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:
The Division of Medicaid has implemented On-Site Compliance Reviews (OSCRs) for all ID/DD Waiver providers to determine compliance with the waiver and all other Medicaid policies.

Reserved waiver capacity is being increased to prioritize access to waiver services for individuals transitioning from state operated ICF/IIDs, private ICF/IIDs and nursing facilities. Historical data as well as the anticipated number of enrollees for next fiscal year was used to calculate the number of individuals anticipated to transition. Additionally, reserved waiver capacity slots will be requested for emergency/crisis admissions.

The minimum number of waiver services an individual is required to receive each month changed from two (2) to one (1) to ensure individuals who may utilize only Support Coordination during a given month can remain eligible for the waiver.

Team members for initial evaluations now include, at a minimum, a psychologist and a social worker. Other disciplines participate as indicated by individual need.

Level of Care Criteria was condensed to take out extraneous and duplicative wording. The changes will not affect the eligibility of anyone currently enrolled in the ID/DD Waiver.

A Level of Care Reevaluation tool has been developed to replace the ICAP. The tool was developed as a joint effort between all Diagnostic and Evaluation Teams. It will be used as a functional assessment to inform ongoing level of care decisions; it is not the assessment used for initially determining eligibility for ICF/IID level of care.

New Services: Crisis Support, Crisis Intervention, Host Homes, Job Discovery, Transition Assistance, and Supported Living.

ICF/IID Respite was removed but Crisis Support is an equivalent service; it expands the definition of who may receive temporary, crisis services in an ICF/IDD.

In-Home Nursing Respite will now require that a physician state the medical treatments an individual requires and how long the need for the treatment(s) is expected to last. Also, Private Duty Nursing services through EPSDT must be accessed before ID/DD Waiver In-Home Nursing Respite is utilized.

Service Planning was changed to include more person centered planning processes and procedures. The name of the Plan of Care was changed to Plan of Services and Supports (PSS).

The timeline for responses from the DMH for Appeals, Denials, Termination, or Reduction of ID/DD Waiver Services was extended from fifteen (15) to thirty (30) days. Also, the timeline an individual has to appeal the decision of the Executive Director of the DMH was extended from fifteen (15) to thirty (30) days.

The processes related to consumer grievances was redesigned to remove barriers to individuals making their grievances known are included. A level system for the classification of grievances by type and needed response has been created to ensure resolution of grievances. The management system is being updated in order to improve accountability and responsiveness to individuals submitting grievances to the Office of Consumer Supports.

The processes associated with the handling of serious incidents reported by DMH certified providers to increase remediation efforts has been included. A level system for classification of serious incidents by type and needed response has been created. An improved information management system was created in order to improve accountability, including the on-line submission of reports to the Bureau of Quality Management, Operations, and Standards.

The procedures and processes for monitoring medication administration were revised to include monitoring through the Division of Medicaid's On-Site Compliance Review process. Also included are procedures for monitoring providers who administer medication; this will be done by a nurse from the Division of Medicaid.

The use of physical restraints will be allowed under certain circumstances, as outlined in this application and DMH Operational Standards.

The Quality Assurance appendix has been revised to reflect DMH's current procedures for ensuring provider compliance with DMH Operational Standards as well as for measuring overall system performance. The process has been significantly revised and now focuses on system-wide improvements based on findings at the local level. Applicable data will be aggregated on a regular basis and Performance Measures will be reviewed by DMH's Quality Management Council. The Quality Management Council's core membership is composed of DMH's eight 8 functional/programmatic areas (inclusive of the Bureau of Intellectual/Developmental Disabilities), the Office of Consumer Supports, the Arc of MS (as the contractor responsible for serving as the lead for DMH's peer review quality assurance activities), and a member of the Certified Peer Support Specialist Network. Ad hoc members consist of an experienced Director of Risk Management from a DMH-operated program, DMH legal staff, and DMH's Medical Director. This information will be used to determine trends and patterns regarding both provider adherence with the waiver requirements as well as constant evaluation of the system for system enhancement and improvement.
Rates are being revised.

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Intellectual Disabilities/Developmental Disabilities (ID/DD)

C. **Type of Request:renewal**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MS.0282
Waiver Number:MS.0282.R04.00
Draft ID: MS.09.04.00

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

E. **Proposed Effective Date:** (mm/dd/yy)
07/01/13
Approved Effective Date: 07/01/13

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:

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

- [x] **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR 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 ID/DD Waiver provides service to individuals who, but for the provision of services through this waiver would require care in an intermediate care facility for the mentally retarded (ICF/IID). Services are available statewide without regard to age.

The purpose of the waiver is to provide services to individuals who live in a variety of community settings including their own home, the family home, or another community setting with services and supports appropriate for their needs.

The program proposes to provide the following services:
Supervised Living
Behavior Support
Day Services-Adult
Community Respite
Prevocational Services
Supported Employment
Specialized Medical Supplies
Support Coordination
Occupational, Physical and Speech Therapies
Home and Community Supports
Supported Living
Job Discovery
Crisis Support
Crisis Intervention
Host Homes
Transition Assistance

GOALS AND OBJECTIVES: To provide access to meaningful and necessary home and community based services and supports; to provide services in a culturally competent, person-centered manner; to provide services and supports that facilitate an individual living as independently as possible in his/her community including the facilitation of social relationships and work.

ORGANIZATIONAL STRUCTURE – Mississippi's Division of Medicaid is the single State Medicaid Agency having administrative responsibility in the administration and supervision of the ID/DD Waiver. The Department of Mental Health (DMH), Bureau of Intellectual and Developmental Disabilities (BIDD), Division of HCBS is responsible for the daily operation of the ID/DD Waiver. The Department of Mental Health's Bureau of Quality Management, Operations and Standards (BQMOS) is responsible for the quality management activities of the agency. DMH's BQMOS is responsible for provider certification, analysis of provider serious incidents and resolution of grievances, as well as quality improvement.

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/MR.

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 ID/DD Waiver and its operations is continuously sought and obtained by the Division of Medicaid and BIDD/Division of HCBS. The BIDD retains an Advisory Council comprised of parents, self-advocates, providers and advocates. The BIDD Advisory Council provides guidance and advice in setting goals and objectives for the BIDD. Staff from Medicaid and BIDD/Division of HCBS Services attends and present at conferences for advocates, professionals and self-advocates. This arena provides an excellent means of garnering input from a variety of sources. Staff from the BIDD/Division of HCBS has attended MFP Stakeholders meetings where much input about the waiver and waiver services was obtained.

A survey that contained all draft service definitions was sent to DMH providers as well as advocacy organizations for input. All comments were considered and incorporated into the waiver renewal request where appropriate.

A series of five (5) statewide listening sessions were conducted. They were attended by approximately 95 people, including advocates, parents, self-advocates, and service providers. Notes were taken at the meetings and the input was considered when developing the waiver application. Additionally, announcements of the meetings were published in all of the state’s major newspapers.

Meetings with stakeholders began approximately 6 months prior to the submission date.

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:	Windham
First Name:	Bonlitha
Title:	Office Director, Bureau of Mental Health Programs
Agency:	Mississippi Division of Medicaid
Address:	550 High Street, Suite 1000
Address 2:	Walter Sillers Building

City: Jackson
State: **Mississippi**
Zip: 39201
Phone: (601) 359-6114 **Ext:** ☐ **TTY**
Fax: (601) 359-6294
E-mail: bonlitha.windham@medicaid.ms.gov

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

Last Name: Lacoste
First Name: Ashley
Title: Director of Home and Community Based Services
Agency: Mississippi Department of Mental Health
Address: Robert E. Lee Building
Address 2: 239 North Lamar
City: Jackson
State: **Mississippi**
Zip: 39201
Phone: (601) 359-6240 **Ext:** ☐ **TTY**
Fax: (601) 359-5330
E-mail: ashley.lacoste@dmh.state.ms.us

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:

Jun 13, 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: Mississippi Division of Medicaid

Address: 550 High Street

Address 2: Suite 1000

City: Jackson

State: **Mississippi**

Zip: 39201

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

Fax: (601) 359-6294

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

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

ICF/IID Respite is the only service that is being removed. It is being replaced by Crisis Supports. Respite was removed because admissions to an ICF/IID can be because of a crisis and not necessarily just for respite. A crisis is defined as when an individual's behavioral or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention/Behavior Support Services. People who have received ICF/IID Respite in the past will not be excluded from receiving the service.

DMH Operational Standards for new services will be available September 1, 2013. Training for providers and other interested parties will take place in August 2013. If a person who lives in their own home or apartment is receiving Home and Community Supports, the name of the service will be changed to Supported Living on the Plan of Services and Supports when the person's certification year ends and a new Plan of Services and Supports is developed. There will be no reduction in the amount of service a person receives simply because the name of the service they are receiving changes. New services will be offered to individuals as appropriate and as providers are certified.

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:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Division of Medicaid (DOM) performs the following administrative functions: (1) promulgation of program policies; (2) notification and clarification of policy revisions to the Department of Mental Health (DMH)/Bureau of Intellectual and Developmental Disabilities(BIDD)and waiver providers; (3) monitoring the interagency agreement with DMH/BIDD; and (4) analyzing utilization of services.

DOM performs ongoing monitoring of BIDD/Division of HCBS on a quarterly basis to assess the BIDD/Division of HCBS's operating performance and to assess for compliance with approved 1915 (c) waiver, DOM policies, and specifications in the Interagency Agreement. DOM and BIDD/Division of HCBS participate jointly in at least one annual training event with ID/DD Waiver providers and others as needed. BIDD/Division of HCBS approves all requests for initial enrollment and re-certification of participants. DOM will review a sample of DMH/BMR Division of HCBS actions on requests for initial certifications and re-certifications. DOM and BIDD/Division of HCBS staff meet monthly to review issues surrounding the ID/DD Waiver and to discuss methods of improving service delivery and waiver operations. BIDD/Division of HCBS will track and periodically report its performance in conducting operational functions to DOM.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   - ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
   - ◉ **Not applicable**
   - ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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.

Performance Measure:
AA.a.i. (1) Number and percent of participant record reviews that were completed by DMH as required in the approved waiver within specified timelines. N: # of participant record reviews completed as required. D: # of record reviews required to be completed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA.a.i. (2) Number and percent of individuals who are certified/recertified to receive ID/DD waiver services who meet Medicaid eligibility requirements. N: # of individuals who are certified/recertified to receive ID/DD waiver services who meet Medicaid eligibility requirements. D: # of individuals certified/recertified to receive ID/DD waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial Certification/Recertification

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:
AA.a.i. (3) Number and percent of reserved capacity appropriately allocated to individuals N: # of individuals that utilized reserved capacity as approved in the waiver D: # of reserved capacity utilized

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMH Quarterly Report Reserved Capacity

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

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

Data Aggregation and Analysis:

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

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 monitors the Quality Improvement Strategy (QIS) of the waiver on an ongoing basis through Onsite Compliance Reviews. During the Onsite Complaince Review,if individual problems are discovered,the provider must submit a corrective action plan to DOM for all items cited in the Onsite Compliance Review. A written report of findings is provided to the provider and to the Department of Mental Health.

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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
◉ **Mental Retardation or Developmental Disability, or Both**					
	☑	**Autism**	0		☑
	☑	**Developmental Disability**	0		☑

	☑	**Mental Retardation**	0		☑
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

None

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified

individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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	2100
Year 2	2200
Year 3	2300
Year 4	2400
Year 5	2500

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	
Deinstitutionalization	
Crisis	

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):*

Deinstitutionalization

Purpose *(describe):*

Purpose: To prioritize access to waiver services for individuals transitioning from ICF/IIDs and Nursing facilities. BIDD/Division of HCBS anticipates needing to amend the waiver periodically to keep the projection of this reserved capacity accurate.

Describe how the amount of reserved capacity was determined:

Both projections from Bridge to Independence (Money Follows the Person) and historical data were used to calculate the number of individuals DMH plans to transition.

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4 (renewal only)	50
Year 5 (renewal only)	50

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):*

Crisis

Purpose *(describe):*

Purpose: To allow access to the waiver for people who are experiencing a situation where, because of an individual's behavioral or family/primary caregiver situation factors, there is a need for immediate 1) alternative day or residential placement or 2) immediate specialized behavior services.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data. BIDD/Division of HCBS anticipates needing to amend the waiver periodically to keep the projection of this reserved capacity accurate.

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:

Individuals are enrolled in the waiver based on the date of the evaluation that determined them eligible for the waiver. Enrollment also occurs via the reserved capacity.

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)*:
   - (selected) **§1634 State**
   - **SSI Criteria State**
   - **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - **No**
   - (selected) **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)

- [x] **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:
- [x] **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)**
- [x] **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)**
- [x] **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:

  1902(a)(10)(A)(i)(VII)-Children 100%

1902(a)(10)(A)(ii)(VIII)-Adoption Assist. Foster Children

1902(a)(10)(A)(i)(I)-IVE foster children and adoption assistance

1902(a)(10)(A)(ii)(I)-CWS foster children (reasonable classification of children)

1902(a)(10)(A)(ii)(XVII)-protected foster care adolescents

1902(a) (10) (A) (i) (VI)- Children under age 6 under 133% of poverty

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

  Select one:

  - ◉ **300% of the SSI Federal Benefit Rate (FBR)**
  - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

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

    Specify dollar amount:
- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without 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):*

- (selected) **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*):

  - (selected) **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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- **The following standard included under the State plan**

  Select one:

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

    (*select one*):

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

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

  Specify dollar amount:

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

  Specify percentage:
- **Other standard included under the State Plan**

  Specify:

- **The following dollar amount**

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

  Specify:

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

  Specify:

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

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

  Specify:

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

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

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

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

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

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

Specify:

- **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

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

Select one:

- ◉ **Allowance is the same**

Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

Directly by the Medicaid agency
By the operating agency specified in Appendix A
By 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:

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

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

To complete a LOC evaluation, the Diagnostic and Evaluation Team administers a battery of assessment instruments to each individual. The instruments chosen include standardized measures of intellectual and adaptive functioning such as the Wechsler Child and Adult Intelligence Scales, Vineland Adaptive Behavior Scales, and other standardized instruments deemed appropriate for each individual. As a part of the evaluation process, the ID/DD Waiver Level of Care Reevaluation Tool is completed to establish a general baseline upon which future reevaluations of the individual's continuing need can be compared. The following criteria are used to establish level of care:

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

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

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

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under

the State Plan.

- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

The specific battery of assessment instruments chosen for initial evaluations includes standardized measures of intellectual and adaptive functioning such as the Wechsler Child and Adult Intelligence Scales, Vineland Adaptive Behavior Scales, and other standardized instruments which measure intellectual and adaptive functioning and are deemed appropriate for each individual. Medical, social and other records necessary to have a current and valid reflection of the individual are also reviewed. As a part of the evaluation process, the Level of Care Reevaluation Tool is completed to establish a general baseline upon which future reevaluations of the individual's continuing need for ICF/IID LOC can be compared.

For reevaluation of LOC, the ID/DD Waiver Level of Care Reevaluation Tool is administered at least annually by each individual's Support Coordinator. If there is a significant change in the Level of Care Reevaluation Tool that cannot be attributed to psychosocial/health factors, a review by the Diagnostic and Evaluation Team may take place to determine if the individual's level of care needs have changed.

All LOC evaluations are reviewed by staff of the Bureau of Intellectual and Developmental Disabilities/Division of HCBS staff to ensure level of care criteria are applied appropriately.

.

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

  Reevaluations of level of care are conducted by ID/DD Waiver Support Coordinators. Each Support Coordinator is a state employee who meets the Mississippi State Personnel Board's minimum qualifications for their positions. Generally, these positions are occupied by individuals who hold at least a Bachelor's degree in a human services field related to working with individuals with intellectual disabilities/developmental disabilities and at least one year of experience in said field. Each of these Support Coordinators is supervised by at least one Master's level staff person who has at least two years of management experience and whose degree is in a field related to working with people with intellectual disabilities/developmental disabilities. All reevaluations of level of care are reviewed by Master's level staff before submission to the BIDD/Division of HCBS.

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):*

ID/DD Waiver Support Coordinators are responsible for conducting annual reevaluations of each individual to determine if they continue to require ICF/IID level of care. Each month, Medicaid furnishes Support Coordination Directors a Monthly Lock-In Verification Report which lists each individual's certification period. Recertification information must be submitted to the Division of HCBS before the end of someone's certification period. The Division of HCBS staff then approve or disapprove the request for recertification and the Support Coordinator is notified.

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:

An individual's comprehensive record is maintained by the Support Coordinator. The BIDD/Division of HCBS and the Division of Medicaid have access to all information required for initial and recertification through an electronic filing system.

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:
LOC. a.i.a (1) Number and percent of new enrollees who had a level of care evaluation indicating need for ICF/IID level of care prior to receipt of services. N: # of new enrollees who received LOC prior to the receipt of services D: # of new enrollees

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
LOC a.i.b. (1) Number and percent of waiver participants who received an annual level of care evaluation within the one year anniversary date of their last LOC evaluation. N: # of waiver participants reviewed who received an annual LOC evaluation within one year of the date of their last LOC evaluation D: # of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid lockin verification report

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:
LOC a.i.c. (1) Number and percent of LOC evaluations that were completed in accordance with state policies and procedures. N: # of LOC evaluations completed in accordance with state policies & procedures D: # of LOC evaluations reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

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

Data Aggregation and Analysis:

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

Performance Measure:
LOC a.i.c. (2) Number and percent of initial LOC evaluations conducted where the LOC criteria was accurately applied. N: # of initial LOCs reviewed where the LOC criteria outlined in the waiver was accurately applied. D: # of initial LOC evaluations reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
LOC a.i.c. (3) Number and percent of annual LOC evaluations made where the LOC criteria was accurately applied. N: # of annual LOCs reviewed where the LOC criteria outlined in the waiver was accurately applied. D: # of annual LOC evaluations reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.
DMH/BIDD staff will provide technical assistance to the five (5) state-operated Diagnostic and Evaluation Teams (D&E Teams) when it is determined the LOC criteria was not applied as outlined in the waiver. Should a determination be made that an individual does not meet LOC criteria, DMH will notify the Support Coordinators and/or D&E Team and referrals to non-waiver services will be made. At that time, an individual would be informed of their right to appeal the LOC determination.

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).

Upon determination of eligibility and again when an individual is admitted to the waiver, individuals are informed of their ability to choose between services provided in an ICF/IID setting or those provided through the ID/DD Waiver. The individual/legal representative indicates his/her choice on the appropriate form and signs the form. The forms are maintained in each individual's ID/DD Waiver Support Coordination record. During record reviews DMH staff verifies there is documentation the individual was offered a choice and chose ID/DD Waiver services.

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.

These forms are maintained in the ID/DD Waiver Support Coordination record.

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):
For those presenting for an assessment, each of the DMH's 5 Regional Programs have available to them a list of interpreters to use when an individual seeks and/or receives services through the ID/DD Waiver.

For calls regarding information about the program or eligibility, DOM subscribes to a language line service which provides interpretation services for incoming calls from the individuals with limited English proficiency (LEP). The interpretation service provides access within minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office has an automated access code under the State identification code.

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

The purpose of the telephone language interpreter service is to provide meaningful access to information about benefits and services for LEP persons and to ensure the interpreter assistance provided results in accurate and effective communication between the Division of Medicaid and applicants/beneficiaries to determine their specific circumstances and needs.

Appendix C: Participant Services

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

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

Service Type	Service	
Statutory Service	Day Services-Adults	
Statutory Service	In-Home Nursing Respite	
Statutory Service	Prevocational Services	
Statutory Service	Supervised Living	
Statutory Service	Support Coordination	
Statutory Service	Supported Employment	
Statutory Service	Supported Living	
Extended State Plan Service	Specialized Medical Supplies	
Extended State Plan Service	Therapy Services	
Other Service	Behavior Support Services	
Other Service	Community Respite	
Other Service	Crisis Intervention	

Other Service	Crisis Support
Other Service	Home and Community Supports
Other Service	Host Home
Other Service	Job Discovery
Other Service	Transition Assistance

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Services-Adults

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

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

Service Definition *(Scope):*

Day Services-Adult is the provision of regularly scheduled activities in a non-residential setting, separate from the individual's private residence or other residential living arrangements, such as assistance and acquisition, retention, or improvement in social, self-help, socialization and other adaptive skills that enhance social development and skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Services-Adult must have a community integration component that meets each individual's need for community integration and participation in activities.

The cost for transportation is included in the rate paid to the provider. Time spent in transportation to and from the program shall not be included in the total number of service hours provided per day. Transportation for community outings can be counted in the total number of service hours provided per day.

Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day. A private changing/dressing area must be provided to ensure the dignity of each individual.

Staff must provide each individual assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.

Participants receiving Day Services-Adult may also receive Prevocational, Supported Employment, or Job Discovery services but not at the same time of the day.

Individuals must be at least 18 years of age.

Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Services may be provided at the day

program site or in the community. When provided in the community, Day Services - Adult may be offered individually or in groups of up to three (3) people.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Providers may bill for a maximum of 138 hours per month for an individual in a month which has 23 working days, a provider may bill a maximum of 132 hours per month for an individual in a month which has 22 working days.
Providers may only bill for the actual amount of service provided.

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	Day Services Adult Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Day Services Adult Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Initally and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Nursing Respite

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

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

Service Definition *(Scope):*

In-Home Nursing Respite is provided by a registered or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations. In-Home Nursing Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Nursing Respite staff provides all the necessary care the usual caregiver would provide during the same time period. In-Home Nursing Respite may also be provided when the usual caregiver is unexpectedly absent or incapacitated due to hospitalization, illness, injury or upon their death, depending on individual circumstances. The nurse may accompany the individual on short outings.

In-Home Nursing Respite is provided to individuals who are unable to care for themselves in the absence or need for relief of the primary caregiver. In-Home Nursing Respite is provided in the individual's family home.

In-Home Nursing Respite is not available for people who receive Supported Living, Supervised Living, Host Home services, or who live in any other type of staffed residence. In-Home Nursing Respite is not available to individuals who are in the hospital, an ICF/IID

In-Home Nursing Respite is provided by a registered or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations. In-Home Nursing Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Nursing Respite staff provides all the necessary care the usual caregiver would provide during the same time period. In-Home Nursing Respite may also be provided when the usual caregiver is unexpectedly absent or incapacitated due to hospitalization, illness, injury or upon their death, depending on individual circumstances. The nurse may accompany the individual on short outings.

In-Home Nursing Respite is provided to individuals who are unable to care for themselves in the absence or need for relief of the primary caregiver. In-Home Nursing Respite is provided in the individual's family home.

In-Home Nursing Respite is not available for people who receive Supported Living, Supervised Living, Host Home services, or who live in any other type of staffed residence. In-Home Nursing Respite is not available to individuals who are in the hospital, an ICF/IID

In-Home Nursing Respite is provided by a registered or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations. In-Home Nursing Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Nursing Respite staff provides all the necessary care the usual caregiver would provide during the same time period. In-Home Nursing Respite may also be provided when the usual caregiver is unexpectedly absent or incapacitated due to hospitalization, illness, injury or upon their death, depending on individual circumstances. The nurse may accompany the individual on short outings.

In-Home Nursing Respite is provided to individuals who are unable to care for themselves in the absence or need for relief of the primary caregiver. In-Home Nursing Respite is provided in the individual's family home.

In-Home Nursing Respite is not available for people who receive Supported Living, Supervised Living, Host Home services, or who live in any other type of staffed residence. In-Home Nursing Respite is not available to individuals who are in the hospital, an ICF/MR, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

Private Duty Nursing through EPSDT must be carefully coordinated with waiver services and be closely monitored to ensure EPSDT services are exhausted before waiver services are utilized.

An individual must have a statement from his/her physician/nurse practitioner stating: 1) the treatments/procedures the individual needs in order to justify the need for a nurse in the absence of the primary caregiver, and 2) how long the treatment(s) and/or procedure(s) are expected to continue.

In-Home Nursing Respite includes administration of medication and other treatments to the extent permitted by state law.

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	In-Home Nursing Respite Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
In-Home Nursing Respite Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify):*
DMH certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Intially and every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

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.**
- (selected) **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual.

Individuals receiving Prevocational Services must have employment related goals in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment goals. Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of Prevocational Services.

Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Examples include but are not limited to: ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Prevocational Services include activities that are not directed at teaching job specific skills but at underlying habilitative goals such as attention span, motor skills, and interpersonal relations that are associated with building skills necessary to perform work and optimally perform in competitive, integrated employment.

The distinction between vocational and Prevocational Services is that Prevocational Services, regardless of setting, are developed for the purpose of furthering habilitation goals that will lead to greater job opportunities. Vocational services teach job specific task skills required by a participant for the primary purpose of completing these tasks for a specific job and are delivered in an integrated work setting through Supported Employment.

Participation in Prevocational Services is not a prerequisite for Supported Employment. An individual receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force.

Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each individual at least one time per month.

Individuals may be compensated in accordance with applicable Federal Laws.

Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).

Transportation is a component of Prevocational Services. Time spent in transportation to and from the program shall not be included in the total number of service hours provided per day. However, time spent in transportation to and from the program for the purpose of training may be included in the number of hours of services provided per day for the period of time specified in the Plan of Services and Supports.

Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

At least annually, providers will conduct an orientation informing individuals about Supported Employment and other competitive employment opportunities in the community.

Personal care assistance from staff may be a component of Prevocational Services. Individuals cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.

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

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

Individuals receiving Prevocational Services may also receive Day Services-Adult, Job Discovery, and/or Supported Employment, but not at the same time of day.

Individuals must be at least 18 years of age to participate in Prevocational Services.

Providers may bill for a maximum of 138 hours per month for an individual who attends each working day in a month which has 23 working days. Providers may bill a maximum of 132 hours per month for an individual who attends each working day in a month which has 22 working days. Providers may only bill for the actual amount of service provided.

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	Prevocational Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Prevocational Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initially and at least every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):
Supervised Living

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

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

Service Definition *(Scope):*
Supervised Living provides individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Services provided include: direct personal assistance activities such as grooming, eating, bathing, dressing, and personal hygiene as well as instrumental activities of daily living which include assistance with planning and preparing meals, cleaning, transportation or assistance in securing transportation, assistance with ambulation and mobility, supervision of the individual's safety and security, banking, shopping, budgeting, facilitation of the individual's inclusion in community activities, use of

natural supports and typical community services available to all people, social interaction, participation in leisure activities, and development of socially valued behaviors. It also includes assistance with scheduling and attending appointments. Supervised Living Services may be provided in settings owned or leased by a provider agency or settings owned or leased by waiver participants.

Habilitation, learning and instruction are coupled with the elements of support, supervision, and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. This service includes activities to promote independence as well as care and assistance with activities of daily living when the individual is dependent on others to ensure health and safety. Supervised Living providers have staff on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests/needs for assistance. Accommodations must be made when an individual(s) wants to remain at home rather than joining group activities or if the individual is ill and must stay home from day activities.

If individual staff members have been unable to participate in the development of the Plan of Services and Supports, staff must be trained regarding the individual's Plan of Services and Supports prior to beginning work with the individual. This training must be documented and available for review.

The cost to transport individuals to work or day programs, social events or community activities when public transportation is not available will be included in payments made to providers of Supervised Living. Supervised Living staff may transport individuals in their own vehicles as an incidental component of this service but must have a valid driver’s license, current insurance, and registration.

Nursing services are also a component of Supervised Living services and must be provided in accordance with the Mississippi Nurse Practice Act.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Payments do not include payments made directly or indirectly to members of the individual’s family. Separate payment will not be made for routine care and supervision which is normally provided by a family or for activities or supervision for which a payment is made by a source other than Medicaid.

The Supervised Living provider shall oversee the individual’s healthcare needs by assisting with making appointments, transporting, and accompanying the individual to such appointments and, if the individual gives consent, talking with medical professionals.

Providers must provide furnishings used in common areas (den, dining, and bathrooms), kitchen supplies, cleaning supplies, and at least 2 sets of linens (including towels-bath towel, hand towel and wash cloth) per person. Providers are responsible for bedroom furnishings (bed frame, box springs, mattress, headboard, chest, night stand and lamp) if an individual has none. If individuals transitioning from institutions (ICF/IID and nursing facilities) do not receive these items through Bridge to Independence (Money Follows the Person) or Transition Assistance through this waiver, the provider is responsible for supplying the items for the individual.

The Supervised Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the individual is not participating in an activity during the day or is not at work. The provider may not receive or disburse funds on the part of the individual unless authorized by the Social Security Administration. The individual cannot also receive Home and Community Supports, Supported Living, In-Home Nursing Respite, Community Respite, or Host Home Services. An individual must be at least 18 years old to receive Supervised Living. Reimbursement for Supervised Living shall not include payment for services provided by a family member of any degree. Payment for Supervised Living can be made if a person is present for any part of the day.

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	DMH Certified Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supervised Living

Provider Category:
Agency

Provider Type:
DMH Certified Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initally and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Support Coordination

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

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Support Coordination is responsible for monitoring and coordinating all services an individual on the ID/DD Waiver receives, regardless of funding source, to ensure services are adequate, appropriate, meet individual needs, and ensure the individual's health and welfare needs are met.

Support Coordination activities must include:
1. Developing/reviewing/revising each individual's approved Plan of Services and Supports.
2. Informing each individual about all certified providers for the services on his/her approved Plan of Services and Supports at least annually or if an individual becomes dissatisfied with their current provider.
3. Submitting all required information for review/approval/denial to BIDD/Division of HCBS
4. Notifying each individual of approval/denial for:
a. Initial enrollment
b. Requests for additional services
c. Requests for increases in services
d. Requests for recertification of ICF/IID level of care
e. Requests for readmission
5. Notifying each individual of:
a. Approval of service(s)
b. Reduction in service(s)
c. Termination of service(s)
d. Discharge from the ID/DD Waiver
6. Informing and providing the individual/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services
7. Sending Service Authorizations to providers upon receipt of approval from BIDD/Division of HCBS.
8. Monitoring and assessment of the individual's Plan of Services and Supports must be ongoing and include:
a. Information on the individual's health and welfare, including any changes in health status
b. Information about the individual's satisfaction with current services(s) and providers(s) (ID/DD Waiver and others)
c. Information addressing the need for any new services (ID/DD Waiver or other) based upon expressed needs or concerns or changing circumstances and actions taken to address the need(s)
d. Information addressing whether the amount/frequency of services(s) listed on the Plan of Services and Supports remains appropriate
e. Review of individual plans developed by agencies which provide ID/DD Waiver services to the individual
f. Ensuring all services an individual receives, regardless of funding source, are coordinated to maximize the benefit for the individual
9. Making monthly contacts in the manner required by BIDD/Division of HCBS
10. Performing all necessary functions for the individual's annual recertification of ICF/IID level of care.
11. Conducting at least quarterly face-to-face visits with each individual according to BIDD requirements
12. Educating families on individual's rights and the procedures for reporting instances of abuse, neglect and exploitation
13. Completing the Risk Assessment Tool to be included in each provider's plan(s) for the individual.

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	DMH Regional Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency

Provider Type:
DMH Regional Program

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
DMH certification

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Intially and every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

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

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

Service Definition *(Scope)*:
Supported Employment is the ongoing support to individuals who, because of their disabilities, need intensive, ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment. Employment should be in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Providers must work to reduce the number of hours of staff involvement over the first few weeks of employment as the supported employee becomes more productive and less dependent on paid supports. This is decided on an individual basis based on the individual's identified need for support as established in the Plan of

Services and Supports.

Supported Employment includes activities needed to sustain paid work by individuals, including supervision and training. When Supported Employment services are provided in a work site where individuals without disabilities are employed, payment is made only for adaptations, supervision, and training required by individuals receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting.

Activities that constitute Supported Employment can include the following: assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction and ongoing job support and monitoring. If an individual moves from one job to another, it is the Supported Employment provider's responsibility to update the profile created during Job Discovery (if applicable) and to use the profile in obtaining another job for the individual.

Transportation will be provided between the individual's place of residence and the site of the individual's job or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of Supported Employment. Transportation cannot comprise the entirety of the service.

Supported Employment may also include services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include: (a) aiding the individual to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary for the individual to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched. Payment is not made for any expenses associated with starting up or operating a business.

Supported employment providers will immediately notify the individual's waiver Support Coordinator of any changes affecting the individual's income. The service provider shall work with both the individual and the Support Coordinator to maintain eligibility under the ID/DD Waiver, as well as health and income benefits through the Social Security Administration and other resources.

Assistance with toileting, hygiene, and transportation may be a component part of Supported Employment but may not comprise the entirety of the service.

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

Individuals cannot receive Supported Employment and Job Discovery at the same time.

Supported Employment does not include facility based or other types of services furnished in a specialized facility that are not part of the general workforce. Supported Employment cannot take place in a facility based program.

Supported Employment does not include volunteer work.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer's participation in the Supported Employment program; or 2) payments that are passed through to users of Supported Employment Services.

Individuals receiving Supported Employment may also receive Prevocational Services or Day Services-Adult services, but not at the same time of day.

An individual must be at least 18 years of age to participate in Supported Employment..

The service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq). Records for individuals receiving ID/DD Waiver Supported Employment Services will document that the Mississippi Department of Rehabilitation Services (MDRS) was unable to serve the individual.

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	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Supported Living

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

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living. Supported Living provides individuals with direct personal assistance activities such as grooming, eating, bathing, dressing, and personal hygiene as well as instrumental activities of daily living which include assistance with planning and preparing meals (but not include the cost of the meals themselves), cleaning, transportation or assistance in securing transportation, assistance with ambulation and mobility, supervision of the individual's safety and security, banking, shopping, budgeting, facilitation of the individual's inclusion in community activities, use of natural supports and typical community services available to all people in order to facilitate meaningful days. It also includes assistance with scheduling and attending appointments. The provider may not receive or disburse funds on the part of the individual.

Staff providing Supported Living may not sleep during billable hours. Supported Living may be shared by up to 3 individuals who may or may not live together and who have a common direct service provider agency. Individuals may share Supported Living staff when agreed to by the individuals and the health and welfare can be assured for each individual.

Supported Living includes transportation when necessary. The cost is included in rate paid to the provider. Staff providing transportation must have documentation of: a valid driver's license, registration, and current insurance.

Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the program site, depending on the type of emergency.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported Living is not available to individuals receiving Supervised Living, Host Home services, In-Home Nursing Respite, Home and Community Supports, or Community Respite.

Individuals must be at least 18 years of age to receive Supported Living. Supported Living cannot be provided to someone who is an inpatient of a hospital, ICF/IID, nursing facility, or any type of rehabilitation facility when the inpatient facility is billing Medicaid, Medicare or private insurance.

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	Supported Living Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:
Agency

Provider Type:
Supported Living Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
DMH certification

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initially and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Specialized Medical Supplies

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

- (selected) **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)*:
Specialized Medical Supplies are those that are in excess of Specialized Medical Supplies covered in the State Plan, either in amount or type. Specialized Medical Supplies will be provided under the State Plan until the individual reaches his/her maximum type/amount. Supplies covered under the waiver include only specified types of catheters, diapers and underpads.

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	Durable Medical Equipment (DME)

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Durable Medical Equipment (DME)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DME providers must be certified as a DME supplier under Title XVII (Medicare) of the Social Security Act and provide current documentation of their authorization to participate in the Title XVII program to DOM.
Other Standard *(specify):*
DME providers must meet all applicable requirements of law to conduct business in the State and must be enrolled as a Medicaid provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
The DOM fiscal agent.
Frequency of Verification:
Will be verified by DOM fiscal agent when enrolled and when original certification expires.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Therapy Services

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

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

Service Definition *(Scope):*
Therapy services are Physical Therapy (PT), Occupational Therapy (OT), and Speech/Language Therapy (ST) that are in excess of therapy services covered in the State Plan, either in amount, duration or scope are included as waiver services.

Therapy services will be provided under the State Plan until the individual reaches his/her maximum health care goal or is no longer eligible for prior approval from the DOM Quality Improvement Organization (QIO) based on medical necessity criteria established for State Plan services.

Therapy services through the ID/DD Waiver begin at the termination of State Plan therapy services.

These services are only available through the waiver when not available through the IDEA (20 U.S.C 1401 et seq.) or through Expanded EPSDT.

Therapy services provided through the ID/DD Waiver begin at the termination of State Plan therapy services.

These services are only available under the waiver when not available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 etseq.) or through Expanded EPSDT.

Therapy services must be approved on the individuals approved Plan of Care (POC).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum of 3 hours per week of physical therapy. Maximum of 3 hours per week of speech therapy. Maximum of 2 hours per week of occupational therapy.

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	DOM Approved Agency
Individual	Physical Therapist, Occupational Therapist and Speech-Language Pathologist (Speech Therapist)

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
DOM Approved Agency

Provider Qualifications

License *(specify):*
Individuals providing therapy services must be licensed by the State in their respective discipline.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

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

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapist, Occupational Therapist and Speech-Language Pathologist (Speech Therapist)

Provider Qualifications

License *(specify):*

Physical Therapists, Occupational Therapists, and Speech-Language Pathologist (Speech Therapist) must be licensed by the State in their respective discipline.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Services

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

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

Service Definition *(Scope):*

Behavior Support provides systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration and/or are threatening to require movement to a more restrictive setting. This service also includes consultation and training provided to families

and staff working with the individual. The desired outcome of the service is long term behavior change.

Behavior Support may not replace educationally-related services provided to individuals when the service is available under IDEA or is covered under an Individualized Family Service Plan (IFSP) through First Steps. All other sources such as EPSDT must be exhausted before waiver services can be approved. Behavior Support can be provided simultaneously with other waiver services if the purpose is to: 1) conduct a Functional Behavior Assessment; 2) provide direct intervention; or 3) provide training to staff/parents on implementing and maintaining the Behavior Support Plan.

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

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	Behavior Support Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Services

Provider Category:
Agency

Provider Type:
Behavior Support Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
DMH Certification

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Respite

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

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

Service Definition *(Scope):*

Community Respite is provided in a community setting (DMH certified site which is not a private residence) and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home. Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which has scheduled activities to address individual preferences/requirements and also provides for the health and socialization needs of the individual. Community Respite services are generally provided in the afternoon, early evening, and on weekends. The Community Respite provider must assist the individual with toileting and other hygiene needs. Individuals must be offered and provided choices about snacks and drinks. There must be meals available if Community Respite is provided during a normal meal time such as breakfast, lunch or dinner.

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

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

Individuals who receive Host Home services, Supervised Living, and Supported Living cannot receive Community Respite.

Community Respite cannot be provided overnight.

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	Community Respite Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Respite

Provider Category:

Agency

Provider Type:
Community Respite Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH Certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Crisis Intervention

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

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

Service Definition *(Scope):*
Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or others and/or may result in the individual's removal from his/her current living arrangement.

There are three models: 1) Crisis Intervention in the individual's home 2) Crisis Intervention provided in an alternate community living setting or 3) the individual's usual day setting. Regardless of the setting, Crisis Intervention staff will deliver services in such a way as to maintain the individual's normal routine to the maximum extent possible. This includes support during Day Services-Adult, Prevocational Services, or Supported Employment. These services may be billed at the same time as Crisis Intervention.

The outcome of Crisis Intervention is to phase out the support as the individual becomes more able to function behaviorally in his/her daily routines/environments and is able to return to his/her home or to Supervised Living or Supported Living.

Crisis Intervention includes consultation with family members, providers and other caregivers to design and implement individualized Crisis Intervention Plans and provide additional direct services as needed to stabilize the situation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Crisis Intervention is authorized for up to 24 hours per day in 7 day segments with the goal of being a phased out 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	Crisis Intervention Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:
Agency
Provider Type:
Crisis Intervention Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH Certication
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Intially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Crisis Support

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

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

Service Definition *(Scope):*
Crisis Support services are provided in an ICF/IID and are used when an individual's behavioral or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention/Behavior Support. Crisis Support is time limited in nature and provides the individual with the behavioral and emotional supports necessary to allow the individual to return to his/her living arrangement. Crisis Support is not billed to the State Plan; it is a waiver service. The DMH reviews and approves all requests for admission to ICF/IIDs; therefore the Crisis Support provider cannot admit an individual to their ICF/IID program without prior approval from the DMH.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a maximum of 30 days per stay. Additional days must be prior authorized by the Director of BIDD or DMH Clinical Services Liaison.

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	ICF/IID

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Support

Provider Category:
Agency

Provider Type:
ICF/IID

Provider Qualifications

License *(specify):*
ICF/IID

Certificate *(specify):*
Medicaid certified

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
MS Department of Health

Frequency of Verification:

At least annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home and Community Supports

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

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

Service Definition *(Scope):*

Home and Community Supports is for individuals who live in the family home and provides assistance with ADLs and IADLs such as bathing, toileting, transfer and ambulation, meal preparation (but not the cost of the meals themselves), assistance with eating, assistance with incidental household cleaning and laundry which are essential to the health, safety, and welfare of the individual. Home and Community Supports also includes facilitation of the individual's inclusion in the community. Meaningful days are the ultimate outcome for everyone. Activities can include assistance with keeping appointments, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities and shopping and money management as long as the provider is not disbursing funds on behalf of the recipient.

Home and Community Supports may be shared by up to three individuals who have a common direct service provider agency. Individuals may share Home and Community Supports staff when agreed to by the participants and the health and welfare can be assured for each participant. The shared staff must be reflected on the participants' Plans of Services and Supports.

Transportation is included in the rate paid to the provider. Home and Community Supports staff must transport individuals in their own vehicles as an incidental component of this service, but must possess a valid driver's license, current insurance, and registration.

Home and Community Supports cannot be provided in a school setting or be used in lieu of school services or other available day services.

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

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

The amount of Home and Community Supports provided by a family member cannot exceed 40 hours per week.

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	DMH Certified Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
DMH Certified Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Intially and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Host Home

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

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Host Homes are private homes where an individual lives with a family and receives personal care and supportive

services. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment. Host Home agencies are to take into account compatibility with the Host Home Family member(s) including age, support needs, and privacy needs. The individual receiving Host Home services must have his/her own bedroom.

Host Home Services include assistance with personal care, leisure activities, social development, family inclusion, community inclusion, and access to medical services. Natural supports are encouraged and supported. Supports are to be consistent with the participant's skill level, goals, and interests.

Host Home agencies must: ensure availability, quality and continuity of Host Homes, recruit, train, and oversee the Host Home Family (training must be approved by the DMH); have 24 hour responsibility which includes back-up staffing for scheduled and unscheduled absences of the Host Home Family.

Relief staffing may be provided in the individual's Host Home by another Host Home Family or staff of the Host Home agency or in another Host Home Family's home.

Host Home Family: The principal caregiver in the Host Home must attend and participate in the meeting to develop the individual's Plan of Services and Supports. The Host Home Family must follow all aspects of the individual's Plan of Services and Supports and any support/activity plan; assist the individual in attending appointments (i.e., medical, therapy, etc.); provide transportation as would a natural family member; maintain required documentation; meet all staff training requirements as outlined in the DMH Operational Standards; and participate in training provided by the Host Home agency.

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

The maximum number of waiver participants who may live in a Host Home is (one) 1. Individuals receiving services must be at least 18 years of age.

Payment does not include room and board or maintenance, upkeep or improvement of the Host Home Family's residence. Environmental adaptations are not available to participant's receiving Host Home services since the participant's place of residence is owned or leased by the Host Home Family. The Host Home agency is responsible for ensuring the individual has basic furnishings in his/her bedroom if those furnishings are not available from another source such as Bridge to Independence (Money Follows the Person) or Transition Assistance through the waiver.

Individuals receiving Host Home services are not eligible for Home and Community Supports, Supported Living, Supervised Living, In-Home Nursing Respite, or Community Respite.

Individuals receiving Host Home services must be able to self-administer their medication(s).

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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Host Home Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:
Agency
Provider Type:
Host Home Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Initally and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Job Discovery

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

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

Service Definition *(Scope):*
Job Discovery includes, but is not limited to, the following types of person-centered services: Assisting the individual with volunteerism, self-determination and self-advocacy, identifying wants and needs for supports, developing a plan for achieving integrated employment, job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, employment preparation (i.e. resume development, work procedures), and business plan development for self-employment. Job discovery is intended to be time-limited. The initial discovery process should result in the development of a person-centered career profile and employment goal or career plan. Individual staff must receive or participate in at least 8 hours of training on Customized Employment before providing Job Discovery services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Job Discovery should not exceed 20 hours of service over a three (3) month period and will result in the development of a career profile and employment goal or career plan. Additional monthly increments/hours must be justified and prior authorized by the BIDD.

Individuals who are currently employed may not receive Job Discovery.

Individuals must be at least 18 years of age to participate in Job Discovery.

An individual cannot receive Prevocational Services or Day Services-Adult at the same time of day as Job Discovery. Individuals cannot recieve Supported Employment and Job Discovery at the same time.

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	Job Discovery Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job Discovery

Provider Category:
Agency

Provider Type:
Job Discovery Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DMH

Frequency of Verification:
Initially and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Transition Assistance

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

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

Service Definition *(Scope):*
Transition Assistance is a one-time, set-up expense for individuals who transition from an institution (ICF/IID or a Title XIX Nursing Home) to a less restrictive community living arrangement such as a house or apartment where they receive Supervised or Supported Living services, or a Host Home living arrangement and who do not use services provided through Bridge to Independence (Money Follows the Person).

To be eligible:

1) The individual cannot have another source to fund or attain the items or support and
2) The individual must be transitioning from a setting where these items were provided and
3) The individual must be moving to a residence where these items are not normally furnished
Items bought using these funds are for individual use and are to be property of the individual if an individual moves from a residence owned or leased by a waiver provider.

There is a one-time, life time maximum service of $800 per individual. Service expenditures must be on the approved Plan of Services and Supports.

Examples of expenses that may be covered include:
• Expenses to transport furnishings and personal possessions to the new living arrangement;
• Essential furnishing expenses required to occupy and use a community domicile;
• Linens and towels
• Cleaning supplies
• Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
• Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
• Initial stocking of the pantry with basic food items
• Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Transition Assistance services shall not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes such as televisions, cable TV access or VCRs or DVD players.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual's whose ICF/IID or NF stay is acute or is for rehabilitative purposes is not eligible for 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	Supported Living Agency

Agency	Supervised Living Agency
Agency	Host Home Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance

Provider Category:
Agency
Provider Type:
Supported Living Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH Certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Intially and every 3 years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance

Provider Category:
Agency
Provider Type:
Supervised Living Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DMH certification
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Initially and at least every 3 years thereafter

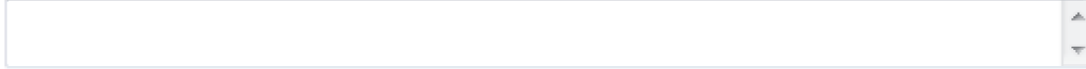
Appendix C: Participant Services

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

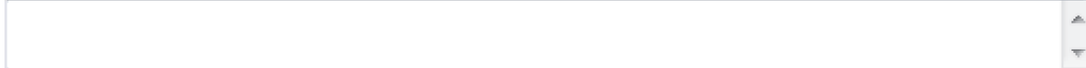
Service Type: Other Service
Service Name: Transition Assistance

Provider Category:

Provider Type:
Host Home Agency
Provider Qualifications
License *(specify):*



Certificate *(specify):*
DMH certification
Other Standard *(specify):*



Verification of Provider Qualifications
Entity Responsible for Verification:
DMH
Frequency of Verification:
Intially and every 3 years thereafter.

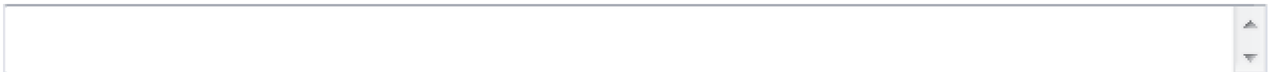
Appendix C: Participant Services

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:



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):

All providers are certified for a three year period. During the three year period, DMH staff conducts on-site monitoring visits two out of the three years, based on a rotating schedule, to ensure compliance with DMH Operational Standards. Part of the on-site monitoring process includes reviewing personnel records of staff providing services. One of the elements reviewed is whether the criminal history/background investigation was conducted and returned indicating no criminal activity before the staff person began providing services. If it is found that a criminal history/background check 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. In order for the staff member(s) to return to service delivery, the provider must provide evidence to DMH that a criminal history/background investigation has been conducted. The maximum length of time for the submission of a corrective action plan is 30 days, which may be altered by DMH given the nature and severity of the concern. Plans must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Executive Leadership Team reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. Should a Plan not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

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):

All providers are certified for a three year period. During the three year period, DMH staff conducts on-site monitoring visits two out of the three years, based on a rotating schedule, to ensure compliance with DMH Operational Standards. 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 activity 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 he 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 DMH given the nature and severity of the concern. Plans must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Executive Leadership Team reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. Should a Plan not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

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	
Adult Group Home	

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.

Supervised living sites must duplicate a “home-like” environment. All furnishings must be safe, comfortable, appropriate and adequate in order to meet the needs of the individuals served at that location. Prior to receiving DMH certification for a supervised living program location, DMH reviews the location to ensure access to community resources and supports typically found in communities.

The DMH Operational Standards and monitoring process ensure the following:
A. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
B. Each individual has privacy in their sleeping or living unit:
C. Units have lockable entrance doors, with appropriate staff having keys to doors;
D. Individuals share units only at the individual’s choice; and
E. Individuals have the freedom to furnish and decorate their sleeping or living units.
F. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
G. Individuals are able to have visitors of their choosing at any time; and
H. The setting is physically accessible to the individual.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Services-Adults	☐
Therapy Services	☐
Behavior Support Services	☐
In-Home Nursing Respite	☐
Host Home	☐
Supported Living	☐
Supervised Living	☑
Job Discovery	☐

Supported Employment	☐
Transition Assistance	☐
Support Coordination	☐
Crisis Intervention	☐
Prevocational Services	☐
Crisis Support	☐
Community Respite	☐
Specialized Medical Supplies	☐
Home and Community Supports	☐

Facility Capacity Limit:

6

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*:

- (selected) **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.*

- (selected) **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.

  Home and Community Supports: Providers seeking approval for a family member to provide Home and Community Supports regardless of relationship or qualifications, must get prior approval from the DMH Executive Leadership Team. Each request is considered on a case-by-case basis. Each request for approval must include a copy of the proposed staff's high school diploma or GED equivalent as well as documentation of reference checks. If the requested staff member does not meet the minimum qualifications as outlined in the DMH Operational Standards, a waiver of the DMH Operational Standard must be requested through the Bureau of Quality Management, Operations, and Standards. The following types of family members will not be considered for approval and are not allowed to provide Home and Community Supports: those who live in the same home, those that are parents/step-parents of the individual receiving services, those who are a spouse, legal guardian, or anyone else who is normally expected to provide care for the individual receiving services. Anyone who lives in the home with the individual, regardless of relationship, cannot provide Home and Community Supports. Family members employed as staff to provide Home and Community Supports must meet the qualifications and training requirements outlined in the DMH Operational Standards. Although the State does not make direct payment to family members, it does reimburse providers who employ qualified relatives who meet all DMH Operational Standards.

Host Homes: Providers seeking approval for a family member to provide Host Home services, regardless of relationship or qualifications, must get prior approval from the DMH Executive Leadership Team. Each request is considered on a case-by-case basis. Each request must include a copy of the Host Home provider's application packet as well as the results of required background checks. The following types of family members will not be considered for approval and are not allowed to provide waiver services: parents who are legal guardians or anyone who is the individual's representative payee. Family members employed as staff to provide waiver services must meet the qualifications and training requirements outlined in the DMH Operational Standards and the Host Home Provider's training requirements. Although the State does not make direct payment to family members, it does reimburse providers who employ qualified relatives who meet the DMH Operational Standards.

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:

DMH's website has information regarding requirements and procedures for becoming a DMH certified provider. Additionally, DMH's BQMOS conducts quarterly provider orientation sessions to inform potential providers of the process, requirements and timeframes for becoming a DMH certified provider. The Division of Medicaid also participates in the New Provider Orientation to provide information regarding the processes and timelines for becoming a Medicaid provider. The DMH Operational Standards contain the processes, procedures for becoming a DMH certified provider.

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:
QP a.i.a. (1) Number and percent of provider agencies that initially meet DMH certification requirements prior to service delivery. N: # of provider agencies meeting initial certification requirements prior to service delivery D: # of provider agencies seeking initial DMH certification

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

DMH Certification Database

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

Data Aggregation and Analysis:

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

QP a.i.a. (2) Number and percent of provider agencies that continue to meet DMH requirements for certification. N: # of waiver agencies who continue to meet DMH requirements for certification D: total # of waiver agencies

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

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

Data Aggregation and Analysis:

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

☐ Continuously and Ongoing
☐ Other Specify:

Performance Measure:
QP a.i.a (3) Number and percent of provider agencies that initially meet Medicaid provider requirements prior to service delivery. N: # of provider agencies meeting initial Medicaid provider requirements prior to service delivery D: # of provider agencies seeking initial Medicaid Provider status

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intial provider applications submitted to fiscal agent

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:
QP a.i.a. (4) Number and percent of provider agencies that continue to meet Medicaid provider requirements. N: # of waiver provider agencies who continue to meet Medicaid requirements as a provider D: total # of waiver provider agencies

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

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.

Performance Measure:
The state does not have non-licensed or non-certifed providers.

Data Source (Select one):
Other
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: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: N/A
	☑ **Other** Specify: N/A	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/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:
QP a.i.c. (1) Number and percent of DMH provider agencies who meet training requirements N: # of DMH ID/DD Waiver provider agencies meeting training requirements D: # of DMH ID/DD Waiver provider agencies

Data Source (Select one):
Other

If 'Other' is selected, specify:

DMH Written Reports of Findings

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.
N/A

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.
DMH certified provider agencies are required to submit Plans of Compliance within 30 days or sooner, if indicated by DMH, for approval should problems be identified. Plans of Compliance must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Executive Leadership Team reviews and approves or disapproves all Plans of Compliance. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. DMH does provide technical assistance to a provider agency to assist them with developing an acceptable Plan of Compliance. Should a Plan of Compliance not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

In addition to the possibility of suspension or termination of certification based on an unacceptable Plan of Compliance, DMH certified providers can also have their certification status affected for egregious acts such as endangerment of the health and welfare of an individual being served, unethical conduct, or failure to comply with fiscal requirements.

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*).

- (selected) **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 D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Plan of Services and Supports

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Each Support Coordinator is a state employee who meets the Mississippi State Personnel Board's qualifications for their positions. Generally, these positions are occupied by individuals who hold at least a bachelor's degree in a human services field related to working with individuals with intellectual disabilities and/or developmental disabilities and at least one year of experience in said field.

- [ ] **Social Worker.**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

ID/DD Waiver Support Coordinators are located at each of the state's 5 Regional Programs. In addition to housing the Support Coordinators, each of the 5 Regional Programs also provide other ID/DD Waiver services. While ID/DD Waiver Support Coordinators are employed by Regional Programs which also provide direct services, the two functions are kept distinctly and carefully separate to avoid any conflict of interest. DMH Operational Standards specifically state that ID/DD Waiver Support Coordinators cannot supervise or provide any other waiver services. Each individual is offered a choice of certified providers for each service on his/her approved Plan of Services and Supports. Individuals are offered literature from certified agencies to review to assist in making a decision. Additionally, the individual/family may wish to speak with a representative from one or more agencies before making a decision. The ID/DD waiver Support Coordinator helps facilitate the process if requested. When an individual chooses a provider, his/her choice is documented in the individual's record. If at any time an individual becomes dissatisfied with a provider, he/she is again apprised of all certified providers from which to choose. Additionally, BIDD/Division of HCBS staff review individual records to ensure individuals are offered a choice of providers at least annually, when a new provider is qualified, or if an individual becomes dissatisfied with their current provider. Additionally, DMH maintains a comprehensive statewide database of certified providers which is searchable by county and can be found on the DMH website.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Each individual and/or their chosen representative is meaningfully and actively engaged in the development and maintenance of the Plan of Services and Supports in several ways. The individual/chosen representative chooses the people he/she would like to attend the development/review of the Plan of Services and Supports. The individual/chosen representative, through a person-centered planning process, determines the outcomes he/she would like to happen as a result of receiving ID/DD Waiver services. Additionally, they request the types and amounts of services, as well as the provider they would like to have render the services.

Throughout an individual's certification year, the Support Coordinator is in constant contact with the individual/chosen representative and the individual's service providers. During these contacts, the Support Coordinator is able to gather information from the individual regarding any adjustments that are needed to the Plan of Services and Supports or to the Individual Activity Plan which guides the daily provision of services at the provider level. The Support Coordinator communicates this information to the provider and revises the Plan of Services and Supports as needed.

At each annual meeting to develop the Plan of Services and Supports, providers make available the person's Individual Activity Plan which describes what the individual does during the provision of the service and how the service meets the individual's chosen outcomes. Part of the development of the Plan of Services and Supports involves the individual/chosen representative determining the activities he/she would like to do on a daily basis during the provision of ID/DD Waiver Services. All of this information is reviewed and discussed at the Plan of Services and Supports development meeting and included in the Plan of Services and Supports. Providers are given this information for use in developing Individual Activity Plans to be used during the daily provision of services.

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):

(a) The development of the Plan of Services and Supports is driven by the person centered planning process. The individual or legal representative (if applicable), the Support Coordinator, and others of the individual's choosing participate in the development of the Plan of Services and Supports. The Plan of Services and Supports must be revised at least annually or when changes in need arise. The Plan of Services and Supports must be submitted to the BIDD/Division of HCBS before the end of the individual's certification period to ensure there is no lapse in services. The Plan of Services and Supports is valid for one year from the individual's certification begin date.

(b) Before enrollment in the ID/DD Waiver, individuals have to first be evaluated by one of the state's five Diagnostic and Evaluation Teams. The information from the evaluation is used as part of the basis for the development of the initial Plan of Services and Supports. After the initial assessment, the person-centered planning meeting that leads to the development of the Plan of Services and Supports is considered to be the assessment for the individual. An individual's needs are continually being assessed through monthly and quarterly contacts with the individual and with his/her providers. Adjustments to the Plan of Services and Supports and/or Individual Activity Plans are made when the individual requests such. The State of Mississippi is participating in the Balancing Incentive Program. As part of that, the state is required to develop a Core Standardized Assessment to be used to assess all populations' functional needs. When that is developed, it will become part of the assessment process for the ID/DD Waiver.

(c) The individual is informed about all certified providers before he/she is initially certified and at least annually thereafter, when new providers are certified, or if the individual becomes dissatisfied with his/her provider. The Support Coordinator is knowledgeable of all available waiver services and certified providers.

(d) In Supervised and Supported Living services and in Host Homes, providers are required to document each visit a person makes to a health care provider. This documentation includes the reason for the visit and the physician's instructions, including monitoring for any potential unwanted side effects of the prescribed medication(s). This documentation is reviewed by all staff and the review is documented via their initials on the form.

Support Coordinators are also required to inquire about each individual's health care needs and changes in such during monthly and quarterly contacts. Additionally, the Division of Medicaid provides a monthly utilization report to Support Coordinators that lists all Medicaid services a person receives each month. This is one tool the Support Coordinator can use to determine if the person has been to the doctor, been hospitalized, or changed medications. Health care needs are also addressed with providers. Providers are contacted at least quarterly to ascertain how their services are assisting the individual in meeting stated outcomes. One of the questions is to review any changes in the individual's health status.

(e) The coordination of waiver and other services is a constant activity for Support Coordinators. Through at least monthly contacts, the Support Coordinator is able to determine which services are being utilized, what new services may be needed and what services may need to be reviewed for effectiveness. Through at least quarterly face-to-face contacts in the individual's service settings, Support Coordinators are able to observe the individual, talk with the individual and talk with staff to ensure all services the individual receives are adequate and appropriate.

Each provider is required to submit a quarterly report summarizing the level of support provided to each individual based on the Plan of Services and Supports. The Support Coordinator reviews these reports for consistency with the Plan of Services and Supports and works with providers as needed to address findings from these reviews.

Any needed back up arrangements are discussed during the development of the Plan of Services and Supports. Types of back up arrangements include: Emergency contact information for staff; provider arrangements for an additional staff person if the regularly scheduled one cannot be present; natural supports including families, neighbors and friends; use of generators in case of power outages if the individual requires electricity powered medical devices; other individually tailored arrangements, depending on each person's identified risks.

(f) The Support Coordinator is responsible for ensuring all services are implemented as approved on the individual's Plan of Services and Supports. This is accomplished through monitoring service provision during Onsite and face-to-face visits, review of the monthly utilization reports and review of quarterly provider reports.

g) The Plan of Services and Supports is reviewed at a minimum every 90 days and updated at least annually. A change in the Plan of Services and Supports can be requested by the individual at any time, whether it is a new service provider, or change in the type/amount of service. The Support Coordinator is responsible for coordinating any requests for changes and submitting the required information for such to the BIDD/Division of HCBS. There must be documentation to support the need for a change if it is a change in the type/amount of service.

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.

Support Coordinators must, in conjunction with the individual and his/her service providers, complete The Risk Assessment Tool. The tool identifies mitigation and emergency back-up strategies. The Risk Assessment Tool is completed at least annually by the Support Coordinator with input from the individual and all providers. The tool is then shared with all providers for them to review incorporate identified risks and mitigation strategies into the individual plan(s) developed by the provider(s).

Any needed back up arrangements are discussed during the development of the Plan of Services and Supports. Types of back up arrangements include: Emergency contact information for staff; provider arrangements for an additional

staff person if the regularly scheduled one cannot be present; natural supports including families, neighbors and friends; use of generators in case of power outages if the individual requires electricity powered medical devices; other individually tailored arrangements, depending on each person's identified risks.

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.

Support Coordinators provide people with a list of certified providers for the service(s) they are requesting on their Plan of Services and Supports. The Support Coordinator will assist the individual in arranging tours of service sites if the individual so chooses or in interviewing/meeting with agency representatives until the individual chooses a provider. If at any time an individual becomes dissatisfied with his/her provider, he/she can contact the Support Coordinator and choose a new provider from the list of certified providers. Additionally, the DMH maintains a comprehensive statewide database of certified providers which is searchable by county and can be found on the DMH website.

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):

All documentation for initial certification, recertification or change in type/amount of service is submitted electronically. Both the Bureau of Intellectual and Developmental Disabilities/Division of HCBS and Medicaid have access to these documents at any time. BIDD/Division of HCBS approves/disapproves all requests for initial certification, recertification and changes in type/amount of service. Documentation of BIDD/Division of HCBS's action is maintained in an electronic filing system so that Medicaid has immediate access and can review documentation used to make decisions any time.

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

Specify:

The Support Coordinators maintain the full electronic record at each Regional Program. Copies of Plans of Services and Supports are submitted electronically for review by BIDD/Division of HCBS staff at least annually. Both DMH and Medicaid have access to all Plans of Services and Supports at all times via an electronic filing system.

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.

Support Coordinators monitor implementation of the Plan of Services and Supports as well as individual health and welfare on a monthly basis. Support Coordinators also speak with individuals/legal representatives at least two times per month or more frequently as determined by the Plan of Services and Supports or see the individual during a face-to-face contact. Detailed documentation of all contacts is maintained in the ID/DD Waiver Support Coordination contact summaries. During monthly contacts, the Support Coordinator talks with the individual to:

a. Determine if needed supports and services in the Plan of Services and Supports have been provided
b. Review implementation of strategies, guidelines, and action plans to ensure specified need, preferences, and desired outcomes are being met
c. Review the individual's progress and accomplishments
d. Review the individual's satisfaction with services and providers
e. Identify any changes to the individual's needs, preferences, desired outcomes, or health status
f. Identify the need to change the amount or type of supports and services or to access new waiver or non-waiver services
g. Identify the need to update the Plan of Services and Supports

Support Coordinators are also required to have face-to-face visits with each individual at least once every three months, rotating service settings and talking to staff.

The effectiveness of back up plans is monitored by the Support Coordinator. Monitoring methods include talking with the individual at least two times per month to determine if back-up plans have been needed and if so, how were they utilized, did the plan work appropriately, and what changes, if any, need to be made to the back-up plan. Additionally the use of back up plans is monitored through quarterly contact with providers to determine if the plan has been used and if any changes/modifications are necessary to increase efficiency and effectiveness.

Access to health care services is monitored by Supervised and Supported Living service providers and Host Home providers as well as Support Coordinators. In Supervised and Supported Living services and in Host Homes, providers are required to document each visit a person makes to a health care provider. This documentation includes the reason for the visit and the physician's instructions, including monitoring for any potential unwanted side effects of the prescribed medication(s). This documentation is reviewed by all staff and the review is documented via their initials on the form. Staff from the DMH monitors provider records to determine if individuals have and are accessing health care services. Support Coordinators are also required to inquire about each individual's health care needs and changes in such during monthly and quarterly contacts. Additionally, the Division of Medicaid provides a monthly utilization report to Support Coordinators that lists all Medicaid services a person receives each month. This is one tool the Support Coordinator can use to determine if the person has been to the doctor, been hospitalized, or changed medications. Staff from the DMH monitor Support Coordination records to determine Support Coordinators are ensuring individuals have and are accessing health care services and if not, what steps are being implemented to ensure access.

Individuals are afforded a choice of providers when the Plan of Services and Supports is initially developed, annually at the Plan of Services and Supports meeting, when new providers are certified or at any time they become unhappy with a current provider(s). Support Coordinators are responsible for informing individuals about all certified providers for the services listed on the Plan of Services and Supports and for routinely assessing an individual's satisfaction with services and providers (two monthly phone contacts and quarterly face-to-face visits). The DMH also maintains and electronic database on its website that allows individuals to search for providers by county.

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:*

Quality improvement at the individual level is focused on monitoring and improving care and outcomes for the individual. The individual's Support Coordinator is primarily responsible for quality improvement at the individual level. Individual level discovery takes place through the monthly and quarterly contacts that a Support Coordinator makes with the individual and his/her providers. When a Support Coordinator discovers an issue related to the individual's Plan of Services and Supports, he/she is responsible for addressing the issue with the individual's provider and developing remedial actions to address the issue. If a provider is not responsive to individual level remediation, a Support Coordinator is responsible for reporting the issue as a grievance through DMH's established grievance reporting procedures.

The Offices of Consumer Supports(OCS) notifies BIDD of grievances related to implementation of Plans of Services and Supports. OCS and BIDD staff work together to determine the needed remediation steps based on programmatic requirements. OCS staff notifies the provider of the required remedial action and timelines for implementation. The provider is required to submit documentation that the identified issue has been remediated. The Support Coordinator also receives a copy of the DMH requirements and provider's response. The Support Coordinator follows-up to determine adherence to the requirements specified by BIDD and OCS. The Support Coordinator and provider work to make any needed revisions of the Plan of Services and Supports.

In addition to individual level discovery and remediation that occurs as a responsibility of Support Coordinators, DMH is also responsible for discovery related to individual level remediation. Through DMH's on-site monitoring process, which includes individual record review, individual issues are identified for remediation by the Support Coordinator. These issues include, but are not limited to, follow up regarding accessing community resources, identification of additional needs, etc. Individual level discovery and remediation also occurs through DMH's serious incident reporting/tracking processes and grievance process. Data from the results of provider monitoring, serious incidents, and grievances is available on an individual, provider or system level basis dependent upon the format needed for remediation and quality improvement.

DMH submits quarterly reports to the Division of Medicaid summarizing issues identified during reviews of Plan of Services and Supports. Entire reports are available to Medicaid.

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:
SP a.i.a. (1) Number and percent of Plans of Services and Supports in which the services and supports align with assessed needs including health and safety risks. N: # of Plans of Services and Supports reviewed in which services and supports align with identified needs D: # of Plans of Services and Supports reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5%margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
SP a.i.a. (2) The proportion of individuals reporting that Support Coordinators (SC) help them get what they need. N: # of individuals who report SC help them get what they need D: # of individuals included in survey sample

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
National Core Indicators- Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants who were afforded a choice of waiver providers. N # of sampled participants who were afforded a choice of waiver providers. D # of participants sampled.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DMH Written reports of findings

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95% with +/- 5% margin of error
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
SP a.i.b. (1) Number and percent of Plans of Services and Supports developed as required by approved waiver N: # of Plans of Services and Supports developed as required D: # of Plans of Services and Supports reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
[ ] **State Medicaid Agency**	[ ] **Weekly**	[ ] **100% Review**
[x] **Operating Agency**	[ ] **Monthly**	[x] **Less than 100% Review**
[ ] **Sub-State Entity**	[ ] **Quarterly**	[x] **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
[ ] **Other** Specify:	[ ] **Annually**	[ ] **Stratified** Describe Group:
	[x] **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**
[x] **Operating Agency**	[ ] **Monthly**
[ ] **Sub-State Entity**	[x] **Quarterly**
[ ] **Other** Specify:	[ ] **Annually**
	[ ] **Continuously and Ongoing**
	[ ] **Other** Specify:

Performance Measure:

SP a.i.b. (2) The proportion of people who report involvement in creating their Plan of Services and Supports. N: # of people who report involvement in creating their Plan of Services and Supports D: # of people in the survey sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators- Consumer Survey Results

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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:
SP a.i.c. (1) Number and percent of Plans Services and Supports in which changes in needs resulted in revisions to services N: # of Plans of Services and Supports changed based on identified needs D: # of people with changes in needs identified in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review - monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5 % margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP a.i.c. (2) Number and percent of Plans of Services and Supports revised within 365 days of the last Plan of Services and Supports. N: # of Plans of Services and Supports revised within 365 days of last Plan of Services and Supports D: # of Plans of Services and Supports reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin or

		error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
SP a.i.d(1) Number and percent of services and supports that were provided in the type, scope, amount, duration and frequency as defined in the POC N: # of Plans of Services and Supports reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the Plans of Services and Supports D: All Plans of Services and Supports 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):*
[x] **State Medicaid Agency**	[ ] **Weekly**	[ ] **100% Review**
[ ] **Operating Agency**	[ ] **Monthly**	[x] **Less than 100% Review**
[ ] **Sub-State Entity**	[ ] **Quarterly**	[x] **Representative Sample** Confidence Interval = 95% +/- 5% margin of error
[ ] **Other** Specify:	[x] **Annually**	[ ] **Stratified** Describe Group:
	[x] **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):*
[x] **State Medicaid Agency**	[ ] **Weekly**
[ ] **Operating Agency**	[ ] **Monthly**
[ ] **Sub-State Entity**	[ ] **Quarterly**
[ ] **Other** Specify:	[x] **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:
SP a.i.e. (1) Number and percent of individuals who were given a choice of institutional care versus waiver services N: Number of individuals given a choice D: All waiver individuals in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95% with +/- 5% margin of error
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

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 Monitoring Checklist utilized to review individual records addresses the performance measures related to service planning. Should the review of individual records indicate that performance measures are not being met, the Support Coordination provider will be required to submit a Plan of Compliance within 30 days that addresses the corrective action to remediate the individual problem (if possible) and plans for continued compliance that address system/organizational processes and practices so that the provider agency remains in compliance with DMH Operational Standards. DMH's Executive Leadership Team reviews and approves or disapproves all Plans of Compliance. DMH does provide technical assistance to a provider agency to assist them with developing an acceptable Plan of Compliance. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. Should a Plan of Compliance not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

In addition to the possibility of suspension or termination of certification based on an unacceptable Plan of

Compliance, DMH certified providers can also have their certification status affected for egregious acts such as endangerment of the health and welfare of an individual being served, unethical conduct, or failure to comply with fiscal requirements.

Due to the anonymity of results, performance measures that incorporate the National Core Indicator Survey Results are not subject to remediation. Results are utilized for system improvement purposes only.

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

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

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

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

If, upon initial evaluation it is determined that an individual does not meet LOC requirements, the individual/legal guardian is sent a notice within 10 business days of the ineligibility determination for ICF/IID Level of Care and the Intellctual Disabilities Waiver. This notice outlines the procedures for appealing this decision, supporting documentation required and the address to where to send this information. These requests are sent to the Director of the Bureau of Intellectual and Developmental Disabilities (BIDD).

The procedures for appealing the denial of LOC eligibility are as follows:

1. The individual applying for services will be notified in writing with 10 business days of the denial of eligibility for LOC and, thus, his/her ineligibility for ID/DD Waiver services.

2. The individual/legal representative has 30 calendar days from the date of the “Notice of Ineligibility for ICF/IID Level of Care” to submit an appeal to the Director of the BIDD. The appeal must be in writing. If the individual/legal representative so desires, he/she may submit additional justification with the appeal, other than the reports from evaluators, to support his/her request. The “Notice of Ineligibility for ICF/IID Level of Care” must be included in the appeal.

3. The Director of BIDD must respond in writing within 30 calendar days of receipt of the appeal by BIDD. If sufficient justification was not submitted with the appeal,the Director may request additional information before making a decision, thus extending the 30 day time line.

4. If the Director of BIDD disagrees with the denial of eligibility for ICF/IID LOC, he/she will notify the D&E Team in writing and send a copy of the decision to the person/legal representative. At that point, the person’s application for ID/DD Waiver services can be processed.

5. If the Director of BIDD agrees with the determination of ineligibility for ICF/IID LOC, the individual has the right to appeal the decision to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director by the date indicated in the letter.

6. The Executive Director of the DMH will respond in writing, within 30 calendar days. If he/she feels additional information is required to make a decision he/she will request such, thus extending the 30 day time line.

7. The decision of the Executive Director of the DMH is final.

The procedures for appealing the Denial, Reduction or Termination of ID/DD Waiver services are:

If an individual requests a service on his/her initial Plan of Services and Supports, an increase in the amount of previously approved services, or an additional service and the BIDD/Division of HCBS denies the request, he/she can appeal to the Director of the BIDD. If BIDD/Division of HCBS staff determines a service on an individual's Plan of Services and Supports is no longer appropriate and terminates the service, the individual can appeal the decision tothe Director of the BIDD. The individual/legal representative must submit the appeal to the Director of the BIDD within 30 calendar days of the date

provided in the response. The appeal must be in writing. If the individual/legal representative so desires, he/she may submit additional justification, other than what has already been received by the BIDD/Division of HCBS, to support the appeal. During the pendency of the appeal, the services on the Plan of Services and Supports remain the same as before the appeal. The same timelines as listed above for ICF/IID appealing denial of eligibility for Level of Care are used in this process.

If it is determined an individual is no longer eligible for ICF/IID Level of Care, or if his/her needs exceed the scope of services the ID/DD Waiver can provide, he/she can be discharged/terminated from the ID/DD Waiver. This decision can be appealed to the Director of the BIDD. The same timelines for appealing denial of ICF/IID Level of Care are used in this process. During the pendency of the appeal, services must remain as they were before the termination.

If the Director of the BIDD does not approve an appeal with regard to the denial, termination or reduction of services or termination from the ID/DD Waiver, he/she can appeal to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director within 30 calendar days of the date listed in the letter from the Director of BIDD. The Executive Director of the DMH will respond in writing within 30 calendar days. If he/she feels additional information is required to make a decision, he/she will request such, thus extending the 30 day time line.

If the individual/legal representative does not agree with the decision of the Executive Director of the DMH, he/she can appeal to the Executive Director of the Division of Medicaid.

If requested, the ID/DD Waiver Support Coordinator will prepare a copy of applicable documents in the case record and forward it to DMH/BIDD staff who reviews and forwards it to the Division of Medicaid no later than five (5) days after notification of the appeal.

The Division of Medicaid will assign a hearing officer. The beneficiary/legal representative must be given advance notice of the hearing date, time, and place, if applicable. The hearing will be held by telephone unless valid reason is provided by the beneficiary for an in-person hearing. The decision to hold an in-person hearing is at the discretion of the hearing officer. The hearing must be recorded.

The hearing officer will make a recommendation, based on review of documentation submitted by DMH and presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, must be made within ninety (90) days of the date of the initial request for a hearing. DMH/BIDD will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations or sexual harassment by the service providers. The ID/DD Waiver Support Coordinator is responsible for ensuring that the beneficiary, continues to receive all services that were in place prior to the notice of change.

All records that pertain to adverse actions, the opportunity to request a fair hearing, appeal documentaion and final determiniations are filed in the electronic file by BIDD/Division of HCBS and the Division of Medicaid/BMHP.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Mississippi Department of Mental Health

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 MS Department of Mental Health operates a grievance system through the Office of Consumer Support (OCS) within the Bureau of Quality Management, Operations, and Standards. Within the past year, OCS has revised its grievance system to be more consumer and family friendly and eliminate perceived barriers associated with the grievance process. OCS accepts a broad range of grievances. Grievances often include, but are not limited to, dissatisfaction with an individual service provider, dissatisfaction with a provider agency, alleged violations of individual rights, environmental issues, and access to services.

Individuals, family members, caregivers, or other interested parties have multiple avenues for filing a grievance. Grievances are received by phone, written format, or email. Upon receipt of a grievance, a Consumer Advocate within the Office of Consumer Supports categorizes the grievance based on an established level system. Information that differentiates the grievance process from the fair hearing process is disseminated to the individual and their family members during the initial enrollment and annually thereafter. Also, the individual is informed that they do not to file a grievance prior to requesting a fair hearing.

Level I grievances are areas of concern related to an individual's issues including, but not limited to, care, treatment, or allegations related to their participant rights. Level I grievances are typically resolved with an explanation of policy, regulation or standard. Level I grievances may also include a referral to other services and/or supports.

Level II grievances are areas of concern of a more serious nature such as a possible serious incident. Level II grievances require DMH inquiry to support or disprove an area of concern. DMH inquiry includes requests for information related to the concern and can also include an on-site inquiry to obtain information and/or interview staff.

Level III grievances are areas of concern of the most serious nature, such as alleged lack of attention to health/welfare, mistreatment of individual and/or denial of services. Level III grievances require DMH inquiry to support or disprove an area of concern. DMH inquiry includes requests for information related to the concern and can also include an on-site inquiry to obtain information and/or interview staff.

All grievances are resolved within 30 days of OCS receipt. The individual filing the grievance is provided formal notification from the Director of OCS of the resolution and activities performed in order to reach the resolution.

The grievance process does include an opportunity for the individual to request reconsideration should he/she not be satisfied with the resolution. The individual filing the grievance can request reconsideration from the Director of the Bureau of Quality Management, Operations and Standards. The individual will be formally notified in writing of the decision related to the reconsideration. Should the individual originally filing the grievance not be satisfied with the reconsideration decision of the BQMOS Director, he/she can appeal to the Executive Director of the DMH. The Executive Director will formally notify the individual of his/her decision. All decisions of the DMH Executive Director are final.

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).

DMH BQMOS is responsible for incident reporting requirements, maintenance of the incident management information system and investigation of reported incidents. All waiver providers (inclusive of Support Coordination) are required to report serious incidents to DMH's BQMOS within twenty-four (24) hours of the incident or the next working day, with the exception of death which should be reported within 8 hours of the event. In addition to reporting to DMH, incidents of suspected abuse and/or neglect must be reported to the MS Department of Human Services, and/or the Office of the Attorney General, dependent upon the type of event.

Serious incidents to be reported within twenty-four (24) hours include, but are not limited to: suicide attempts on provider property or at a provider-sponsored event, unexplained absence from a community living program for a twenty-four (24) hour period, incidents involving consumer injury while on provider property or at a provider-sponsored event, emergency hospitalization or treatment while participating in a program, medication errors, accidents associated with suspected abuse or neglect, or use of seclusion or restraint that is not part of an individual's Plan of Services and Supports, Crisis Intervention Plan, or Behavior Support plan.

Reportable incidents include: death of an individual on provider property, participating in a provider-sponsored event, being served through a certified community living program, or during an unexplained absence of the individual from a community living residential program must be reported verbaally to the Office of Consumer Support within eight (8) hours to be followed by the written Serious Incident Report within twenty-four (24) hours.

Upon receipt of a serious incident report, DMH's Incident Management Review Coordinator categorizes the incident by type, assigns the incident a level and enters the information into the incident management tracking system. Serious incidents are assigned Levels 1-III.

Level I incidents have been resolved at the service provider level. No further action is required by DMH Staff.
Level II incidents require inquiry by DMH staff. Additional information is needed for resolution and/or to establish whether or not a pattern is being/has been established. Inquiry may include the submission of requested information or an on-site inquiry.
Level III incidents require immediate inquiry by DMH staff due to their severity, potential for harm or other special circumstances, such as high visibility.

The DMH Quality Management Council is responsible for analyzing data to identify trends and patterns and support improvement strategies. The DMH Quality Management Council is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to the Bureau of Quality Management, Operations and Standards. Data sources include the serious incident tracking database, Refer© for the tracking of grievances, DMH Written Reports of Findings, and client level data reported by certified providers. Data sources are analyzed dependent upon the data elements. All sources can be analyzed by provider. Serious incidents can be analyzed by type of incident, level of incident, participant involved, staff involved, time of incident, time of reporting and cause of incident. Grievances

can be analyzed by type of grievance, level of grievance, and participant involved. Information from each data source is shared with the Quality Management Council to identify emerging trends or patterns based on a comparison of the data.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon admission and at least annually thereafter, every service provider is required to provide individuals receiving services and/or their legal guardians, both orally and in writing, the DMH's and program's procedures for protecting individuals from abuse exploitation and any other form of abuse. Each individual/legal guardian is provided a written copy of their rights. Program staff reviews the rights with each individual/legal guardian and the individual/legal guardian signs the form indicating the rights have been presented to them both orally and in writing, in a way which is understandable to them. Contained in the rights is information about how the individual/legal representative can report any suspected violation of rights and/or grievances, to the DMH Office of Consumer Supports. The toll free Help Line number is posted in prominent places throughout each program site. Upon admission and at least annually thereafter, individuals are also provided information, in writing and orally, about the procedures for filing a grievance.

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.

DMH BQMOS is responsible for incident reporting requirements, maintenance of the incident management information system and investigation of reported incidents. All waiver providers (inclusive of Support Coordination) are required to report serious incidents to DMH's BQMOS within twenty-four (24) hours of the incident or the next working day, with the exception of death which should be reported within 8 hours of the event. Serious incidents can be reported via secure email or fax. Serious incidents may also be reported via telephone with subsequent written documentation received via email or fax. In addition to reporting to DMH, incidents of suspected abuse and/or neglect must be reported to the MS Department of Human Services, and/or the Office of the Attorney General, dependent upon the type of event.

Serious incidents to be reported within twenty-four (24) hours include, but are not limited to: suicide attempts on provider property or at a provider-sponsored event, unexplained absence from a community living program for a twenty-four (24) hour period, incidents involving consumer injury while on provider property or at a provider-sponsored event, emergency hospitalization or treatment while participating in a program, medication errors, accidents associated with suspected abuse or neglect, or use of seclusion or restraint that is not part of an individual's Plan of Services and Supports, Crisis Intervention Plan, or Behavior Support plan.

Reportable incidents include: death of an individual on provider property, participating in a provider-sponsored event, being served through a certified community living program, or during an unexplained absence of the individual from a community living residential program must be reported verbally to the Office of Consumer Support within eight (8) hours to be followed by the written Serious Incident Report within twenty-four (24) hours.

Upon receipt of a serious incident report, DMH's Incident Management Review Coordinator categorizes the incident by type, assigns the incident a level and enters the information into the incident management tracking system. Serious incidents are assigned Levels 1-III.

Level I incidents have been resolved at the service provider level. No further action is required by DMH Staff.

Level II incidents require inquiry by DMH staff. Additional information is needed for resolution and/or to establish whether or not a pattern is being/has been established. Inquiry may include the submission of requested information or an on-site inquiry.

Level III incidents require immediate inquiry by DMH staff due to their severity, potential for harm or other special circumstances, such as high visibility.

An inquiry into reported serious incidents is conducted within thirty days. DMH Operational Standards require certified providers to participate with this process. Based on the submission of requested information or the conclusion of an on-site visit, should corrective action be required DMH issues a report of findings based on the Serious Incident. That report of findings must be addressed by the provider within thirty days, or sooner if determined by DMH, of receipt of the findings. Corrective action must be put in place by the provider and approved

by DMH. The DMH Incident Review Coordinator will notify the participant's in writing of the outcome of an inquiry related to a reported serious incident.
Serious incidents are reviewed by DMH's Quality Management Council to identify trend and pattern data to be utilized for quality improvement activities.

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.

DMH is responsible for overseeing the reporting and follow up to serious incidents that affect individuals enrolled in the waiver. Oversight is conducted on an ongoing basis through the process outlined in b-d above. DMH also utilizes its Quality Management Council in an advisory capacity to review trend and pattern data related to serious incidents. As the operating agency for the waiver, DMH provides the Division of Medicaid quarterly summary reports of the categories of serious incidents related to individuals enrolled in the waiver.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. **Use of Restraints or Seclusion.** *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion 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 or Seclusion.** 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 or 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).

DMH's Operational Standards for the safe and appropriate use of seclusion can be found at the following link: http://www.dmh.ms.gov/pdf/2012DMHOperationalStandards.Finalfordistribution.pdf

Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

Crisis Support Services providers follow all applicable state and federal ICF/IID regulations related to the use of seclusion or restraint.

Mechanical restraints and seclusion are not allowed in community-based programs. Physical restraints are used within the guidelines established in the Mandt System®. All staff that may use physical restraints will be trained in the Mandt System®. The Mandt System® offers graded alternatives from least restrictive to most restrictive (philosophy and attitude, non-verbal communication, verbal communication, walking with/accompanying, supporting, avoiding, redirecting, releasing, physical touching). (Mandt Sytem ®, page 10) De-escalation strategies such as health relationships, non-use of uniforms, use of non-scented shampoos, deodorants, etc. for all staff, minimizing the number of people interacting with the individual served, especially if they are escalating, having only one staff working with them and another close by, keep movements slow with hands open and relaxed, being aware of any trauma in the individual's past and avoiding situations which may elicit responses to those memories, active listening, and other techniques as indicated by individual need and as described in the Mandt System®(pages 44-45).

Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

Providers must ensure that all staff who may utilize physical restraint/escort successfully complete training and hold Mandt certification.

Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:
1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
(a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
(b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

In emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others. An emergency is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff.

Time out may not be used by the ID/DD Waiver providers.

The following are practices employed to ensure the health and safety of individuals:

A. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

B. Providers are prohibited from the use of seclusion.

C. Providers are prohibited from the use of time out.

D. Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

E. Providers must ensure that all staff who may utilize physical restraint/escort successfully complete training and hold a nationally recognized certification or complete a DMH-approved program for managing aggressive or risk-to-self behavior.

F. Providers must maintain a listing of all supervisory or senior staff members who have successfully completed required training and demonstrate competency in utilization of physical restraint.

G. Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:

1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
(a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
(b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.
2. Requirements that in emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others. An emergency is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff.

H. Requirements that physical restraints/escorts are used as specified in the Behavior Support Plan only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm. The utilization of other less restrictive alternatives must be documented in the individual's case record.

I. Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, individuals must not be restrained for more than sixty (60) minutes at any one time. They must be released after those sixty (60) minutes. A face-to-face assessment must take place at least every twenty (20) minutes while the individual is being restrained.

J. Providers must establish and implement policies and procedures specifying that physical restraint (s)/escort must be in accordance with a written modification to the comprehensive Individual Plan of the individual being served as well as all of the following:

1. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;
2. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, appropriate restraining techniques; and;
3. Requirement(s) that physical restraint(s)/escort must be ended at the earliest possible time (i.e., when the individual's behavior has de-escalated and that individual is no longer in danger of harming him/herself or others);
4. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;
5. Requirement(s) that supine and prone restraints are prohibited; and
6. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding Mandt certification.

K. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support/Crisis Intervention Plan by order of a physician or other licensed independent practitioner as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider and documented in the case record.

L. Providers must establish and implement written policies and procedures regarding the use of physical restraint(s)/escort with implementation (as applicable) documented in the Behavior Support Plan and in each individual case record:

1. Orders for the use of physical restraint(s)/escort must never be written as a standing order or on an as needed basis (that is, PRN).
2. A Behavior Support/Crisis Intervention Plan must be developed by the individual's team when these techniques are implemented more than three (3) times within a thirty (30) day period with the same individual. The Behavior Support/Crisis Intervention Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support/Crisis Intervention Plan must be developed with the signature of the program's director
3. In physical restraint situations, the treating physician must be consulted within twenty-four (24) hours and this consultation must be documented in the individual's case record.
4. A supervisory or senior staff person with training and demonstrated competency in physical restraint(s) who is competent to conduct a face-to-face assessment will conduct such an assessment of the individual's mental and physical well-being as soon as possible but not later than within one (1) hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained monitors the situation for the duration of the intervention.
5. Requirements that staff records an account of the use of a physical restraint(s)/escort in a behavior management log that is maintained in the individual's case record by the end of the working day.

The state ICF/IID regulations can be viewed by going to the following website: http://www.msdh.state.ms.us/msdhsite/_static/resources/119.pdf.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DMH Quality Management Council is responsible for analyzing data to identify trends and patterns and support improvement strategies. The DMH Quality Management Council is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to the Bureau of Quality Management, Operations and Standards. Data sources include the serious incident tracking database, Refer© for the tracking of grievances, DMH Written Reports of Findings, and client level data reported by certified providers. Data sources are analyzed dependent upon the data elements. All sources can be analyzed by provider. Serious incidents can be analyzed by type of incident, level of incident, participant involved, staff involved, time of incident, time of reporting and cause of incident. Grievances can be analyzed by type of grievance, level of grievance, and participant involved. Information from each data source is shared with the Quality Management Council to identify emerging trends or patterns based on a comparison of the data.

At the state level, data is collected directly from the standardized data elements that are contained in DMH's serious incident reporting form. Each data element is recorded into the serious incident tracking database by DMH's Incident Review Coordinator and a scanned copy of the reported incident is attached in that database to create a historical record. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined. Serious incident data is reviewed quarterly by DMH's Quality Management Council to provide oversight to the incident management process.
At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH BQMOS staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

All reported serious incidents are reviewed and categorized upon receipt. Reported Serious Incidents categorized as a Level III are reported upon receipt to the Director of the Bureau of Quality Management, Operations and Standards and the Director of the Bureau of Intellectual/Developmental Disabilities by the Incident Review Coordinator and an inquiry is initiated. Data analysis is conducted on an ongoing basis by the Incident Review Coordinator with oversight from the Quality Management Council occurring on a quarterly basis. Additionally, DMH oversight activities related to providers also occur on an ongoing basis and provider monitoring occurs throughout the year.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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 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.

Mechanical restraints, time out and seclusion are not allowed in community-based programs. Physical restraints are used within the guidelines established in the Mandt System®. All staff that may use physical restraints will be trained in the Mandt System®. The Mandt System® offers graded alternatives from least restrictive to most restrictive (philosophy and attitude, non-verbal communication, verbal

communication, walking with/accompanying, supporting, avoiding, redirecting, releasing, physical touching). (Mandt Sytem ®, page 10) De-escalation strategies such as health relationships, non-use of uniforms, use of non-scented shampoos, deodorants, etc. for all staff, minimizing the number of people interacting with the individual served, especially if they are escalating, having only one staff working with them and another close by, keep movements slow with hands open and relaxed, being aware of any trauma in the individual's past and avoiding situations which may elicit responses to those memories, active listening, and other techniques as indicated by individual need and as described in the Mandt System®(pages 44-45).
Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.
Providers must ensure that all staff who may utilize physical restraint/escort successfully complete training and hold Mandt certification.
Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:

1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
(a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
(b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

In emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others. An emergency is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff.
Physical restraints/escort are implemented in the least restrictive manner possible. Physical restraints/escort are in accordance with safe, appropriate restraining techniques as taught in the Mandt System®© Physical restraints/escort are ended at the earliest possible time (i.e. when the individual's behavior has de-escalated and that individual is no longer in danger of harming him/herself or others). Physical restraints/ escort is not used a form or punishment, coercion or staff convenience. Supine and prone restraints are prohibited

Through DMH Operational Standards, safeguards are in place concerning the use of restrictive interventions. Safeguards include protection of the rights of individuals and protocols for the development of Behavior Support/Crisis Intervention Plans that do not incorporate aversive methods. A Behavior Support/Crisis Intervention Plan must be developed by the individual's team providing Behavior Support or Crisis Intervention Services. Behavior Support or Crisis Intervention services when these techniques are implemented more than three (3)times within a thirty (30) day period with the same individual. The Behavior Support/Crisis Intervention Plan must address the behaviors warranting the continued utilization of physical restraint (s)/escort procedure in emergency situations. The Behavior Support/Crisis Intervention Plan must be developed with the signature of the program's director.

Mississippi requires the use of the Mandt System®© in all community-based programs.

a. First use of non-aversive methods;
De-escalation techniques, touch (ask permission to touch, touch only when necessary, know how to touch, know where to touch, relax and slowly touch), assisting, (stance and balance, body mechanics, body positioning) and re-direction. (Mandt System ®© pages 48, 222-223)
b. Methods to detect unauthorized use of restrictive interventions;
The unapproved use of restrictive interventions is monitored through the reporting of serious incidents and grievances and the DMH on-site monitoring process. Additionally, Support Coordinators speak with each individual/legal representative at least two times per month and have quarterly face-to-face contact in which the unauthorized use of restrictive interventions can be detected and reported.

c. Required documentation for each use of restrictive interventions; and
A Behavior Management Log is maintained in the individual's case record. The log must include:
i. Name of the individual for whom the physical restraint/escort intervention was implemented

ii. Time that the physical restraint(s)/escort intervention began
iii. Behavior warranting utilization of physical restraint/escort intervention
iv. Type of physical restraint/escort utilized during the intervention
v. Documentation that less restrictive alternative methods of managing behavior which have been determined to be ineffective in the management of the individual's behavior
vi. Documentation of visual observation by staff of individual while he/she is in a physical restraint/escort, including description of behavior at that time
vii. Time the physical restraint/escort intervention ended
viii. Signature of staff implementing physical restraint/escort intervention and staff observing individual for whom physical restraint/escort intervention was implemented
ix. Documentation of supervisory or senior staff member's assessment of the restrained/escorted individual's mental and physical well being during and after the physical restraint/escort utilization, including the time the assessment was conducted
x. Documentation of the use of physical restraint/escort

d. Required education and training of personnel involved in authorization and administration of restrictive interventions.
Mississippi requires the use of the Mandt System®© in all ID/DD Waiver programs. Staff must be certified in the Mandt System®© before providing Behavior Support Intervention or Crisis Intervention Services. Staff with at least a Master's degree in a field related to individuals with intellectual and developmental disabilities and experience providing behavior services oversee the administration of any restrictive interventions

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:

The DMH Quality Management Council is responsible for analyzing data to identify trends and patterns and support improvement strategies. The DMH Quality Management Council is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to the Bureau of Quality Management, Operations and Standards. Data sources include the serious incident tracking database, Refer© for the tracking of grievances, DMH Written Reports of Findings, and client level data reported by certified providers. Data sources are analyzed dependent upon the data elements. All sources can be analyzed by provider. Serious incidents, including the use of restraints, can be analyzed by type of incident, level of incident, participant involved, staff involved, time of incident, time of reporting and cause of incident. Grievances can be analyzed by type of grievance, level of grievance, and participant involved. Information from each data source is shared with the Quality Management Council to identify emerging trends or patterns based on a comparison of the data.
At the state level, data are collected directly from the standardized data elements that are contained in DMH's serious incident reporting form. Each data element is recorded into the serious incident tracking database by DMH's Incident Review Coordinator and a scanned copy of the reported incident is attached in that database to create a historical record. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined. Serious incident data is reviewed quarterly by DMH's Quality Management Council to provide oversight to the incident management process.
At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH BQMOS staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

At the state level, data are collected directly from the standardized data elements that are contained in DMH's serious incident reporting form. Each data element is recorded into the serious incident tracking database by DMH's Incident Review Coordinator and a scanned copy of the reported incident is attached in that database to create a historical record. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined. Serious incident data is reviewed quarterly by DMH's Quality Management Council to provide oversight to the incident management process.
At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH BQMOS staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

All reported serious incidents are reviewed and categorized upon receipt. Reported Serious Incidents

categorized as a Level III are reported upon receipt to the Director of the Bureau of Quality Management, Operations and Standards and the Director of the Bureau of Intellectual/Developmental Disabilities by the Incident Review Coordinator and an inquiry is initiated. Data analysis is conducted on an ongoing basis by the Incident Review Coordinator with oversight from the Quality Management Council occurring on a quarterly basis. Additionally, DMH oversight activities related to providers also occur on an ongoing basis and provider monitoring occurs throughout the year.

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.

DOM is responsible for oversight of medication management and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for recipients of Supervised Living is vested in a licensed physician. Each Supervised 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 Supervised Living setting. Staff monitoring focuses on areas identified by the physician and /or pharmacist which may be of concern. If a service recipient is using a behavior modifying medication (psychotropic medication), the DOM program nurse will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; and (2) the service recipient or the service recipient’s family member or guardian/conservator was provided information about the risks and benefits of the medication. Staff observations regarding the behavior which the medication has been prescribed to reduce are reported to the provider. Each contracted 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.

After each doctor’s visit, and with the individual’s consent, Supervised Living staff document the reason for the visit, the physician’s instructions, including monitoring for any potential unwanted side effects of prescribed medication(s). Documentation regarding visits to physicians is reviewed by all staff and the review is documented via their initials on the form.

All treatment shall be provided by, or provided under the direction or supervision, of professionally qualified staff. Medication is reviewed by appropriately qualified staff. Appropriately qualified staff includes

physicians, physician assistants, and advanced registered nurse practitioners acting with the scope of their professional licensure.

DOM specifies the treating physician shall perform any physiological testing or other evaluation(s) necessary to monitor the individual for adverse reactions, or other health related issues which might arise in conjunction with taking medication, including prescribed psychotropic medications.

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.

DOM specifies the treating physician shall perform any physiological testing or other evaluation(s) necessary to monitor the individual for adverse reactions or other health related issues which might arise in conjunction with taking medication, including prescribed psychotropic medications.

DOM is responsible for oversight of medication management. DOM employs a licensed nurse who makes annual reviews of Supervised Living providers to ensure they are following required procedures regarding the medication regimen of individuals who require such. During annual on-site compliance reviews, DOM reviews the service recipient's Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. During annual on-site compliance reviews, the DOM program nurse reviews a sample of service recipient Medication Administration Records to identify potentially harmful practices and to ensure compliance with medication administration documentation requirements. Medication error reports are also reviewed. Provider medication management policies and practices are reviewed to ensure that:
a. The Medication Administration Record correctly lists all medications taken by the service recipient;
b. The Medication Administration Record is updated, signed, and maintained in compliance with DOM medication administration documentation requirements;
c. All medications are administered in accordance with physician's orders;
d. Medications are administered by appropriately trained staff;
e. Medications are kept separated for each service recipient and are stored safely, securely, and under appropriate environmental conditions.

Providers are required to report medication errors that have caused, or are likely to cause harm to a service recipient. DOM staff receives and reviews reportable incident forms for completeness and determination of the nature of the incident. DOM monitors for medication error trends utilizing data from the Incident and Investigations database. Personal Records are reviewed to ensure that staff who administers medications are appropriately licensed. When the DOM on-site compliance review team identifies potentially harmful medication administration/management practices, the team notifies the provider during the review, and then reviews such issues during the exit conference at the end of the review. In addition, the provider is notified in writing of any problems identified during the review. Any ID/DD Waiver provider receiving a rating of Review, Probation or Suspension must submit a
Corrective Action Plan (CAP). The CAP must be received by DOM no later than ten (10) working days following the ID/DD Waiver provider's receipt of its status ruling.

Providers are required to complete a reportable incident form for medication errors. If the medication error caused, or is likely to cause, harm, the provider must submit a copy of the Reportable Incident Form to the Division of Medicaid. The DOM program nurse reviews medication error incident forms for completeness and determination of the nature of the incident. Provider agencies are responsible for identifying medication error trends.

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)*

- (selected) **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).

DMH requires that the administration of all prescription drugs must be directed and supervised by a licensed physician or licensed nurse in accordance with the MS Nursing Practice Law. Practices for the self-administration of medication by individuals served are developed in consultation with the medical staff of the provider or the individual's treating medical provider(s). Non-medical waiver providers cannot administer or oversee the administration of medications.

iii. Medication Error Reporting. *Select one of the following:*

- (selected) **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:

  DMH BQMOS, Division of Medicaid, and appropriate licensure boards

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

  Physician error, Pharmacy error, unavailable medications, meds given at the wrong time, incorrect dosages, missed dosages, incorrect route, meds given to wrong patient

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

  Medications given to wrong patient, overdoses, missing medications

- **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.

On-Site compliance reviews will be conducted annually by the DOM program nurse. The nurse will check for compliance by reviewing medication storage, documentation in medication records and staff qualifications. A sample of nursing staff must demonstrate competence by correctly answering oral interview questions regarding medications and the administration procedures. The DOM program nurse will also observe the facility nurse as he/she administers medication to an individual. Educational outreach will be provided as needed from these reviews and from the evaluation of incident reports.

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:
HW a.i. (1) Number and percent of waiver individuals whose records document informing of Rights and Options, which includes the right to be free from abuse, in addition to procedures for reporting grievances (inclusive of serious incidents). N: # of records that indicated acknowledgement of Rights and Options and grievance procedures (inclusive of serious incidents) D: # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual record review- monitoring checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW a.i. (2) Number and percent of serious incidents reported to DMH, OCS within timelines N: # of serious incidents received within timelines D: # of serious incidents reported

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DMH Incident Management Information System

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:
HW a.i. (3) Number and percent of serious incidents that recieved and inquiry as required. N: # of serious incidents that received an inquiry as required D: # of serious incidents subject to inquiry

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMH Incidnet Management Information System

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:
HW a.i. (4) Number and percent of serious incidents that included follow up action that was completed as a result of inquiry N: # of serious incidents completed that included follow up action D: # of serious incidents requiring follow up action

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMH Written Report of Findings

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:
HW.a.i (5) Number and percent of serious incidents related to medication errors where provider corrective action was taken. N: # of serious incidents related to medication errors D: # of serious incidents received by DMH requiring provider corrective action

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMH Serious Incident Management Information System

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:
HW a.i. (6) Number and percent of waiver providers that require corrective action related to DMH requirements for storage of medications. N: # of waiver providers with corrective action for storage of medications D: # of providers reviewed storing medication

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMH Written Reports of Findings

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

☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95% +/- 5% margin of error
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW a.i. (7) The proportion of individuals who report that they feel safe in their home, neighborhood, workplace and day program/ other daily activities. N: # of individuals who report feeling safe in their home, neighborhood, workplace and day program/other daily activities D: # of individuals in survey sample

Data Source (Select one):
Other

If 'Other' is selected, specify:
Naitonal Core Indicators- Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

HW a.i. (8) The proportion of individuals who report having a primary care doctor. N: # of individuals reporting having a primary care doctor D: # of individuals in survey sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5% margin error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
HW a.i. (9) The proportion of individuals who have had a routine dental exam in the past year. N: # of individuals who have had a routine dental exam in the past year D: # of individuals in survey sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HW a.i. (10) Number and percent of individuals with whom restrictive intervention was utilized that use was in compliance with DMH Operational Standards N: # individuals with whom restrictive intervention was utilized that use was in compliance with DMH Operational Standards D: # of individuals who had restrictive intervention

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Record Review and DMH Serious Incident Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.
Individual problems related to the health and welfare of individuals enrolled in the waiver are discovered through several mechanisms – Support Coordinators identify concerns through ongoing contact, DMH review of individual records, peer review, serious incidents, and grievances. The method of addressing the problems is dependent upon the discovery mechanism. As individual problems are identified by Support Coordinators, Support Coordinators work with the individual/legal guardian and/or provider to modify the Plan of Services and Supports to ensure health and welfare concerns are addressed in a timely manner. Individual problems identified through DMH review of individual records, peer review, serious incidents and/or grievances, are subject to the DMH process of requiring a provider to develop plans that must be approved by DMH. The maximum length of time for the submission of a corrective action plan is 30 days, which may be altered by DMH given the nature and severity of the concern. Plans must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Executive Leadership Team reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. DMH does provide technical assistance to a provider agency to assist them with developing an acceptable Plan. Should a Plan not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

Due to the anonymity of results, performance measures that incorporate the National Core Indicator Survey Results (measures HW a.i. (7-9) are not subject to remediation. Results are utilized for system improvement purposes only.

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.

- (selected) **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 systems in place to measure and improve performance in meeting the six specific waiver assurances. 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 individual, provider and system wide levels.

Quality improvement at the individual level is focused on monitoring and improving care and outcomes for the individual. The individual's Support Coordinator is primarily responsible for quality improvement at the individual level. Individual level discovery takes place through the monthly and quarterly contacts that a Support Coordinator makes with the individual and his/her providers. When a Support Coordinator discovers an issue related to the individual's Plan of Services and Supports, he/she is responsible for addressing the issue with the individual's provider and developing remedial actions to address the issue. If a provider is not responsive to individual level remediation, a Support Coordinator is responsible for reporting the issue as a grievance through DMH's established grievance reporting procedures.

In addition to individual level discovery and remediation that occurs as a responsibility of Support Coordinators, DMH is also responsible for discovery related to individual level remediation. Through DMH's on-site monitoring process, which includes individual record review, individual issues are identified for remediation by the Support Coordinator. These issues include, but are not limited to, follow up regarding accessing community resources, identification of additional needs, etc. Individual level discovery and remediation also occurs through DMH's serious incident reporting/tracking processes and grievance process. Data from the results of provider monitoring, serious incidents, and grievances is available on an individual, provider or system level basis dependent upon the format needed for remediation and quality improvement.

Quality improvement at the provider level is focused on monitoring and improving services delivered by providers. DMH's Bureau of Quality Management, Operations and Standards (BQMOS) is responsible for coordinating the development of provider standards and monitoring. All providers are certified for a three year period. During that three year period, on-site monitoring takes place two out of the three years based on a rotating schedule to ensure compliance with DMH Operational Standards. As providers seek DMH certification for additional services and/or program locations, DMH also conducts on-site monitoring to ensure compliance with DMH Operational Standards. Thus, the number of on-site monitoring visits increases based on the provision of additional services and programs. As issues are identified through on-site monitoring, providers are required to submit Plans of Compliance for DMH approval. Additionally, all providers are required to have Quality Management Committees that are responsible for written analysis of serious incidents, analysis of client level data, and oversight for the development and implementation of DMH

required plans of compliance. 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 individual and provider levels is utilized for system level quality improvement activities.

BQMOS facilitates the Quality Management Council to provide guidance on needed system level improvements. The DMH Quality Management Council is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to BQMOS. In order to provide status reports and make quality improvement recommendations, the Quality Management Council reviews data related to serious incidents (inclusive of reported deaths), grievances, and deficiencies related to DMH monitoring visits to identify trends and patterns among the data sets. The Quality Management Council also reviews quarterly status reports being submitted to the administrative agency related to the performance measures established to address the required assurances and subassurances for the waiver. Additionally, the Council reviews Plans of Compliance from DMH certified providers and makes recommendations regarding needed quality improvement activities.

The Quality Management Council consists of a core membership from DMH's 8 functional/programmatic areas (inclusive of the Bureau of Intellectual/Developmental Disabilities), the Office of Consumer Supports, the Arc of MS (as the contractor responsible for serving as the lead for DMH's peer review quality assurance activities), and a member of the Certified Peer Support Specialist Network. Ad hoc members consist of an experienced Director of Risk Management from a DMH-operated program, DMH legal staff, and DMH's Medical Director.

System improvements are identified by the Quality Management Council and recommended to BQMOS and the other members of the DMH Executive Leadership Team. System improvements include, but are not limited to, structural procedural changes to improve outcomes, activities to improve program performance (i.e. technical assistance and training), and policy revisions to improve structural procedures and outcomes for people.

As part of the administrative oversight of the Division of Medicaid (DOM), DOM conducts On-Site Compliance Reviews (OSCR). The OSCR examines adherence to the six sub-assurances of the waiver. DOM issues a report of findings that identifies issues found during the OSCR. Through regular meetings between DMH and DOM, the two agencies share decision making concerning corrective action. As a mitigation strategy, DMH BQMOS 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:

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 – individual, provider and systemic. In order for system improvements and evaluation of those improvements to take place, many parties are involved.

The responsibility for individual level improvements is vested with the individual's Support Coordinator through the Plan of Services and Supports. Revisions to the Plan of Services and Supports occur as individual needs change. Through monthly and quarterly contacts, Support Coordinators assess the health and welfare of the individual and whether or not the Plan of Services and Supports is meeting the needs of the individual. Changes to the Plan of Services and Support are communicated to the appropriate providers.

At the provider level, providers are responsible for the reporting of serious incidents. Quality Management Committees at the provider level are responsible for reviewing serious incidents and putting action(s) in place to prevent future occurrence. DMH, through BQMOS, is responsible for tracking data related to the type of incident, individuals 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, DMH notifies the Support Coordinator of the incident and begins an immediate inquiry. 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. DMH BQMOS staff remain involved in an incident until there is resolution of the incident or adequate investigation has been concluded.

At the systemic level, the Quality Management Council 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. Should there not be cooperation in implementing quality improvement activities, the Council will inform the DMH Executive Leadership Team to engage their assistance in determining adequate consequences related to certification status.

System design changes are communicated through a variety of methods. Since most system design changes require changes to DMH 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. In addition to following the administrative rules process, system design changes are also communicated to the BIDD Advisory Council that includes participants, families, and other interested parties.

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 Quality Management Council, BQMOS, BIDD, and DOM review 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. Payments will be monitored through monthly reports by the Bureau of Mental Health Programs. 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 ID/DD Waiver providers are conducted. The Division will also generate all required financial reporting for each ID/DD 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:
FA a.i. (1) Number and percent of claims for which payment was made where the service was included in the individual's Plan of Services and Supports. N: # of claims paid that were included in the individual's Plan of Services and Supports D: # of total claims paid

Data Source (Select one):
Financial audits
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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
FA a.i. (2) Number and percent of claims for which payment was made where the procedures code was specified in the waiver N: # of claims paid that included a correct procedure code as specified in the waiver D: # of total claims paid

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

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:
FA a.i. (3) Number and percent of claims for which payment was made where the beneficiary met all waiver eligibility requirements N: # of claims paid for beneficiaries meeting waiver eligibility requirements D: # of total claims paid

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

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.
DOM is responsible for ensuring financial audits of providers. These audits verify that appropriate financial records are maintained and claims are coded and paid accurately. Systems edits in the MMIS prevent claims from paying when individuals are not eligible for Medicaid on the date of service. DMH staff use the Monthly Utilization Report from DOM to verify services provided were included in the individual's Plan of Services and Supports.

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).

DOM worked closely with MS Department of Mental Health, and Milliman, an actuary organization and other stakeholders to carefully consider the service descriptions and provider handbook information for each waiver service. We determined whether certain services had essentially the same provider education requirements, expectations and billable productivity levels. If so, we grouped these services together for purposes of rate development. For all services reviewed, we either compared current waiver rates to the same non-waiver Medicaid service rates, or we performed a thorough "ground up" provider rate development.

For Adult Day Services, Home and Community Supports and Case Management services, we built initial rates from

the ground up using the following rating variables:

> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hour's practitioners are at work
> Percentage of time and 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, public and private provider surveys, and DOM and Milliman experience.

Once we calculated initial service rates, we compared them to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates to ensure access and availability of services statewide. Projected rates 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 paymentt rates is made available to waiver participants through the DOM website. The ID/DD Waiver fee schedule is updated when their are any changes.

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:

Provider billing flows directly from providers to the State's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (selected) **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:

There are systems edits in the MMIS to prevent claims from paying when individuals are not eligible for Medicaid on the date of service. DMH staff will validate claims paid reports to verify services provided were included in the participant's Plan of Services and Supports, until such time that edits can be put in place for prior authorization to prevent claims from paying for services not included on the Plan of Services and Supports. DMH will review the Monthly Utilization Report with individuals/families to verify the services were provided according to the claims listed in the Utilization Report.

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*):

- (selected) **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.*

Regional Programs can provide the following waiver services: Behavior Support, Prevocational Services, Day Services-Adult, Supported Employment, Respite Services, Therapy Services, Home and Community Supports, Supervised Living, Supported Living, Crisis Support, Job Discovery, Crisis Intervention and Support Coordination, and Transition Assisstance.

Community Mental Health Centers can provide the following services: Prevocational Services, Day Services-Adult, Supervised Living, Supported Living, Crisis Intervention, Behavior Support, Job Discovery, Respite, Supported Employment, and Transition Assistance.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (selected) **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:*

- (selected) **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:*

- (selected) **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:

The Department of Mental Health receives an appropriation from State Tax Revenues, specifically on a line item for the non-federal matching funds required to operate the ID/DD Waiver program. The Division of Medicaid bills the Department of Mental Health for the non-federal share of matching funds in advance of claims payments based on estimates from historical paid claims data. The Department of Mental Health remits these amounts to the Division of Medicaid in the form of an Intergovernmental Transfer.

☐ **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:

The rate is set for the cost of supervision/support provided in order to maintain the individual in the residential setting, including transportation cost. The costs for room and board are not included in the calculations used to set rates of the services provided in a residential setting.

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*:

- (selected) **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: ICF/MR

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	28414.00	2606.00	31020.00	108197.00	2405.00	110602.00	79582.00
2	30715.20	2736.00	33451.20	113606.00	2525.00	116131.00	82679.80

3	31444.00	2843.00	34287.00	119286.00	2651.00	121937.00	87650.00
4	35557.00	2985.00	38542.00	125250.00	2784.00	128034.00	89492.00
5	39165.00	3134.00	42299.00	131512.00	2923.00	134435.00	92136.00

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: ICF/MR
Year 1	2100	2100
Year 2	2200	2200
Year 3	2300	2300
Year 4	2400	2400
Year 5	2500	2500

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 average length of stay was determined by the 372 reports for this waiver for FY 2011. Based on that report the ALOS was 361 days. The State recognized this is an average and averages change based on individual consumption of services. The estimated average of 361 from historical data does not preclude anyone from receiving hospital services and therefore falling below the expected average. The State recognizes the average length of stay is long, but that is in part due to the fact there were few hospitalizations for the high number of participants.

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 of Factor D for each year are derived by projecting the average number of users for each service, the average number of units per beneficiary and the rate set for each service. The number of users and average units per user are projected using the 372 lag report for the state fiscal year 2011.

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:

Factor D' equals the average per capita annual costs for all other Medicaid services (ancillary) to HCBS DD

Waiver beneficiary (excluding HCBS DD Waiver services cost). These estimates are based on actual costs from claims data in our MMIS system for SYF 2012 projected out with a 5% growth factor over the duration of the waiver renewal. The Factor D' assumptions are from the cost of all State Plan services while the participant was on the HCBS DD 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 estimates of Factor G for each waiver year are derived using the average per diem rate for ICF/IID for SFY 2011. Future years are derived by projecting growth using 5% with is the five year average increase in rates for ICF/IDD provider type in Mississippi.

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' estimates for State Plan services utilization for inpatient intermediate care facility, sub-acute and hospital level of care are derived from experience as reported in MS claims data for SFY 2012. The calculations are projected out with a growth factor of 5% over the horizon of the renewal of the waiver. The assumptions used for obtaining the aggregate Factor G' are the cost of all state plan services furnished during the beneficiary institutional stay in an ICF/IID facility. The Medicare Part D drug costs are not included in the Factor G' estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Day Services-Adults
In-Home Nursing Respite
Prevocational Services
Supervised Living
Support Coordination
Supported Employment
Supported Living
Specialized Medical Supplies
Therapy Services
Behavior Support Services
Community Respite
Crisis Intervention
Crisis Support
Home and Community Supports
Host Home
Job Discovery
Transition Assistance

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						**6083280.00**
Day Services-Adults	15 minutes	355	4800.00	3.57	**6083280.00**	
In-Home Nursing Respite Total:						**4465000.00**
In-home Nursing Respite	15 minutes	250	2000.00	8.93	**4465000.00**	
Prevocational Services Total:						**10955000.00**
Prevocational Services	hour	875	1000.00	12.52	**10955000.00**	
Supervised Living Total:						**9936225.00**
Supervised Living	day	325	300.00	101.91	**9936225.00**	
Support Coordination Total:						**4928112.00**
Support Coordination	monthly	2100	12.00	195.56	**4928112.00**	
Supported Employment Total:						**345000.00**
Supported Employment	15 minutes	230	240.00	6.25	**345000.00**	
Supported Living Total:						**124560.00**
Supported Living	15 minutes	25	960.00	5.19	**124560.00**	
Specialized Medical Supplies Total:						**1768300.00**
Underpads	each	400	1000.00	0.84	**336000.00**	
Disposable briefs	each	400	1800.00	0.72	**518400.00**	
Catheters	each	100	740.00	12.35	**913900.00**	
Therapy Services Total:						**95750.00**
Physical Therapy	15 minutes	20	100.00	25.65	**51300.00**	
Speech Therapy	15 minutes	10	100.00	17.80	**17800.00**	
Occupational Therapy	15 minutes	10	100.00	26.65	**26650.00**	
Behavior Support Services Total:						**2815540.00**
Behavior Support Services	hour	65	700.00	61.88	**2815540.00**	
Community Respite Total:						**47840.00**
Community Respite	15 minutes	50	260.00	3.68	**47840.00**	
Crisis Intervention Total:						**61560.00**
Crisis Intervention	day	15	10.00	410.40	**61560.00**	

Crisis Support Total:						**39600.00**
Crisis Support	day	15	10.00	264.00	**39600.00**	
Home and Community Supports Total:						**17905500.00**
Home and Community Supports	15 minutes	1150	3000.00	5.19	**17905500.00**	
Host Home Total:						**68750.00**
Host Home	day	5	250.00	55.00	**68750.00**	
Job Discovery Total:						**13704.00**
Job Discovery	15 minutes	15	80.00	11.42	**13704.00**	
Transition Assistance Total:						**16000.00**
Transition Assistance	lifetime	20	1.00	800.00	**16000.00**	
GRAND TOTAL:						**59669721.00**
Total Estimated Unduplicated Participants:						**2100**
Factor D (Divide total by number of participants):						**28414.00**
Average Length of Stay on the Waiver:						361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						**6732000.00**
Day Services-Adults	15 minutes	375	4800.00	3.74	**6732000.00**	
In-Home Nursing Respite Total:						**4114000.00**
In-home Nursing Respite	15 minutes	220	2000.00	9.35	**4114000.00**	
Prevocational Services Total:						**11501600.00**
Prevocational Services	hour	880	1000.00	13.07	**11501600.00**	
Supervised Living Total:						**13650000.00**
Supervised Living	day	350	300.00	130.00	**13650000.00**	
Support Coordination Total:						**5294784.00**
Support Coordination	month	2200	12.00	200.56	**5294784.00**	
Supported Employment						

Total:						**561600.00**
Supported Employment	15 minutes	240	360.00	6.50	**561600.00**	
Supported Living Total:						**183120.00**
Supported Living	15 minutes	35	960.00	5.45	**183120.00**	
Specialized Medical Supplies Total:						**1889720.00**
Underpads	each	400	1000.00	0.90	**360000.00**	
Disposable briefs	each	400	1800.00	0.77	**554400.00**	
Catheters	each	100	740.00	13.18	**975320.00**	
Therapy Services Total:						**61575.00**
Physical Therapy	15 minutes	10	100.00	26.15	**26150.00**	
Speech Therapy	15 minutes	5	100.00	18.55	**9275.00**	
Occupational Therapy	15 minutes	10	100.00	26.15	**26150.00**	
Behavior Support Services Total:						**3640000.00**
Behavior Support Services	hour	80	700.00	65.00	**3640000.00**	
Community Respite Total:						**57200.00**
Community Respite	15 minutes	55	260.00	4.00	**57200.00**	
Crisis Intervention Total:						**86000.00**
Crisis Intervention	day	20	10.00	430.00	**86000.00**	
Crisis Support Total:						**79200.00**
Crisis Support	day	10	30.00	264.00	**79200.00**	
Home and Community Supports Total:						**19620000.00**
Home and Community Supports	15 minutes	1200	3000.00	5.45	**19620000.00**	
Host Home Total:						**72187.50**
Host Home	day	5	250.00	57.75	**72187.50**	
Job Discovery Total:						**14400.00**
Job Discovery	15 mintes	15	80.00	12.00	**14400.00**	
Transition Assistance Total:						**16000.00**
Transition Assistance	lifetime	20	1.00	800.00	**16000.00**	
GRAND TOTAL:						**67573386.50**
Total Estimated Unduplicated Participants:						**2200**
Factor D (Divide total by number of participants):						**30715.20**
Average Length of Stay on the Waiver:						361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						**7451280.00**
Day Services-Adults	15 minutes	395	4800.00	3.93	**7451280.00**	
In-Home Nursing Respite Total:						**4419000.00**
In-home Nursing Respite	15 minutes	225	2000.00	9.82	**4419000.00**	
Prevocational Services Total:						**10279500.00**
Prevocational Services	hour	890	1000.00	11.55	**10279500.00**	
Supervised Living Total:						**15356250.00**
Supervised Living	day	375	300.00	136.50	**15356250.00**	
Support Coordination Total:						**5535456.00**
Support Coordination	month	2300	12.00	200.56	**5535456.00**	
Supported Employment Total:						**429600.00**
Supported Employment	15 minutes	250	240.00	7.16	**429600.00**	
Supported Living Total:						**247104.00**
Supported Living	15 minutes	45	960.00	5.72	**247104.00**	
Specialized Medical Supplies Total:						**1813398.00**
Underpads	each	425	100.00	0.96	**40800.00**	
Disposable briefs	each	425	1800.00	0.82	**627300.00**	
Catheters	each	110	740.00	14.07	**1145298.00**	
Therapy Services Total:						**110250.00**
Physical Therapy	15 minutes	15	100.00	27.05	**40575.00**	
Speech Therapy	15 minutes	15	100.00	19.40	**29100.00**	
Occupational Therapy	15 minutes	15	100.00	27.05	**40575.00**	
Behavior Support Services Total:						**4825240.00**
Behavior Support Services	hourly	95	700.00	72.56	**4825240.00**	

Community Respite Total:						**47580.00**
Community Respite	15 minutes	60	260.00	3.05	**47580.00**	
Crisis Intervention Total:						**90300.00**
Crisis Intervention	day	20	10.00	451.50	**90300.00**	
Crisis Support Total:						**79200.00**
Crisis Support	day	10	30.00	264.00	**79200.00**	
Home and Community Supports Total:						**21450000.00**
Home and Community Supports	15 minutes	1250	3000.00	5.72	**21450000.00**	
Host Home Total:						**151600.00**
Host Home	day	10	250.00	60.64	**151600.00**	
Job Discovery Total:						**20160.00**
Job Discovery	15 minutes	20	80.00	12.60	**20160.00**	
Transition Assistance Total:						**16000.00**
Transition Assistance	lifetime	20	1.00	800.00	**16000.00**	
			GRAND TOTAL:			**72321918.00**
			Total Estimated Unduplicated Participants:			**2300**
			Factor D (Divide total by number of participants):			**31444.00**
			Average Length of Stay on the Waiver:			361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						**8521440.00**
Day Services-Adults	15 minutes	410	4800.00	4.33	**8521440.00**	
In-Home Nursing Respite Total:						**4981800.00**
In-home Nursing Respite	15 minutes	230	2000.00	10.83	**4981800.00**	
Prevocational Services Total:						**11457000.00**
Prevocational Services	hourly	900	1000.00	12.73	**11457000.00**	

Supervised Living Total:						**18058800.00**
Supervised Living	day	400	300.00	150.49	**18058800.00**	
Support Coordination Total:						**6350400.00**
Support Coordination	month	2400	12.00	220.50	**6350400.00**	
Supported Employment Total:						**490464.00**
Supported Employment	15 minutes	260	240.00	7.86	**490464.00**	
Supported Living Total:						**1332672.00**
Supported Living	hourly	55	960.00	25.24	**1332672.00**	
Specialized Medical Supplies Total:						**2328514.00**
Underpads	each	425	1000.00	1.02	**433500.00**	
Disposable briefs	each	425	1800.00	0.88	**673200.00**	
Catheters	each	110	740.00	15.01	**1221814.00**	
Therapy Services Total:						**158420.00**
Physical Therapy	15 minutes	20	100.00	28.99	**57980.00**	
Speech Therapy	15 minutes	20	100.00	21.23	**42460.00**	
Occupational Therapy	15 minutes	20	100.00	28.99	**57980.00**	
Behavior Support Services Total:						**6544230.00**
Behavior Support Services	hourly	110	700.00	84.99	**6544230.00**	
Community Respite Total:						**52416.00**
Community Respite	15 minutes	60	260.00	3.36	**52416.00**	
Crisis Intervention Total:						**99556.00**
Crisis Intervention	day	20	10.00	497.78	**99556.00**	
Crisis Support Total:						**79200.00**
Crisis Support	day	10	30.00	264.00	**79200.00**	
Home and Community Supports Total:						**24609000.00**
Home and Community Supports	15 minutes	1300	3000.00	6.31	**24609000.00**	
Host Home Total:						**167150.00**
Host Home	day	10	250.00	66.86	**167150.00**	
Job Discovery Total:						**88896.00**
Job Discovery	hourly	20	80.00	55.56	**88896.00**	
Transition Assistance Total:						**16000.00**

Transition Assistance	lifetime	20	1.00	800.00	16000.00	
GRAND TOTAL:						85335958.00
Total Estimated Unduplicated Participants:						2400
Factor D (Divide total by number of participants):						35557.00
Average Length of Stay on the Waiver:						361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						**9845280.00**
Day Services-Adults	15 minutes	430	4800.00	4.77	**9845280.00**	
In-Home Nursing Respite Total:						**5611800.00**
In-home Nursing Respite	15 minutes	235	2000.00	11.94	**5611800.00**	
Prevocational Services Total:						**12627000.00**
Prevocational Services	hourly	900	1000.00	14.03	**12627000.00**	
Supervised Living Total:						**21154800.00**
Supervised Living	day	425	300.00	165.92	**21154800.00**	
Support Coordination Total:						**7293000.00**
Support Coordination	monthly	2500	12.00	243.10	**7293000.00**	
Supported Employment Total:						**559224.00**
Supported Employment	15 minutes	270	240.00	8.63	**559224.00**	
Supported Living Total:						**434304.00**
Supported Living	15 minutes	65	960.00	6.96	**434304.00**	
Specialized Medical Supplies Total:						**2551822.00**
Underpads	each	430	1000.00	1.09	**468700.00**	
Disposable briefs	each	430	1800.00	0.93	**719820.00**	
Catheters	each	115	740.00	16.02	**1363302.00**	
Therapy Services Total:						**171820.00**

Physical Therapy	15 minutes	20	100.00	31.33	**62660.00**	
Speech Therapy	15 minutes	20	100.00	23.25	**46500.00**	
Occupational Therapy	15 minutes	20	100.00	31.33	**62660.00**	
Behavior Support Services Total:						**9004625.00**
Behavior Support Services	hourly	125	700.00	102.91	**9004625.00**	
Community Respite Total:						**57720.00**
Community Respite	15 minutes	60	260.00	3.70	**57720.00**	
Crisis Intervention Total:						**109760.00**
Crisis Intervention	day	20	10.00	548.80	**109760.00**	
Crisis Support Total:						**79200.00**
Crisis Support	day	10	30.00	264.00	**79200.00**	
Home and Community Supports Total:						**28188000.00**
Home and Community Supports	15 minutes	1350	3000.00	6.96	**28188000.00**	
Host Home Total:						**184275.00**
Host Home	day	10	250.00	73.71	**184275.00**	
Job Discovery Total:						**24496.00**
Job Discovery	15 minutes	20	80.00	15.31	**24496.00**	
Transition Assistance Total:						**16000.00**
Transition Assistance	lifetime	20	1.00	800.00	**16000.00**	
GRAND TOTAL:						**97913126.00**
Total Estimated Unduplicated Participants:						**2500**
Factor D (Divide total by number of participants):						**39165.00**
Average Length of Stay on the Waiver:						361