must include the following items:
1) Basic charges agreed upon, separating costs for room and board and personal care services
2) Period of coverage
3) Services for which charges are made
4) An agreement regarding refunds for payments
Participant admission 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.
Admission agreements must be reviewed and approved by the Division of Medicaid prior to admission into the waiver and subsequently every time there is a change or update to the agreement. Regardless of any agreement between the participant or the participant's family or guardian, the provider must not charge for services over and above what Medicaid has agreed to pay.

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

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	19189.00	6861.00	26050.00	46540.00	6860.00	53400.00	27350.00
2	19744.00	7204.00	26948.00	48867.00	7203.00	56070.00	29122.00
3	20233.85	7564.00	27797.85	51310.00	7564.00	58874.00	31076.15
4	20815.00		28758.00			61817.00	33059.00

		7943.00		53875.00	7942.00		
5	21402.15	8304.00	29706.15	56569.00	8339.00	64908.00	35201.85

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	900	900
Year 2	900	900
Year 3	1000	1000
Year 4	1000	1000
Year 5	1100	1100

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.

The estimated average length of stay is 341 days based on a review of the past waiver years.

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 for these estimates is as follows:

The estimates for Factor D were calculated automatically from the numbers entered for number of users, average units per user, and average cost per unit for each component of waiver service. An estimated increase of 2% annually for service rates after the first year represents the gradual increase over the course of the waiver.

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 D' are based upon the actual D' value from the CMS 372 Lag Report for FY 2011. The first year estimate is the the actual D' value from the CMS 372 Lag Report for FY 2011 plus a 5%% medical inflation rate. Every year after is projected using the 5% medical inflation rate. The Factor D’ assumptions are from the cost of all State Plan services while the participant was on the HCBS Waiver excluding drug cost.

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 Division of Medicaid's analysis of nursing home expenditures per recipient for FY 2012 and the first year is based upon the analysis plus 5% medical inflation rate. The specific nursing home expenditures analyzed are actual paid claims per Medicaid recipient. Every year after is projected using the 5% medical inflation rate.

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 Factor G' is based upon the current year estimate of all other Medicaid costs furnished while the individual is institutionalized, with a 5% medical inflation rate applied for the first year. Every year after is projected using the 5% medical inflation rate.

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants
Assisted Living

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**682000.00**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	341.00	400.00	**682000.00**	
Assisted Living Total:						**16587945.00**
Assisted Living	per day	900	341.00	54.05	**16587945.00**	
				GRAND TOTAL:		**17269945.00**
				Total Estimated Unduplicated Participants:		**900**
				Factor D (Divide total by number of participants):		**19189.00**
				Average Length of Stay on the Waiver:		341

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**701760.00**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	344.00	408.00	**701760.00**	
Assisted Living Total:						**17068248.00**
Assisted Living	per day	900	344.00	55.13	**17068248.00**	
				GRAND TOTAL:		**17770008.00**
				Total Estimated Unduplicated Participants:		**900**
				Factor D (Divide total by number of participants):		**19744.00**
				Average Length of Stay on the Waiver:		344

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**722037.60**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	347.00	416.16	**722037.60**	
Assisted Living Total:						**19511810.00**
Assisted Living	per day	1000	347.00	56.23	**19511810.00**	
				GRAND TOTAL:		**20233847.60**
				Total Estimated Unduplicated Participants:		**1000**
				Factor D (Divide total by number of participants):		**20233.85**
				Average Length of Stay on the Waiver:		347

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**742840.00**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	350.00	424.48	**742840.00**	
Assisted Living Total:						**20072500.00**
Assisted Living	per day	1000	350.00	57.35	**20072500.00**	
				GRAND TOTAL:		**20815340.00**
				Total Estimated Unduplicated Participants:		**1000**
				Factor D (Divide total by number of participants):		**20815.00**
				Average Length of Stay on the Waiver:		350

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
Adult Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**766356.90**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	354.00	432.97	**766356.90**	
Assisted Living Total:						**22776006.00**
Assisted Living	per day	1100	354.00	58.49	**22776006.00**	
				GRAND TOTAL:		**23542362.90**
				Total Estimated Unduplicated Participants:		**1100**
				Factor D (Divide total by number of participants):		**21402.15**
				Average Length of Stay on the Waiver:		354