

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:

On July 1, 2012, the Mississippi Division of Medicaid (DOM) Federal Balancing Incentive Program (BIP) Grant went into effect. With this Grant, DOM is in the process of establishing and implementing a strategic plan for expanding access to the State's Home and Community Based Services (HCBS). Our strategic plan includes the development of a person-centered, data-driven approach to creating a sustainable long-term care system. This system will enable individuals who are disabled and aging to exercise independent judgment in choosing between long term care services in a home or community setting versus an institutional setting.

DOM and other State partners have been working on developing a Long Term Services and Support System (LTSS) to include at a minimum, a No Wrong Door System, Conflict Free Case Management, a Core Standardized Assessment Instrument, Information and Referral System, Electronic Visit Verification and a Quality Assurance Improvement strategy that reaches across all waivers.

Effective October 1, 2013, DOM entered into a contract with FEi Systems to assist the State in fulfilling the BIP requirements. As a part of this process, the State is developing a comprehensive LTSS assessment tool that will replace the current Pre-admission Screening (PAS) tool. The current case management system, Omnitrack, will also be replaced by a new system designed by FEi to meet all necessary requirements, specifically, 1) gathering, storing and reporting data, 2) improving communications between care providers, DOM and other State partners, 3) detecting and reducing fraud, and 4) ensuring the State's LTSS program is efficient and effective at providing the highest quality of care possible. LTSS systems improvements are being implemented by phases over the next year. The projected implementation date for the LTSS system is September 30, 2015.

The Division of Medicaid made application to CMS for the Section 1915(b)(4) Waiver Fee-for-Service Selective Contracting Program. The 1915(c) TBI/SCI waiver is administered by the Division of Medicaid (DOM) and operated by the Mississippi Department of Rehabilitation Services (MDRS) through an interagency agreement.

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*):
Traumatic Brain Injury/Spinal Cord Injury Waiver

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: MS.0366

Waiver Number: MS.0366.R03.00

Draft ID: MS.016.03.00

D. Type of Waiver (select only one):

Regular Waiver

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

07/01/15

Approved Effective Date: 07/01/15

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 in 42 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:

Eligibility is limited to individuals with the following diagnoses or condition(s):

☐ Traumatic Brain Injury

Traumatic brain injury is defined as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

☐ Spinal Cord Injury

Spinal cord injury defined as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

The extent of injury must be certified by their physician. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that results (intentionally or unintentionally) from medical intervention, is excluded.

The participant must be determined medically stable by a physician. Medical stability is defined as the absence of any of the following:

(a) An active, life threatening condition (e.g., sepsis, respiratory, or other conditions requiring systematic therapeutic measures);

(b) IV drip to control or support blood pressure; and

(c) intracranial pressure or arterial monitoring.

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

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

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

1. Request Information (3 of 3)

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

Select one:

- Not applicable**
 Applicable

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
 Waiver(s) authorized under §1915(b) of the Act.

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

An initial submission of the 1915(b)(4) for Case Management services was submitted on _____ for approval.

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 Eligibility 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 purpose of this waiver is to provide cost-effective in-home support services to Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) participants who, but for the assistance provided by this waiver, would require institutionalization in a Nursing Facility.

The goal of the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver is to provide participants seeking Long Term Care assistance, meaningful choices to allow residency in the HCBS. The waiver strives to identify the needs of the dependent participant and provide services in the most cost efficient manner possible with the highest quality of care. This is accomplished through the utilization of a comprehensive Long Term Support Services (LTSS) assessment process that provides a No Wrong Door entry concept for individuals seeking long term care services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.

This waiver is administered by the DOM (otherwise known as the State) and operated statewide by Mississippi Department Rehabilitation Services (MDRS) (otherwise known as the Department) through an interagency agreement. The services provided under the TBI/SCI Waiver are case management, personal care attendant service, environmental accessibility adaptation, specialized medical equipment and supplies, respite, and transition assistance.

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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
DOM actively sought public input during the development of this waiver renewal by seeking comments, conducting group meetings, and meeting with providers and stakeholders. Sixty days prior to submission of the waiver renewal application to CMS, the Mississippi Band of Choctaw Indians was notified via certified mail of the renewal process including proposed changes and considerations. A formal request was made for participation in the renewal process with encouragement to provide comments about the waiver document. Prior to submission of the waiver applications to The Centers of Medicare and Medicaid, draft copies were sent to the Choctaw Tribe for review and comments. A face-to-face visit was made to the Reservation to discuss the waiver renewal process and proposed changes with Tribal representatives.
- Mississippi also obtains public input through the TBI/SCI waiver review and audit process. A DOM HCBS review team regularly audits each HCBS waiver case management and service provision. This process includes participant home visits to a sample population being served in a particular area. During this home visit, direct feedback is received from the waiver participant and/or their family members. Specific feedback is obtained regarding the participants satisfaction with their services, their satisfaction with their case manager/counselor, any additional services that they believe that they could benefit from. This feedback is utilized to improve and/or further develop waiver services. Public input is also obtained through calls from waiver participants, family members or applicants regarding inquiries, complaints, or appeals.
- Stakeholder meetings were initiated prior to submission of the waiver documents to The Centers of Medicaid and Medicare which included providers, waiver participants, advocates and representatives of the operating agency.
- 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:

Johnson

First Name:

Paulette

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Mississippi****Zip:****Phone:**Ext: TTY**Fax:****E-mail:**

Attachments

Margaret.Wilson@medicaid.ms.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Based upon the State's assessment of the HCBS settings in the Traumatic Brain Injury waiver, the State confirms that services in this waiver are rendered in a home and community setting. Waiver participants reside in private home dwellings located in the community. This waiver does not provide services in either congregate living facilities, institutional settings or adjacent to or on the grounds of institutions. No further transition plan is required.

The State provided a 30-day public notice and comment period regarding the transition plan. This notice was publicized in the newspaper and on the Division of Medicaid website. Two public hearings and teleconferences were also held in the presence of a court reporter. The State did not receive any public comments.

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

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

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

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

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

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

No transition plan is required. Completed.

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:

Mississippi Department of Rehabilitation Services (MDRS)

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:

Mississippi Department of Rehabilitation Services (MDRS) is responsible for the operational management of the waiver on a day-to-day basis and is accountable to Division of Medicaid (DOM) which ensures that the waiver operates in accordance with federal waiver assurances.

1) Waiver enrollment managed against approved waiver limits – MDRS notifies DOM monthly of enrollment numbers

- 2) Waiver expenditures managed against approved waiver levels - MDRS notifies DOM monthly of expenditures; DOM verifies that expenditure limits are not exceeded.
- 3) Level of care evaluation; MDRS obtains physician certification of level of care and DOM verify that level of care has been determined prior to approving each case.
- 4) Development, review and update of participant service plans – With the participant’s input MDRS develops and updates the participant service plans; DOM reviews and approves all services on the service plan
- 5) Qualified provider enrollment, - MDRS and DOM
- 6) Quality assurance and quality improvement activities and, - MDRS and DOM
- 7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program. – MDRS and DOM (with DOM having the final authority)

An interagency agreement between the DOM and MDRS is renewed each fiscal year and updated as needed. DOM monitors this agreement to assure that the provisions specified are met.

In the agreement, DOM designates the assessment, evaluation, and reassessment of waiver participants to be conducted by qualified individuals as specified in the current waiver. Medical certification and re-certification of the need for HCBS waiver programs shall be certified by a licensed physician. All such evaluations for certification or re-certification are subject to DOM's review and approval.

DOM performs monitoring of the multi-site offices of MDRS on an annual basis to assess their operating performance and compliance with all rules and regulations. DOM registered nurses perform 100% desk reviews of all Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) certifications, both initial and annual recertification. Home visits are conducted to assess compliance with waiver requirements.

MDRS is responsible for the waiver participant’s assessment, evaluation, and reassessment conducted by appropriate professionals as specified in the waiver. In addition, MDRS State office management staff is responsible for initial and ongoing training of the MDRS Regional Directors, individual case manager/counselors, registered nurses, and personal care attendants (PCA).

MDRS is also responsible for verifying the registrations and status verification for all PCAs and newly hired employees. MDRS is responsible for obtaining criminal background checks on all personnel who provide direct care to waiver participants.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

1) Number and percent of monthly enrollment reports submitted by MDRS indicating that current census and unduplicated count do not exceed estimates in the waiver.

N:Number of monthly enrollment reports submitted by MDRS indicating that current census and unduplicated count do not exceed estimates in the waiver. **D:**Total number of enrollment reports that were required to be submitted by MDRS

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid from Operating Agency

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

2)Number and percent of monthly waiver expenditures reports submitted by MDRS that on average are at or below the projected expenditure levels for the month. N:Number of monthly waiver expenditure reports submitted by MDRS on average are at or below the projected expenditure levels for the month. D:Total number of monthly waiver expenditure reports that were required to be submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid from Operating Agency

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

3) Number and percent of initial level of care evaluations completed by MDRS by qualified staff as specified in the waiver application. Numerator: Number of initial level of

care evaluations completed by MDRS by qualified staff. Denominator: Total number of initial level of care evaluations that were required to be reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

Performance Measure:

4) Number and percent of waiver participant service plans updated quarterly by MDRS as specified in the waiver application. Numerator: Number of waiver participant service plans updated quarterly by MDRS. Denominator: Total number of waiver participant service plans that where supposed to be updated quarterly.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid Agency from the Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

5) Number and percent of rehabilitation counselors/case managers hired by MDRS using qualifications as stated in the waiver. Numerator: Number of rehabilitation counselors/case managers hired by MDRS using qualifications as stated in the waiver. Denominator: Total number of new rehabilitation counselors/case managers hired by MDRS each month.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid Agency from Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

6) Number and percent of monthly reports submitted by MDRS within specified time frames (a comprehensive monthly report is due at DOM no later than the eighth business day). Numerator: Number of monthly reports submitted by MDRS within specified timeframe. Denominator: Total number of monthly reports that were required to be submitted within a specified timeframe.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid Agency from Operating Agency

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- 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.
 For Performance Measure 1, DOM will (a) require MDRS to provide report monthly and (b) DOM and MDRS will cease enrollment immediately if current census and unduplicated count exceed estimates of the waiver.

For PM 2, DOM will (a) require MDRS to provide report monthly and (b) DOM and MDRS will cease enrollment immediately if expenditures exceed estimates of the waiver.

For PM 3, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; (d) require MDRS to conduct a new LOC evaluation by a qualified staff person within seven business days, if indicated; and (e) approve LOC evaluation within seven business days of receipt.

For PM 4, DOM will have MDRS to (a) examine the cause within thirty days; (b) conduct the quarterly review and update the Plan of Care within thirty days; (c) provide staff training within thirty days; and (d) refund the payment within thirty days.

For PM 5, DOM will have MDRS to (a) remove individual immediately and (b) review hiring practices and modify if necessary in thirty days.

For PM 6, DOM will (a) require MDRS to submit the missing reports within seven business days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically as needed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	-Disabled (Physical)	0	0	
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	-Brain Injury	0		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Eligibility is limited to individuals with the following diagnoses or conditions(s):

- Traumatic Brain Injury

Traumatic brain injury is defined as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

- Spinal Cord Injury

Spinal cord injury defined as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

The extent of injury must be certified by their physician. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that results (intentionally or unintentionally) from medical intervention, is excluded.

In addition, individuals must be certified as medically stable by their physician. Medical stability is defined as the absence of the following:

- An active, life threatening condition (e.g., sepsis, respiratory, or other condition requiring systematic therapeutic measures)
- Intravenous drip to control or support blood pressure
- Intracranial pressure or arterial monitoring

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:

There is no maximum age limit for this waiver.

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)

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

Prior to the admission to this waiver, the case management team completes a thorough comprehensive Long Term Support Services (LTSS) assessment to determine how the applicant/participant could be best served. The overall assessment of the waiver applicant/participant provides an estimated projection of the total cost for services to determine whether the applicant's/participant's needs are able to be met in a manner that ensures the applicants/participant's health and welfare. Along with the LTSS assessment, the case management team supplies DOM with a Plan of Care (Service Plan) with specific service needs of the applicant/participant. An oversight review by a registered nurse at DOM is conducted to ensure the waiver applicant's/participant's needs are able to be met by the specified services. If an applicant's/participant's needs cannot be met within the capacity of the waiver, it is explained to the applicant/participant along with a Notice of Action for a Fair Hearing. Suggestions are given for other long term care alternatives.

On average, the cost for a waiver applicant/participant must not be above the average estimated cost for nursing home level of care approved by CMS for the current waiver year. DOM and MDRS must ensure the waiver is cost neutral.

If MDRS determines a particular applicant's/participant's care costs are threatening the cost neutrality of the waiver, the operating agency must collaborate with DOM as soon as possible to review the plan of care. If entrance into the waiver is denied the waiver applicant/participant will be informed in writing for the denial and provided the opportunity for a fair hearing.

- 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:

Each additional service requested is thoroughly reviewed by the administrative staff at MDRS and additionally by a Medicaid program nurse. If the service is deemed appropriate, the Medicaid program nurse will approve the request and will notify the staff at MDRS of the approval.

If the additional services requested are determined to exceed the average estimated cost, then the request may be denied per MDRS and the applicant or participant will be notified of their right to appeal DOM (Appendix F).

MDRS must notify DOM of the following types of denials of waiver services: equipment, home modifications, and waiver admissions.

The denial must not compromise the quality of care of the individual in any way; if so, an approval may be granted by overriding the denial via management of DOM and/or MDRS.

If an increase in services is denied, the waiver participant will be informed and given the opportunity to request a fair hearing.

- Other safeguard(s)

Specify:

DOM and MDRS work collectively to ensure the waiver participant's needs are met. This process includes examining third-party resources, possible transition to another waiver or institutional services. Medicaid waiver funds are to be utilized as a payor of last resort.

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	2400
Year 2	2700
Year 3	3000
Year 4	3300
Year 5	3600

- 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

Purposes
Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers.

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):

Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers.

Purpose (describe):

MDRS agrees to reserve capacity for each waiver year for individuals transitioning from nursing facilities and other home and community-based services (HCBS) waivers.

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

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of referrals received for transition from nursing facilities and bridge to independence services to a community setting for FY 2013. The findings revealed that approximately 522 referrals were received by the HCBS department. These referrals, if appropriate, were transitioned into the community with services of either of the four waivers administered by the LTC Division of Medicaid. It was determined that reserving capacity for 25 TBI/SCI waiver participants in addition to capacity reserved in other waivers would be sufficient to meet the needs of individuals wishing to transition out of nursing facilities into a Home and Community setting.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

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:

MDRS maintains a statewide referral database of individuals who request waiver services through the TBI/SCI waiver. The statewide database is maintained on date of referral. Waiver participants are selected based on functional, technical and financial criteria. Participants must meet nursing home level of care and have a diagnosis of Traumatic Brain Injury/Spinal Cord Injury.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. Miller Trust State.

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

- No
 Yes

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

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

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

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

Specify:

42 CFR § 435.110 - other caretaker relatives;
 42 CFR § 435.118 - children specified (100% children);
 42 CFR § 435.222 – CWS Foster Children;
 42 CFR § 435.227 – Adoptive Assist Foster Children (non-IVE adoption assistance);
 42 CFR § 435.145 - IVE foster children and adoptive assistance;
 42 CFR § 435.226 – Independent Foster Care Adolescents (up to 21); and
 42 CFR § 435.150 – Former Foster Care Children;

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 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

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

- Other**

Specify:

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

- Not Applicable (see instructions)**
 SSI standard
 Optional State supplement standard
 Medically needy income standard
 The following dollar amount:

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

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

Specify:

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

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

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

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

Specify:

- Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan

Select one:

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

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

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:

Due to WMS system constraints on 5/27/2015, this item is selected. However, it is not applicable. The state is applying the spousal impoverishment rules, as described in section 2404 of the ACA.

iii. Allowance for the family (select one):

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

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**

- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

- Other**

Specify:

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

- 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: 2

- 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 Initial Evaluation is conducted by a case manager/counselor and registered nurse using a Long Term Support Services (LTSS) assessment. The case manager/counselor must at a minimum have a Bachelors Degree in Rehabilitation counseling, or other related field and one year relevant experience; in addition, the registered nurse must be licensed without restrictions in the state of Mississippi and/or maintain a compact license. The case management team conducts the assessment at the time of evaluation, and enters the participant's pertinent data into the LTSS assessment. The case manager/counselor does not determine level of care.

- 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.

A comprehensive Long Term Support Services (LTSS) assessment is used to ensure the applicant's needs are fully captured, regardless of current or future placement. The assessment is a collection of objective clinical eligibility criteria that is to be applied uniformly to determine level of care. The process allows persons found clinically eligible for long term care to make an informed choice between institutional and community-based services. It also supports discharges from the nursing facility, if the applicant/participant desires to move into the community. Additionally, the level of care is certified by a physician. Applicants/Participants are also given a choice between appropriate community-based services.

Level of care for the Traumatic Brain Injury/Spinal Cord Injury Waiver is determined through the application of the comprehensive LTSS assessment instrument encompassing activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. The LTSS assessment data is entered into a scoring algorithm to generate a numerical score. The score is compared to a numerical threshold for level of care, with those at or above the threshold deemed clinically eligible. Applicants/participants scoring below the threshold may qualify for a secondary review by a DOM/LTC clinician before waiver services are denied.

If an applicant/participant is denied waiver services based on failure to meet the level of care, he/she will be notified of the reason for denial along with information and assistance if needed, to request and arrange for a fair hearing. Applicant/participants retain their customary appeal/Fair Hearing rights in accordance with Medicaid policy.

- 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:

Initially, the LTSS is completed by the MDRS Case Manager/Counselor and Registered Nurse to ensure the needs of the participant are fully captured. The LTSS process is a collection of clinical eligibility criteria that is used across all HCBS services and Long Term Care Facilities. A scoring algorithm is used from the LTSS using an eligibility threshold per DOM policy. The level of care is certified by a Physician.

During the recertification process, the Case Manager/Counselor may perform the level of care reevaluation without the Registered Nurse.

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

MDRS has district offices throughout the state. Each of these district offices has manual and automated monitoring systems to ensure that re-certifications are completed timely. These procedures are inclusive of:

1. Tickler file;
2. Edits in the computer system; and
3. Component part of case management.

The goal of each office is to renew these in a timely manner so that there will not be a lapse in service for the participant. A statewide tickler file and computer edits are also maintained in the state office of MDRS to further ensure timely reevaluations.

DOM prepares and sends MDRS a monthly eligibility report of all TBI/SCI waiver participants. This report indicates beginning and ending dates of clinical and financial eligibility. The report ensures that MDRS agency is aware of any participant that is about to lose eligibility or waiver services. By reviewing this monthly eligibility report, DOM and MDRS identify certification end dates and prevent deficiencies in timely submission of certifications.

DOM Program Nurses review 100% of reevaluations for timeliness in certification.

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

The original participant record is housed at MDRS. The Long Term Support Services (LTSS) assessment is submitted electronically which produces a copy that is housed in the DOM LTSS System. MDRS is required to keep the entire document for the period of time specified under the current federal guidelines.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Long Term Support Services (LTSS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Omni Track/Long Term Support System (LTSS)

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Omni Track and MMIS (HCBS certification compared to en date of current lock-in)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: As needed	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

4) **Number and percent of participant’s initial and recertification waiver assessments where the criteria are accurately applied. Numerator: Number of participants’ initial and recert waiver assessments where the criteria are accurately applied; Denominator: Total number of initial and recert waiver assessments reviewed.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Home visits with specific questions from waiver assessments that will be used to compare to the criteria applied by the case managers/counselors

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

<i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than representative sample due to representativeness met with 1st Level of Care performance measure
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

- 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.

For Performance Measure (PM) 1, DOM will have (a) MDRS obtain correct documentation prior to DOM completing determination letter; and (b) MDRS will conduct waiver assessment within fifteen days.

For PM 2, DOM will (a) require MDRS to submit waiver assessment within fifteen days; (b) require MDRS to submit Discharge 105 within seven business days; (c) work case as a new case (readmission) within thirty days; and (d) conduct provider training as needed.

For PM 3, DOM will (a) require MDRS to provide provider training within 30 days and (b)require MDRS to close the application and submit a new certification within 30 days.

For PM 4, DOM will (a) hold meetings quarterly to review findings; (b) MDRS and DOM will always use a team approach; and (c) DOM and MDRS will determine potential solutions and present to administration, as needed.

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px;"></div>

c. Timelines

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

- No**
- Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Long Term Support Service (LTSS) assessment process requires the participant or their legal representative to sign and attest to their choice of placement on an Informed Choice form. Long term care options are explained by the counselor prior to enrollment and the participants indicate their choice of waiver services or institutional services by evidence of their signature and initials placed by service choice.

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

The original participant record is maintained at MDRS. The LTSS assessment is to be submitted electronically which produces a copy that is maintained in DOM's LTSS System. MDRS is required to keep the entire document for the period of time specified under the current federal guidelines.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		

Service Type	Service		
Statutory Service	Personal Care Attendant (PCA)		
Statutory Service	Respite		
Other Service	Environmental Accessibility Adaptations		
Other Service	Specialized Medical Equipment & Supplies		
Other Service	Transition Assistance Services		

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:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Case management services will assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Case managers/Counselors shall be responsible for ongoing monitoring of the provision of services included in the participant's plan of care.

Case managers/Counselors shall initiate and oversee the process of assessment and reassessment of the

participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs.

Case Managers/Counselors are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs). Case managers/Counselors will review/update the task assignment sheet annually and as needed with each PCA. Case managers/counselors will make quarterly home visits to ensure all services are being provided according to the approved plan of care. The case Manager/counselor is allowed to conduct quarterly reviews, PCA certifications and annual re-certifications without the RN component, if appropriate.

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

Case Manager/counselor is required to make phone contact at least once monthly and a face to face visit with the participant at least every three months. Case managers are expected to visit more frequently in the event of alleged abuse, neglect or exploitation of waiver participants.

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	Rehabilitation Counselor/Registered Nurse

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Rehabilitation Counselor/Registered Nurse

Provider Qualifications

License (*specify*):

Nurse must have a current and active unencumbered registered nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license, and at least one year of experience with the aged and/or individuals with disabilities. The nurse must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The nurse must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General exclusion list.

Certificate (*specify*):

N/A

Other Standard (*specify*):

The Rehabilitation Counselor must possess at minimum of a Bachelors degree in Rehabilitation Counseling or other related field, and one year of experience working with individuals with disabilities. The rehab counselor must be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population. The rehab counselor's name must not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS) validates qualifications of the RN and rehab counselor. MDRS subscribes with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

Frequency of Verification:

Ongoing and 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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Attendant (PCA)

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Personal Care Services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Personal Care Service may include:

- a) support for activities of daily living such as but not limited to, bathing (sponge, tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.
- b) assistance with housekeeping that is directly related to the participant's disability and which is necessary for the health and well-being of the participant such as, but not limited to, changing bed linens, straightening area used by the participant, doing the personal laundry of the participant, preparation of meals for the participant, cleaning the

participants equipment such as wheelchairs or walkers.

c) food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;

d) support for community participation by accompanying and assisting the participant as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves nor the cost of transportation.

Personal Care Services are non-medical, hands-on care of both a supportive and health related nature. PCAs are instructed to report noted changes in condition and new needs to the counselor as soon as possible. The provision of Personal Care Services is recorded on the plan of care, and is not purely diversional in nature. There must be adequate justification for the relative to function as the PCA attendant, e.g., lack of other qualified PCAs attendants in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the personal care attendant. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

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

The Mississippi State Plan includes personal care services as a 1905(a) service available to some recipients under the age of 21, if medically necessary, and not addressed elsewhere in the State Plan. However, the state ensures that personal care services are not duplicated by this waiver for waiver participants under the age of 21. The case manager identifies all comparable benefits for participants of all services. If a needed service is available through the Medicaid State Plan, Medicare, private insurance, or another funding source, it is provided as a non-waivered service. DOM reviews 100% of all Plans of Care at initial application and each annual recertification. MDRS conducts quarterly reviews of all Plans of Care, Secondary reviews of all Plans of Care by in-house clinical staff, and annual programmatic audits by Program Evaluation. DOM conducts annual compliance reviews and on-site visits to ensure appropriate billing. Additionally, service restrictions are imposed with the use of the lock-in segment in MMIS. A review of claims history can be conducted to determine if personal care services are being provided and covered through the State Plan.

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
Individual	Personal Care Attendant

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Attendant (PCA)

Provider Category:

Individual ▾

Provider Type:

Personal Care Attendant

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

The State has implemented a personal care curriculum which is required for all non-licensed personal care attendants prior to providing any service to waiver participants. Documentation of completion of this course work must be maintained at the operating agency and be made available to the Division of Medicaid upon request. A personal care attendant must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The training, to be conducted by the participant/caregiver and the counselor/registered nurse, or an agency permitted by law to train nurse aides, shall include the purpose and philosophy of self-directed services by the disabled, disability awareness, employee-employer relationships and the need for respect for the participant's privacy and property. Upon hire and annually thereafter, training must also include the Vulnerable Person's Act, caregiver boundaries and managing challenging situations. Instructions will cover the basic elements of body functions, infection control procedures, maintaining a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet. The educational program will be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants will not be provided under the waiver.

The individual must demonstrate competency to perform each activity of daily living task to the participant and counselor/registered nurse prior to rendering any waived services. In addition to the technical skills required, the personal care attendant must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and counselor/registered nurse to be adequate in fulfilling the responsibilities of personal care.

An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements. Competency certification for these personal care attendant by the participant and counselor/registered nurse is required.

A personal care attendant that has satisfactorily provided personal care attendant services for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.

There must be adequate justification for the relative to function as the PCA attendant, e.g., lack of other qualified PCAs attendants in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the personal care attendant. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

Minimum Requirements:

-must be at least 18 years of age;

-must be a high school graduate, have a GED or demonstrates the ability to read and write adequately to complete required forms and reports of visits;

-must be able to follow verbal and written instructions;

-must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;

-must be certified as meeting the training and competence requirement by the participant and the

Counselor/Registered Nurse;

-must be able to communicate effectively and carry out directions.

-must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS)

Frequency of Verification:

Upon hire and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Respite services are provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

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

In-home Companion Respite - 288 hours per year allowed.

In-home Nursing Respite - 288 hours per year allowed.

Institutional Respite - 720 hours per year allowed.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ▼

Provider Type:

Respite

Provider Qualifications**License (specify):**

In-home nursing respite: LPN or RN licensed in the state of Mississippi or privileged to practice in Mississippi on a compact license and have evidence of successfully passing a criminal background check.

Institutional Respite: Medicaid approved hospital, nursing facility, and hospital swing-bed

Certificate (specify):

Other Standard (specify):

In-Home Companion Respite:

The State has implemented a personal care curriculum which is required for all non-licensed in-home respite companions prior to providing any service to waiver participants. Documentation of completion of this course work must be maintained at the operating agency and be made available to the Division of Medicaid upon request.

An entry level in-home respite companion must have completed training/instruction that covers the purpose, functions, and tasks associated with personal care. The training, to be conducted by the participant/caregiver and the case management team, or an agency permitted by law to train nurse aides, shall include the purpose and philosophy of self-directed services by the disabled, disability awareness, employee-employer relationships and the need for the respect for the participant's privacy and property. Instructions will cover the basic elements of body functions, infection control

procedures, maintaining a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub or shower bath, hair care, and nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers and equipment use and maintenance. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet. The cost of the training/institution for in-home respite companions will not be provided under the waiver.

The in-home respite companion must demonstrate competency to perform each task of assistance with the activities of daily living to the participant and counselor prior to rendering any services under the waiver. In addition to the technical skills required, the in-home respite companion must demonstrate the ability to comprehend and comply with basic verbal and written instructions at a level determined by the participant and case management team to be adequate in fulfilling the responsibilities of in-home respite companion.

An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility or home health agency or was continuously employed for twelve months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the training requirements. Competency certification for these individuals by the participant and case management team is required.

An individual that has satisfactorily provided in-home companion respite services for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and case management team, shall be deemed to meet the training requirement.

There must be adequate justification for the relative to function as the in-home respite companion, e.g., lack of other qualified in-home respite companions in remote areas. In-home respite companion services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the in-home respite companion. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

Minimum Requirements

- Must be at least 18 years of age
- Must be a high school graduate, have a GED, or demonstrate the ability to read and write adequately to complete required forms and reports of visits and follow verbal and written instructions;
- Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to the participant;
- Must be certified as meeting the training and competence requirements by the participant and counselor;
- Ability to communicate effectively and carry out directions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS)

Frequency of Verification:

Upon hire and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptations

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Those physical adaptations to the home, required by the participant's plan of care, which are necessary to ensure the health, welfare, and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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	Environmental Accessibility Adaptations

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

General Service Standards:

1. All providers must meet any state or local requirements for licensure or certification, where applicable (such as building contractors, plumbers, electricians or engineers).
2. All modifications, improvements or repairs must be made in accordance with local and state housing and building codes.
3. Quality of work
 - a. all work should be done in a fashion that exhibits good craftsmanship.
 - b. all materials, equipment, and supplies should be installed clean, and in accordance with manufacturer's instructions.
 - c. contractor is responsible for all permits that are required by local government bodies.
 - d. all non-salvaged supplies and/or materials should be new and of best quality, without defects.
 - e. at completion of project, contractor will be responsible for removal of all excess materials and trash, leaving the site clear of debris.
 - f. all work should be accomplished in compliance with applicable codes, ordinances, regulations and laws.
 - g. the specifications and drawings shall not be modified without a written change order from the case manager.
 - h. no barriers shall be created by the modification and/or construction process.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS)

Frequency of Verification:

AS NEEDED

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment & Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications	14031 equipment and technology
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Category 2:

Sub-Category 2:

14 Equipment, Technology, and Modifications	14032 supplies
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Category 3:

Sub-Category 3:

--	--

Category 4:

Sub-Category 4:

--	--

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

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

Service Definition (Scope):

Specialized medical equipment and supplies to include devices, controls, or appliances which enable the participant to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These items must be specified on the plan of care.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items. Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payors (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.

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

Each request for specialized medical equipment is evaluated by the Rehabilitation Counselor or Division of Medicaid (DOM) staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation.

If the LTSS assessment determines that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

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	Specialty Medical

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment & Supplies

Provider Category:

Agency

Provider Type:

Specialty Medical

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Providers of specialized medical equipment and supplies under this home and community -based services waiver shall meet the following minimum qualifications:

A)General Business Standards: a permanent local address & phone number, State of MS sales tax number, Federal I.D. number or social security number, Liability insurance

B)General Service Standards: Manufacturer's guarantee or warranty must be honored as published, provide repair capability for products

Providers should meet the following additional standards for custom in-house seating systems, powered mobility, three wheel scooters, and high-tech systems:

Provide documented proof of attendance of training with seating & positioning, maintain a current list of power chair manufacturers represented, have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer, maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above, must be able to deliver and assemble all equipment to be ready for final adjustment and fitting, have and present at purchase all necessary manuals, warranties, and provide written warranties, and must be able to provide instruction in proper use and care of equipment. Must be capable to provide training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price; must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS)

Frequency of Verification:

Upon hire and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Assistance Services

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services ▼

Category 2:

▼

Sub-Category 2:**Category 3:**

▼

Sub-Category 3:**Category 4:**

▼

Sub-Category 4:

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

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

Service Definition (Scope):

Transition Assistance Services are services provided to a Mississippi Medicaid eligible nursing facility resident to assist in transitioning from the nursing facility into the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver program. Transition assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved plan of care.

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

Transition assistance services are capped at \$800.00 one-time initial expense per lifetime.

Transition Assistance Services include:

- 1) Security deposits that are required to obtain a lease on an apartment or home
- 2) Essential furnishings and moving expense required to occupy and use a community domicile
- 3) Set up fees or deposits for utility or service access (i.e. telephone, electricity, heating)
- 4) Health and safety assurances, such as pest eradication, allergen control, or one time cleaning prior to occupancy

Essential items for an individual to establish his/her basic living arrangement includes such items as a bed, table, chairs, window blinds, eating utensils, and food preparation items.) Diversional or recreational items such as televisions, cable TV access or VCR/DVD's are not considered furnishings.

Need for this service: All items and services covered must be essential to:

- 1) Ensure that the participant is able to transition from the current nursing facility
- 2) Remove an identified barrier or risk to the success of the transition to a more independent living situation.

To be eligible:

- 1) Participant must be a current nursing facility (NF) resident whose NF services are being paid by Medicaid
- 2) Not have another source to fund or attain the items or support

- 3) Transitioning from a living arrangement where these items were provided
- 4) Transitioning to a residence where these items are not normally furnished

The transition service must occur within 90 days of the discharge, but must be completed by the day the participant relocated from the institution.

Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are 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	Case Management

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Assistance Services

Provider Category:

Agency

Provider Type:

Case Management

Provider Qualifications

License (*specify*):

Nurse must be licensed to practice in the state of Mississippi, and have at least one year of experience.

Certificate (*specify*):

N/A

Other Standard (*specify*):

The Rehabilitation Counselor must possess a minimum of a Bachelor's degree in Rehabilitation Counseling or a related field, and one year of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Department of Rehabilitation Services (MDRS)

Frequency of Verification:

At least annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

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

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):

Pursuant to Section 37-33-157 of the Mississippi Code of 1972, annotated, as amended, MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants.

MDRS is authorized to use the results of the investigations for the purpose of employment decisions and/or actions and service provision to consumers of the departments services. Any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed as a personal care attendant.

Personal care attendants must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including , but not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

This background check allows the agency to check things such as credit history, criminal records, work history, and driving record.

- 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):

MDRS is responsible for verifying that any potential personal care attendant providers are not on the Mississippi Nurse Aide Abuse Registry which is housed at the Mississippi State Department of Health within the Division of Licensure and 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).**

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

There must be adequate justification for the relative to function as the PCA attendant, e.g., lack of other qualified PCAs attendants in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the personal care attendant. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers of Medicaid services may apply to the state to become a Medicaid provider. Medicaid providers agree to abide by Medicaid policy, procedure, rules and guidance.

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

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. **Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

1) Number & percent of new RN case manager applications for which the RN obtained licensure in accordance with waiver qualifications prior to service provision. Numerator: # of new RN case manager applications for which the RN obtained appropriate licensure in accordance with waiver qualifications prior to service provision. Denominator: Total # of new RN case manager applications

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid Agency from Operating Agency

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

Performance Measure:

2) Number and percent of enrolled RN case managers who continue to meet applicable licensure following initial enrollment. Numerator: Number of enrolled RN case managers who continue to meet applicable licensure following initial enrollment. Denominator: Total number of enrolled RN case managers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review (Performance and Financial Review)

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

3) Number and percent of enrolled non-licensed/non-certified providers, by provider type, who met initial waiver provider qualifications. Numerator: Number of enrolled non-licensed/non-certified providers, by provider type, who met initial waiver provider qualifications. Denominator: Total number of non-licensed/non-certified provider applications

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid from Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

4) Number and percent of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. Numerator: Number of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. Denominator: Total number of enrolled non-licensed/non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid from Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

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

Performance Measure:

5) Number and percent of enrolled Personal Care Attendants (PCA) meeting provider training requirements. Numerator: Number of enrolled Personal Care Attendants (PCA) meeting provider training requirements. Denominator: Total number of enrolled Personal Care Attendants (PCA).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid from Operating Agency

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.
For Performance Measure (PM) 1, DOM will require MDRS to remove the RN case manager from service provision until the licensure qualification standards are met.

For PM 2, (a) DOM will require MDRS to remove the RN case manager from service provision until the licensure qualification standards are met; and (b) MDRS will take necessary measures to assure the participant continues to receive services immediately.

For PM 3, DOM will require MDRS to immediately remove the non-licensed/non-certified provider from providing care to waiver participants until the non-licensed/non-certified provider qualification standards are met.

For PM 4, DOM will require MDRS to immediately remove the non-licensed/non-certified provider from providing care to waiver participants until the non-licensed/non-certified provider qualification standards are met.

For PM 5, DOM will (a) require MDRS to remove the PCA from providing care to waiver participants immediately; (b) ask MDRS to apply applicable measures to ensure the provider is trained prior to resuming care; and (c) expect MDRS to apply applicable disciplinary action if warranted in accordance with their policies and procedures.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(select one)*.

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

The average cost for a waiver applicant/participant must not be above the average estimated cost for nursing home level of care approved by The Centers of Medicaid and Medicare Services for the current waiver year. DOM and MDRS must assure the waiver remains cost neutral. If the total projected annual cost of all services requested exceeds the most recent annual nursing home bed cost, then the request is denied and returned for reconsideration. The participant is explained the cost neutrality provisions. At that point, some negotiation may occur regarding the amount of services requested under this waiver, whether or not another waiver may have a package of services which can more efficiently meet the needs of the applicant/participant, or whether nursing home is the most appropriate setting based on the amount and complexity of services required. If the annual cost to serve a person in this waiver exceeds the annual nursing home costs, the cost neutrality requirement is jeopardized.

There is reference in Appendix B of this waiver renewal application to provisions for participant safeguards. Following these safeguard procedures, it is possible for an individual to exceed the cost neutrality limit, but the possibility of such occurrences is mitigated by active case management. These requests are considered on an individual basis considering each on its own merits. Related decisions are appealable and covered as addressed in Appendix F of this waiver renewal application.

If a waiver applicant is denied services, the waiver participant will be given a notice of action and the opportunity for a fair hearing.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Based upon the State's assessment of the HCBS settings in the TBI/SCI waiver, the State confirms that services in this waiver are rendered in a HCB setting. Waiver participants reside in private home dwellings located in the community. The TBI/SCI waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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

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

Specify qualifications:

- Social Worker

Specify qualifications:

- 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:*

All Plans of Services and Supports (PSS), in conjunction with the LTSS assessment and the Emergency Preparedness Plan, are reviewed and approved by Division of Medicaid (DOM) Program Nurses prior to service implementation. This review allows DOM Program Nurses to ensure appropriateness and adequacy of services and to ensure that services furnished are consistent with the nature and severity of a participant's disability.

The plan of care, known as the PSS, is a person-centered service plan. It is the fundamental tool by which DOM ensures the health and welfare of participants in the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. DOM's process for developing a person-centered plan requires the PSS to be based on a comprehensive LTSS assessment process. PSS development is conducted with the waiver participant's input to include what is important to the individual with regard to preferences for the delivery of services and supports. The Mississippi Department of Rehabilitation Services (MDRS) case manager engages the participant and other interested parties as requested by the participant in developing a PSS that meets the needs of the participant.

MDRS Case Managers are required, at minimum, to make phone contact monthly and to conduct a face-to-face visit with the participant every three months or more frequently, based on the waiver participants needs, level of involvement the participant wishes the case manager to have, and in the event of alleged abuse, neglect or exploitation of waiver participants.

Case management services are provided by MDRS case managers through the 1915(b)(4) waiver which gives DOM the authority to limit case management services to one provider and allow those services to be delivered as is structured in the 1915(c) waiver and interagency agreement.

MDRS case managers initiate and complete the process of assessment and reassessment of the participant and are responsible for ongoing monitoring of services and supports a participant is receiving in the home and community.

Waiver participants choose their personal care attendants, respite providers, environmental accessibility adaptations, specialized medical supplies and equipment providers. If requested, participants are offered the choice of an alternate MDRS case manager.

Development of the PSS includes the development of an emergency preparedness plan for all waiver participants.

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.

After the applicant understands the criteria for the TBI/SCI Waiver, has made an Informed Choice, and meets clinical eligibility, as determined by the LTSS assessment process, the development of the PSS is initiated. The MDRS case manager engages the waiver participant, caregivers and other interested parties, as requested by the waiver participant, in the development of the PSS. The PSS development includes discussing options, desires, individual strengths, personal goals, emergency preparedness needs, specific needs of the participant, and how those needs can be best met. The meeting is held at a time and location of the applicant/participant's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The LTSS assessment and the PSS development process is driven by the applicant/participant with their informed consent and is conducted by the case management team consisting of the MDRS case manager and a registered nurse. The applicant/participant may freely choose to allow anyone (friends, family, caregivers, etc.) to be present and/or contribute to the process of developing the PSS. The initial PSS is developed at the time of the completion of the LTSS assessment with the MDRS case manager and registered nurse.

Persons found clinically eligible for long-term care are provided information about available services and supports. The participant is given a description and explanation of the services provided by the waiver along with any specific qualifications that apply to each service. The applicant is then allowed to make an informed choice between institutional care and community-based services and among waiver services and providers.

The LTSS assessment includes information about the participant's health status, needs, preferences and goals. The development of the PSS utilizes this information and addresses all service options, desires, personal goals, emergency preparedness needs, other specific needs of the participant and how those needs can be met. The PSS also reflects and identifies the existing services and supports, along with who provides them.

MDRS is responsible for implementing the PSS. DOM and MDRS are jointly responsible for monitoring the PSS. MDRS is responsible for coordination of waiver services, State Plan services, services provided through other funding sources and service agencies.

The PSS is developed at the time of the completion of the LTSS assessment, reviewed quarterly and updated annually or at the request of the waiver participant, without the RN component if appropriate. The PSS is signed by all of the individuals who participated in its development. Each applicant/participant and/or their designee is given a copy of the PSS along with other people involved in the plan. Also, each participant is given the phone number to the Rehabilitation office in their district and a contact name of the MDRS case manager if they have any questions or

concerns regarding their services. The PSS may be updated to meet the needs of the individual at the request of the participant or if changes in the individual's circumstances and needs are identified.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The presence and effect of risk factors must be determined during the LTSS assessment and PSS process. The assessment is specifically designed to assess and document risks an individual may possess. The PSS includes identified potential risk to the participant's health and welfare. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. Risk factors include documented instances of abuse/neglect/exploitation, socially inappropriate behavior, communication deficits, nutrition concerns, environmental security and safety issues, falls, disorientation, emotional/mental functioning deficits, and lack of informal support. Participant involvement and choice is used to develop mitigation strategies for all identified risk. The waiver participant and caregivers/supports are included in developing strategies and are encouraged to comply with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the operating agency and Division of Medicaid. Monthly and quarterly actions are required to review/assess participant service needs, with a new PSS developed every twelve months. The case management team must also determine whether a condition or situation is present that requires specific intervention to prevent a decline in health and safety.

Back up plans are developed by the MDRS case manager in partnership with the waiver participant and their family/caregiver upon admission. The PSS must include back up providers chosen by the participant who will provide services when the assigned provider is unable to provide care. The participant and caregiver identify family members and/or friends who are able to provide services/support in the event of an emergency. MDRS also maintains a list of qualified local community providers from which the participant can choose if the participant's choice is not available. During a community disaster or emergency the MDRS case manager notifies the local first response team (i.e. the Mississippi State Department of Health) of persons with special needs who may require special attention. The development of the PSS also includes developing an emergency preparedness plan for all waiver participants.

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.

Participants in the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver are provided information about providers in accordance with their identified needs, desires and goals noted on the PSS. The MDRS case manager informs the participant of trained, competent and willing providers so the participant may request the provider of choice.

Case management services are delivered under the authority of the 1915(b)(4) waiver and an interagency agreement between DOM and MDRS. While MDRS is the provider of record for the services under the waiver, services other than case management and PCA services are contracted to outside authorized vendors/agencies. The waiver participants are given a choice of personal care attendants, SMS/DME companies, contractors for adaptations/modifications and respite care workers. If requested, participants are also offered the choice of an alternate case manager based on geographical availability.

Participants select the personal care attendant and respite provider of their choice. If a participant knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements to become a personal care attendant/respite provider as set forth in the TBI/SCI Waiver, that individual is allowed to provide the direct care for that waiver participant.

If an individual waiver participant does not have a specific direct care worker, they can select from a list of available, eligible, qualified direct care workers to provide their personal care assistance. Personal care services may be provided by members of the participant's family provided they are not legally responsible for the participant. The parent or step-

parent of a minor child and the participant's spouse are not allowed to provide personal care services. The executor of the participant's estate and/or person with durable/medical power of attorney is not allowed to provide personal care services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

After the participant understands the criteria for the TBI/SCI Waiver, has made an informed choice, and meets clinical eligibility, the LTSS assessment along with the PSS are submitted to the DOM electronically which includes all of the service needs, personal goals and preferences of the applicant. A registered nurse at DOM will review the LTSS assessment and the PSS and notify MDRS in a timely manner of the approval/disapproval of services requested.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MDRS is responsible for the implementation of the PSS which includes coordination of waiver services, State Plan services, and services provided through other funding sources and service agencies. DOM and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the responsibility of overseeing that MDRS has appropriate processes in place to implement each participant's PSS.

MDRS monitors the PSS through monthly contacts and quarterly face-to-face reviews. These contacts and reviews enable the MDRS case manager to determine the utilization and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's needs, preferences and goals. The MDRS case manager documents personal contact with the waiver participant on a monthly basis to receive feedback and assess the sufficiency and effectiveness of the PSS. Additionally, the MDRS case manager ensures that services remain in place without issue and identifies any problems or changes that are required. If changes in the participant's circumstances and needs are identified, the PSS may be updated to meet the participant's needs.

DOM monitors the implementation of the PSS through annual on-site audits, record reviews, participant phone calls, and face-to-face participant/ caregiver interviews. DOM reviews records for required documentation and confirms services are delivered during face-to-face interviews with the waiver participants/care-givers within the representative sample.

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:*

As part of DOM's on-going quality assurance monitoring, DOM reviews the PSS and individual LTSS assessment to ensure that all services are provided in accordance with the approved PSS including the emergency preparedness plan, that participants direct the PSS process, and activities provided meet service definitions of the approved waiver. DOM verifies that the MDRS case manager makes contact with the participants at least monthly by phone through record review. DOM also monitors the delivery of the PSS by reviewing the participant's clinical record during on-site provider compliance reviews conducted at least annually, and during technical assistance provider site visits. Face-to-face interviews allow DOM to monitor that the waiver participants are provided with information regarding the Mississippi Vulnerable Persons Act and waiver participant's rights.

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:

1) Number and percent of participants whose plans of care address their needs, including health and safety risk factors, based on the waiver assessment or recertification. Numerator: Number of participants who have plans of care that

address their needs including health and safety risk factors. Denominator: Total number of participants' plans of care.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Long Term Support Service (LTSS)

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

2) **Number and percent of participants whose plans of care address their personal goals. Numerator:** Number of participants who have plans of care that address their personal goals. **Denominator:** Total number of participants' plan of care reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Long Term Support Service (LTSS)

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

Performance Measure:

3) Number and percent of participants’ plans of care where the individual’s signature indicates involvement in the POC development. Numerator: Number of participants’ plans of care with signature indicating involvement in POC development. Denominator: Total number of participants’ POC reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Long Term Support Service (LTSS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

4) **Number and percent of participants' plans of care whose quarterly updates are performed according to the waiver application. Numerator: Number of participants' plans of care whose quarterly updates are performed according to the waiver application. Denominator: Total number of participants' plans of care reviewed.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review (Performance & Financial Review)

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

Performance Measure:

5) Number and percent of participants' plans of care that are updated annually.

Numerator: Number of participants' plans of care that are updated annually.

Denominator: Total number of participants' plans of care submitted annually and/or recertification.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

6) Number and percent of participants' plans of care that are revised when participants' needs change. Numerator: Number of participants' plans of care that are revised when participants' needs change. Denominator: Total number of participants' plans of care reviewed when a change is needed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Review QA/Medicaid Program Nurse

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than representative sample due to representativeness met with PM 5
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

7) Number and percent of participants who received services in accordance with the service plan in the type, scope, amount, duration, and frequency. Numerator: Number of participants who received services in accordance with the service plan in the type, scope, amount, duration, and frequency. Denominator: Total number of participants' plans of care reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews/Home visit (DOM) by DOM QA Staff

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than representative sample due to representativeness met with PM 5
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

8) Number and percent of participants' informed choice forms with signature indicating choice between institutional care and community based care. Numerator: Number of participants' informed choice forms with signature indicating choice between institutional care and community based care. Denominator: Total number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input checked="" type="checkbox"/> Other Specify: As needed	

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):

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

9) **Number and percent of participants with documented freedom of choice of providers. Numerator: Number of participants with documented freedom of choice of providers. Denominator: Total number of participants reviewed.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review (Performance and Financial Review)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- 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.

For Performance Measure (PM) 1, Division of Medicaid (DOM) will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve plan of care within seven business days of receipt of notification of case manager’s correction/clarification

For PM 2, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve plan of care within seven business days of receipt of notification of case manager’s correction/clarification

For PM 3, DOM (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve plan of care within seven business days of receipt of notification of case manager’s correction/clarification

For PM 4, DOM will (a) require MDRS to complete quarterly update; (b) require MDRS to submit a corrective action plan within thirty days; (c) require MDRS to refund payment within thirty days; and (d) provide case manager training annually.

For PM 5, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b)

require MDRS case manager to respond to deficiency and include reason for the lapse of POC within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve plan of care within seven business days of receipt of notification of case manager’s correction/clarification.

For PM 6, DOM will (a) notify MDRS of identified plans of care (POC) with unaddressed needs within seven business days of a review; (b) require MDRS to submit a copy of the updated POC within seven business days (c) require MDRS to submit a corrective action plan within thirty days, if warranted; and (d) provide case manager training annually

For PM 7, DOM will (a) notify MDRS of identified POC where services were provided outside of the type, scope, amount, duration, and frequency (b) require MDRS to identify the cause of deficiency and intervene within seven business days to assure participants receive services according to the type, scope, amount, duration, and frequency of the (c) require MDRS to submit a revised POC within seven business days; (d) require MDRS to submit a corrective action plan and/or an adjust/void within thirty days, if warranted; and (e) provide case manager training annually, if deemed necessary.

For PM 8, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; (d) approve plan of care within seven business days of receipt of notification of case manager’s correction/clarification

For PM 9, DOM will (a) require the case manager to document freedom of choice within seven business days; and (b) provide case manager training annually.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: as needed

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)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver engages the waiver participants to make choices in regards to participant needs, preferences and desires with all aspects of the services provided.

Once a waiver applicant has been determined eligible for waiver services they are allowed to self-direct their personal care services.

MDRS is recognized as the employer of record. The participant is not allowed to exercise budgetary authority (including salary negotiations, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance). However, the participant is allowed to recruit, hire, and terminate employment of personal care attendants with adequate justification with assistance from the counselor. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the participant and the case management team.

The participant also continually evaluates their medical equipment/supply needs and informs their case manager/counselor if their needs change. The participant and the case manager work together to meet these needs as quickly, safely and efficiently as possible. Medical equipment and environmental accessibility adaptation needs are evaluated by MDRS Assistive Technology Division.

Each participant is involved in the formation of their plan of care with their input into the number of hours of PCA services they need per day/week.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

The individual may live with several other persons in a private residence, apartment.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Applicants, participants and other interested parties expressing an interest in the TBI/SCI waiver are provided information on participant-directed personal care services. MDRS and DOM waiver staff are trained to provide this information upon referral, initial application intake, and ongoing while the participant is enrolled in the waiver. Information is provided to each applicant to assure informed decision making is based on an understanding of the participant directed service delivery method

The case manager also outlines the roles and responsibilities for the participant or the legal representative, the case manager, and the providers.

The TBI/SCI waiver affords each participant the opportunity to select the personal care attendant and respite provider of their choice. The benefit of participant-direction allows the participant to choose a personal care attendant that is proven competent. If a participant knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements as set forth in the TBI/SCI Waiver, that individual is allowed to provide the direct care for that waiver participant. If a participant knows a particular individual with whom they are comfortable providing their personal care and that person does not meet the requirements as set forth in the TBI/SCI

Waiver, that individual is trained and once qualified is allowed to provide the direct care for that waiver recipient. If a waiver participant does not have a specific personal care attendant, they can select from a list of available, eligible, personal care attendants to provide their care. It is explained to the participant by the case manager/counselor that personal care attendant services will not begin prior to the personal care attendant being certified as competent according to the TBI/SCI waiver.

If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six consecutive months, the participant will be reevaluated for the need for waiver services and to determine if the waiver can meet the needs of this participant.

Waiver participants are also allowed to choose State approved vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care Attendant (PCA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- Yes. Financial Management Services are furnished through a third party entity. (*Complete item E-1-i*).

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Once a waiver applicant has been determined eligible for waiver services, if they require a personal care attendant or respite provider, the case manager provides information to each applicant on the participant directed service delivery method.

MDRS is recognized as the employer of record. The participant is not allowed to exercise budgetary authority (including salary negotiations, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance). However, the participant is allowed to recruit, hire, and terminate employment of personal care attendants with adequate justification with assistance from the counselor. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the participant and the case management team.

The case manager confers with the participant to determine who they would desire to provide their personal care services. After the participant has determined who they would desire, the Rehab counselor/nurse goes through the specified steps to determine if the requested personal care attendant meets the minimum requirements.

Once it has been determined that the person meets the requirements, complete training is done with this person, and then as the personal care begins with the participant, ongoing evaluation of the care provided and the satisfaction of the participant is done and alterations, if needed, are made to the plan of care.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage	
Personal Care Attendant (PCA)	<input type="checkbox"/>
Transition Assistance Services	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Case Management	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>

Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage	
Specialized Medical Equipment & Supplies	<input type="checkbox"/>
<input type="checkbox"/> Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.	

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction.

Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant decides that the TBI/SCI Waiver is not the waiver that they can benefit the most from at a certain time, they may choose to transfer to another Home and Community based waiver that they qualify for clinically. There is coordination with program areas in DOM, MDRS and other providers to which the participant will be transitioning.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction.

Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of Participant-Directed personal care services can occur if the following circumstances arise including, but not limited to:

- * The participant's health or welfare is immediately jeopardized
- *Fraudulent Activity
- *Non-compliance related to the plan of care

The case manager/counselor will work to provide continuity of services and ensure the participants health and welfare while coordinating transition to an alternate program.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1	2400		
Year 2	2700		
Year 3	3000		
Year 4	3300		
Year 5	3600		

Appendix E: Participant Direction of Services

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

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Mississippi Department of Rehabilitation Services (MDRS)

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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.

Fair Hearing procedures are based on the DOM Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process

A Case Manager sends a Notice of Action (NOA) to the waiver participant by certified mail (Signature return requested).

Contents of Notice of Action include:

- a. Description of the action the provider has taken or intends to take
- b. Explanation for the action
- c. Notification that the consumer has the right to file an appeal
- d. Procedures for filing an appeal
- e. Notification of consumers right to request a Fair Hearing, and
- f. Notice that the consumer has the right to have benefits continued pending the resolution of the appeal
- g. The specific regulations that support, or the change in Federal or State law that requires, the action

The participant or his representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage participants to request a local hearing first. The request for a state or local hearing must be made in writing by the participant or his legal representative.

The participant may be represented by anyone he designates. If the participant elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the participant has designated him as the participants representative and the participant has not provided written verification to this effect, written designation from the participant regarding the designation must be obtained.

The participant has 30 days from the date the appropriate notice is mailed to request either a local or state hearing. This 30-day filing period may be extended if the participant can show good cause for not filing within 30 days.

A hearing will not be scheduled until a written request is received by either the MDRS or the State DOM office. If the written request is not received within the 30 days of the NOA, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as specified in the Mississippi Medicaid Administrative Code.

At the local hearing level, MDRS will issue a determination within 30 days of the date of the initial request for a hearing. Although the waiver allows 30 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The participant has the right to appeal a local hearing decision by requesting a State hearing; However, the State hearing request must be made within 30 days of the mailing date of the local hearing decision.

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipients case record. The right to have legal representation at the hearing and to bring witnesses.
2. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
3. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the participant or service providers. Upon receipt of the request for a state hearing, the Division of Medicaid, Bureau of Administrative Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The types of disputes that can be addressed by an informal dispute resolution process are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants are encouraged to report disputes to their case manager. If a resolution is not reached by the case manager, the issue is reported to the case manager's supervisor. If a resolution is not reached at this level, the issue is reported to the Division of Medicaid. The Division of Medicaid along with the MDRS will collaborate to achieve a resolution.

In the event the dispute is with the case manager, MDRS will analyze each case on an individual basis to determine the appropriate plan of action. If a new case manager is assigned, the case manager's supervisor evaluates the participant's satisfaction with the new case manager and notifies the Division of Medicaid of the final resolution.

The Division of Medicaid and MDRS are responsible for operating the dispute mechanism. The Division of Medicaid has the final authority over any dispute. The participant is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.

The right to a Fair Hearing is preserved by allowing the participant to request a formal hearing at any time during the informal dispute resolution process unless a formal notice of action has been presented to the participant. Once the notice of action is given to a participant, the participant must follow DOM's Fair Hearing policy.

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 Division of Medicaid (DOM) and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints /grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Waiver participants must first address any complaint/grievance by reporting it to their case manager. The case manager/counselor begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case manager/counselor reports the complaint/grievance to the supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to the Division of Medicaid. The Division of Medicaid along with MDRS will collaborate to achieve a resolution within seven days. In the event the complaint and/or grievance is with the case manager/counselor then MDRS and DOM work with the client. The participant is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievance and hearing. The participant is given their Appeal Rights which addresses disputes, complaints/grievances and hearings.

Local Hearing- must be requested in writing by the participant or their representative to MDRS.

State Hearing- must be requested in writing to the Division of Medicaid

The client and/or representative has thirty (30) days from the date of Notice of Action to request either a state or local hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents are identified as follows:

Abuse (A) -- willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

Neglect (N) -- can include but is not limited to a single incident of the inability of a vulnerable person living alone to

provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.

Exploitation (E) -- Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

The Department of Human Services (DHS), Division of Aging and Adult Services is the agency responsible for investigating allegations of A, N, and E. There is a Memorandum of Understanding (MOU) established between DOM and DHS which allows for a free flow of information between the two agencies to ensure the health and welfare of waiver participants.

DOM provides DHS with a list of participant on a monthly basis. DHS compares this information and alerts DOM of any critical incidents not previously reported.

If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. All reports of abuse, neglect or exploitation are to be reported by phone and written report immediately by the appropriate rehab case manager/counselor to their supervisor at the Department of Rehabilitation Services. The potential A, N, or E is also reported to the Department of Human Services and Division of Medicaid/Long Term care. DOM and MDRS case managers will follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

- 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.

When participants are initially assessed for the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, they are provided the case manager's name and the phone number. Waiver participants are educated on the definitions of A, N and E and how and when to report such allegations. Waiver participants are also provided the telephone number to the DHS 24 hour hotline.

Case managers are trained on identifying and reporting any allegations of A, N or E. The case manager conducts monthly phone contact with each participant and quarterly home visits are conducted to ensure the health and welfare of the participants.

- 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.

All reports of alleged critical incidents are reviewed by MDRS. Potential A, N, or E cases are then reported to the Division of Medicaid/Long Term Care division and the Department of Human Services. Each case will be analyzed on an individual basis to determine the appropriate plan of action.

By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM work with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302.

Mississippi Vulnerable Persons Act, Section 43-47-9 (1). "Upon receipt of a report pursuant to Section 43-47-7 that a vulnerable person is in need of protective services, the department (The Department of Human Services) shall initiate an investigation and/or evaluation within forty-eight (48) hours if immediate attention is needed, or within seventy-two (72) hours if the vulnerable person is not in immediate danger, to determine whether the vulnerable person is in need of protective services and what services are needed."

Communication continues between MDRS, Division of Medicaid, Department of Human Services, and Attorney General's office if necessary, etc., until resolution occurs.

Additionally, DHS provides information on critical incidences involving alleged A, N and E of waiver participants on a

monthly basis. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents.

- 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.

MDRS, DOM, DHS and the Criminal Investigative unit of the Attorney General's office all become involved in these cases as needed.

As these events occur, immediate action takes place and investigation begins and all of the above entities listed keep written records of suspected events of abuse, neglect, and exploitation.

DOM receives a monthly report from the Department of Human Services of critical incidences involving alleged abuse, neglect and/or exploitation of waiver participants. DOM reviews the collected information to reveal any unknown critical incidents. Each case will be analyzed on an individual basis to determine the appropriate plan of action.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

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

MDRS Counselors make scheduled visits to the participant's home quarterly to allow the counselor to observe actual activities in the participant's home and to ensure there are no unauthorized use of restraints. In addition, unscheduled visits are made randomly as needed.

Personal Care Attendants (PCA) are provided information on the unauthorized use of restraints. PCA's are instructed to notify the MDRS counselor of any suspected use of restraints. If a concern were present, the MDRS counselor would make an unscheduled visit and follow up as needed.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

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

MDRS Counselors make scheduled visits to the participant's home quarterly to allow the counselor to observe actual activities in the participant's home and to ensure there are no unauthorized use of restrictive interventions. In addition, unscheduled visits are made randomly as needed.

Personal Care Attendants (PCA) are provided information on the unauthorized use of restrictive interventions. PCA's are instructed to notify the MDRS counselor of any suspected use of restrictive interventions. If a concern were present, the MDRS counselor would make an unscheduled visit and follow up as needed.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

MDRS Counselors make scheduled visits to the participant's home quarterly to allow the counselor to observe actual activities in the participant's home and to ensure there are no unauthorized use of seclusions. In addition, unscheduled visits are made randomly as needed.

Personal Care Attendants (PCA) are provided information on the unauthorized use of seclusions. PCA's are instructed to notify the MDRS counselor of any suspected use of seclusions. If a concern were present, the MDRS counselor would make an unscheduled visit and follow up as needed.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
 Yes. This Appendix applies (complete the remaining items)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- 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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

- i. Provider Administration of Medications.** Select one:

- Not applicable.** (do not complete the remaining items)

- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.***(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

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

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

- 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.

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

1) # and % of participants with identified instances of alleged A,N,E, and/or unexplained/suspicious death that were addressed within required timeframe as stated in the approved waiver. Numerator: # of participants with identified instances of alleged A, N, E, and/or unexplained/suspicious death that were addressed timely. Denominator: Total # of participants with identified instances.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid from Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

2) Number and percent of Personal Care Attendants who received training in the areas of the Mississippi Vulnerable Persons Act. Numerator: Number of Attendants who received training in the area of the Mississippi Vulnerable Persons Act. Denominator: Total number of PCAs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid from Operating Agency

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

3) Number and percent of participants who have been educated on how to report abuse, neglect, and exploitation. Numerator: Number of participants who have been educated on how to report abuse, neglect, and exploitation. Denominator: Total number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS System/Emergency Preparedness Plan (EPP)

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Home visit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than representative sample due to representativeness met with 1st Level of Care performance measure.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

5) Number and percent of complaints that were addressed within required timeframes as specified in the waiver application. Numerator: Number of complaints that were addressed within required timeframes as specified in the waiver application. Denominator: Total number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to State Medicaid from Operating Agency

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

Performance Measure:

6) # & % of participant’s critical incidents that were reported, initiated, reviewed and completed within required timeframes as stated in the approved waiver.
Numerator:# of participant’s critical incidents that were reported, initiated, reviewed and completed within required timeframes as stated in the approved waiver. Denominator:Total # of participants with reported critical incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDRS – Email Notification to DOM within 24 hours of knowledge of the incident and monthly activity 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

7) Number and percent of unauthorized uses of restrictive interventions (critical incident) that were appropriately reported. Numerator: Number of participants with unauthorized use of restrictive intervention that were appropriately reported. Denominator: Total number of participants with unauthorized use of restricted intervention.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Contact Note and Quarterly Visit note; and DOM home visit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
--	--

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

8) Number and percent of waiver participants who were certified as medically stable in accordance with state waiver policies. Numerator: Number of waiver participants who were certified as medically stable in accordance with state waiver policies. Denominator: Total number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

- d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

Performance Measures

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

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

- 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.

For Performance Measure PM 1, DOM will (a) require MDRS to provide the monthly activity report no later than the eighth business day of the month; and b) require MDRS to address instances of abuse, neglect, exploitation, and unexplained/suspicious deaths within the required timeframe as specified in the approved waiver.

For PM 2, DOM will (a) require MDRS to remove the Personal Care Attendant from providing care to waiver participants immediately; (b) ask MDRS to apply applicable measures to ensure the provider is trained prior to resuming care; (c) expect MDRS to remove the PCA if warranted in accordance with their policies and procedures.

For PM 3, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve case within seven business days of receipt of complete Emergency Preparedness Plan (EPP).

For PM 4, DOM will (a) require case manager to provide participant with information as part of the corrective action plan within seven business days; and (b) provide training annually.

For PM 5, DOM will (a) require unresolved complaints to be resolved within seven business days; and (b) address MDRS administrative staff within seven business days.

For PM 6, DOM will a) require MDRS to report critical incidents via email notification within 24 hours of the incident; b) require MDRS to submit a Monthly Activity Report that will include all critical incidents; and c) will require MDRS Counselors to make unscheduled monthly home visits to monitor for the unauthorized use of restrictive interventions with substantiated cases of critical incidents.

For PM 7, DOM will a) require MDRS to report unauthorized use of restrictive interventions (critical incidents) via email notification within 24 hours of knowledge of the incident; b) require MDRS to submit a Monthly Activity Report that will include all critical incidents; c) will require MDRS Counselors to make unscheduled monthly home visits to monitor for the unauthorized use of restrictive interventions with substantiated cases of critical incidents.

For PM 8, DOM will (a) immediately notify case manager of deficiency via unable to process notice; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve case within seven business days of receipt of medical stability form.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory

requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 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.

The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed to develop Customer Service Requests (CSRs), review progress, and test system changes. The meetings involve participation from DOMs Bureau of Systems Management, LTC staff and others as may be deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including QA nurses and MDRS staff are held routinely for the purpose of addressing needs and resolving issues that may involve systems changes.

When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to beneficiaries or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff and the systems staff to address issues that require system changes. Additionally the State has monthly internal Advisory meetings to identify, correct, and implement system changes to improve the States ability to adhere to state and federal regulations, policies and procedures.

System changes have been implemented to allow for electronically capturing data and identifying trends related to the performance measures. Findings are discussed during collaborative Quality Improvement Strategy meetings with MDRS and DOM.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Other Specify: ongoing as needed

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Division of Medicaid (DOM) and Mississippi Rehabilitation Services (MDRS) monitor the Quality Improvement Strategy on a monthly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of the subassurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.

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

Evaluation of the Quality Improvement Strategy (QIS) is a continuous and ongoing endeavor. It is reviewed annually to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible. The operating agency and DOM will meet quarterly to review the overall waiver operation including the QIS strategy for waiver improvement.

Appendix 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).

MDRS case managers are responsible for reviewing time sheets submitted by each personal care attendant. After review and approval, these are submitted to the MDRS state office staff for further review and verification of accuracy. Once verified, MDRS submits claims for waiver payment via the MMIS Medicaid system.

DOM staff also monitor other waiver services for fiscal accountability through post payment audits of paid claims. Audits are conducted as part of the overall monitoring of the waiver during the compliance review. In instances where claims have been paid erroneously, the provider is notified of any necessary recoupment. The LTC staff also closely review the CMS 372 report for accuracy prior to submittal.

Changes in billing rates, or updates, are discussed in staff meetings and at state-wide in-services. MDRS holds regular training sessions at their facilities to teach staff correct procedures. DOM conducts ongoing training and technical

assistance for waiver providers to assure understanding of and adherence with DOM Administrative Codes and reimbursement methodology specified in the waiver.

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. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System (MMIS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

2) Number and percent of claims for which payment was made for the service as specified in the waiver
Numerator: Number of claims paid that included a correct service as specified in the waiver
Denominator: Total number of claims paid

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System (MMIS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

3) Number and percent of provider payment rates that are consistent with rate methodology in the approved waiver application or subsequent amendment.
Numerator: Number and percent of provider payment rates that are consistent with rate methodology in approved waiver application or subsequent amendment.
Denominator: Total number of payments.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information Systems (MMIS)

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: ongoing as needed

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

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

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

- 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.

For Performance Measure (PM) 1 & 2: 1. DOM will recoup money paid erroneously to providers within 30 days of notification; 2. Submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; and 3. Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.

PM 3: DOM will a) annually review payment rates in MMIS; b) submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS; and c) reimburse money to providers within 30 days identification.

- ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid #ccc; height: 20px; width: 100%;"></div>

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).

Rate Determination Methods: DOM contracted with an actuary firm, Milliman, to thoroughly evaluate the service rates.

To set the context for developing service rates, careful consideration was given for service descriptions and provider handbook information for each waiver service. Educational requirements, expectations, and billable productivity levels were also considered.

Current waiver rates were compared to the same non-waiver Medicaid service rates or a ground up analysis was conducted.

For the Personal Care and Case Management services, initial rates were built 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 hours practitioners are at work
- > Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, and Division of Medicaid and Milliman experience.

Once initial service rates were calculated, a comparison was made of them to the current service rates along with consideration for other aspects of the service provision environment. 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. Once Milliman completed their rate analysis, DOM solicited public comments on the rates through stakeholder meetings and notification to the tribal government.

Based on the analysis by Milliman along with other consideration, the Division of Medicaid set the first year personal care attendant rate at \$4.00/15 minute increment (\$16.00 per hour). The rate determination for participant directed personal care service did not differ from the methodology that was utilized when the service is provider managed.

Transitional Assistance rate of \$800.00 per lifetime usage was based upon past utilization practices across all waivers. The specialized medical supplies/equipment and Environmental Accessibility Adaptations rates were determined based on previous utilization patterns and current costs.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services flow directly from providers to the State's claims payment system (MMIS).

Appendix I: Financial Accountability

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

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

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system stores claims data and information that can be produced upon request. The MMIS system has audit functions to deny payment for services when an applicant is not Medicaid eligible on the date of service. The MMIS system also has an audit function to deny any participant who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS system requires a participant to be an approved, eligible Medicaid waiver participant, documented in the MMIS system, in order for the claim to pay. The lock-in function is located in the MMIS system under the participant file and is entered by Medicaid HCBS staff or the Medicaid Fiscal Agent.

The State conducts post utilization reviews to ensure the services provided were on the participant's approved service plan (plan of care).

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The Mississippi Department of Rehabilitation Services (MDRS) is a State agency. It provides case management, specialized medical equipment and supplies, environmental accessibility adaptations, personal care attendant services, respite services and transition assistance services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System.*Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.*Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

a) The Mississippi Department of Rehabilitation Services (MDRS); and

b) MDRS pays the state match in advance to Division of Medicaid (DOM) via an IGT based on the prior quarter's claims payments.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**
Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

 Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

- a. Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	41233.52	9736.00	50969.52	50050.00	21528.00	71578.00	20608.48
2	41953.00	10222.00	52175.00	52553.00	22605.00	75158.00	22983.00
3	42713.00	10734.00	53447.00	55181.00	23735.00	78916.00	25469.00
4	43488.23	11271.00	54759.23	57940.00	24922.00	82862.00	28102.77
5	44248.19	11835.00	56083.19	60837.00	26168.00	87005.00	30921.81

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)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	2400		2400
Year 2	2700		2700
Year 3	3000		3000
Year 4	3300		3300
Year 5	3600		3600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Based on the CMS 372 Report data for the most recent two (2) years (2011 and 2012) the average length of stay for this waiver is 338 days. Based on this information, it is estimated that average length of stay for waiver participants during the course of the waiver renewal period is approximately eleven months.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for Factor D are based on CMS 372 reports and utilization data from prior years of the TBI/SCI waiver.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are based on CMS 372 reports.

- 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 for Factor G are based on actual case histories of individuals institutionalized with these specific injuries/diagnoses and similar conditions at NF level of care.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G" are based on actual case histories of individuals institutionalized with these specific injuries/diagnoses and similar conditions at NF level of care.

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	
Case Management	
Personal Care Attendant (PCA)	
Respite	
Environmental Accessibility Adaptations	
Specialized Medical Equipment & Supplies	
Transition Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							3850440.00
Case Management	<input type="checkbox"/>	month	2400	11.00	145.85	3850440.00	
Personal Care Attendant (PCA) Total:							84096000.00
Personal Care Attendant (PCA)	<input type="checkbox"/>	hour	2400	2190.00	16.00	84096000.00	
Respite Total:							854006.40
Institutional Respite	<input type="checkbox"/>	hour	2	720.00	9.96	14342.40	
Nursing Respite	<input type="checkbox"/>	hour	50	288.00	26.31	378864.00	
Companion Respite	<input type="checkbox"/>	hour	100	288.00	16.00	460800.00	
GRAND TOTAL:							98960446.40
Total: Services included in capitation:							
Total: Services not included in capitation:							98960446.40
Total Estimated Unduplicated Participants:							2400
Factor D (Divide total by number of participants):							41233.52
Services included in capitation:							
Services not included in capitation:							41233.52
Average Length of Stay on the Waiver:							11

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:							4000000.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	modification	200	2.00	10000.00	4000000.00	
Specialized Medical Equipment & Supplies Total:							6000000.00
Specialized Medical Equipment & Supplies	<input type="checkbox"/>	item	1000	2.00	3000.00	6000000.00	
Transition Assistance Services Total:							160000.00
Transition Assistance Services	<input type="checkbox"/>	1- time	200	1.00	800.00	160000.00	
GRAND TOTAL:							98960446.40
Total: Services included in capitation:							98960446.40
Total: Services not included in capitation:							2400
Total Estimated Unduplicated Participants:							41233.52
Factor D (Divide total by number of participants):							41233.52
Services included in capitation:							41233.52
Services not included in capitation:							
Average Length of Stay on the Waiver:							11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							4418172.00
Case Management	<input type="checkbox"/>	month	2700	11.00	148.76	4418172.00	
Personal Care Attendant (PCA) Total:							96500160.00
Personal Care Attendant (PCA)	<input type="checkbox"/>	hour	2700	2190.00	16.32	96500160.00	
Respite Total:							871128.00
GRAND TOTAL:							113272360.00
Total: Services included in capitation:							113272360.00
Total: Services not included in capitation:							2700
Total Estimated Unduplicated Participants:							41953.00
Factor D (Divide total by number of participants):							41953.00
Services included in capitation:							41953.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							11

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite	<input type="checkbox"/>	hour	2	720.00	10.15	14616.00	
Nursing Respite	<input type="checkbox"/>	hour	50	288.00	26.84	386496.00	
Companion Respite	<input type="checkbox"/>	hour	100	288.00	16.32	470016.00	
Environmental Accessibility Adaptations Total:							4590900.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	modification	225	2.00	10202.00	4590900.00	
Specialized Medical Equipment & Supplies Total:							6732000.00
Specialized Medical Equipment & Supplies	<input type="checkbox"/>	item	1100	2.00	3060.00	6732000.00	
Transition Assistance Services Total:							160000.00
Transition Assistance Services	<input type="checkbox"/>	1-time	200	1.00	800.00	160000.00	
GRAND TOTAL:							113272360.00
Total: Services included in capitation:							
Total: Services not included in capitation:							113272360.00
Total Estimated Unduplicated Participants:							2700
Factor D (Divide total by number of participants):							41953.00
Services included in capitation:							
Services not included in capitation:							41953.00
Average Length of Stay on the Waiver:							11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							5007420.00
Case Management	<input type="checkbox"/>	month				5007420.00	
GRAND TOTAL:							128138872.00
Total: Services included in capitation:							
Total: Services not included in capitation:							128138872.00
Total Estimated Unduplicated Participants:							3000
Factor D (Divide total by number of participants):							42713.00
Services included in capitation:							
Services not included in capitation:							42713.00
Average Length of Stay on the Waiver:							11

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			3000	11.00	151.74		
Personal Care Attendant (PCA) Total:							109390500.00
Personal Care Attendant (PCA)	<input type="checkbox"/>	hour	3000	2190.00	16.65	109390500.00	
Respite Total:							888552.00
Institutional Respite	<input type="checkbox"/>	hour	2	720.00	10.35	14904.00	
Nursing Respite	<input type="checkbox"/>	hour	50	288.00	27.37	394128.00	
Companion Respite	<input type="checkbox"/>	hour	100	288.00	16.65	479520.00	
Environmental Accessibility Adaptations Total:							5202000.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	modification	250	2.00	10404.00	5202000.00	
Specialized Medical Equipment & Supplies Total:							7490400.00
Specialized Medical Equipment & Supplies	<input type="checkbox"/>	item	1200	2.00	3121.00	7490400.00	
Transition Assistance Services Total:							160000.00
Transition Assistance Services	<input type="checkbox"/>	1-time	200	1.00	800.00	160000.00	
GRAND TOTAL:							128138872.00
Total: Services included in capitation:							128138872.00
Total: Services not included in capitation:							3000
Total Estimated Unduplicated Participants:							3000
Factor D (Divide total by number of participants):							42713.00
Services included in capitation:							42713.00
Services not included in capitation:							42713.00
Average Length of Stay on the Waiver:							11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							5618151.00
Case Management	<input type="checkbox"/>	month	3300	11.00	154.77	5618151.00	
Personal Care Attendant (PCA) Total:							122714460.00
Personal Care Attendant (PCA)	<input type="checkbox"/>	hour	3300	2190.00	16.98	122714460.00	
Respite Total:							906134.40
Institutional Respite	<input type="checkbox"/>	hour	2	720.00	10.56	15206.40	
Nursing Respite	<input type="checkbox"/>	hour	50	288.00	27.91	401904.00	
Companion Respite	<input type="checkbox"/>	hour	100	288.00	16.98	489024.00	
Environmental Accessibility Adaptations Total:							5836600.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	modification	275	2.00	10612.00	5836600.00	
Specialized Medical Equipment & Supplies Total:							8275800.00
Specialized Medical Equipment & Supplies	<input type="checkbox"/>	item	1300	2.00	3183.00	8275800.00	
Transition Assistance Services Total:							160000.00
Transition Assistance Services	<input type="checkbox"/>	1-time	200	1.00	800.00	160000.00	
GRAND TOTAL:							14351145.40
Total: Services included in capitation:							
Total: Services not included in capitation:							14351145.40
Total Estimated Unduplicated Participants:							3300
Factor D (Divide total by number of participants):							43488.23
Services included in capitation:							
Services not included in capitation:							43488.23
Average Length of Stay on the Waiver:							11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							6251652.00
Case Management	<input type="checkbox"/>	month	3600	11.00	157.87	6251652.00	
Personal Care Attendant (PCA) Total:							136550880.00
Personal Care Attendant (PCA)	<input type="checkbox"/>	hour	3600	2190.00	17.32	136550880.00	
Respite Total:							924148.80
Institutional Respite	<input type="checkbox"/>	hour	2	720.00	10.77	15508.80	
Nursing Respite	<input type="checkbox"/>	hour	50	288.00	28.46	409824.00	
Companion Respite	<input type="checkbox"/>	hour	100	288.00	17.32	498816.00	
Environmental Accessibility Adaptations Total:							6494400.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	modification	300	2.00	10824.00	6494400.00	
Specialized Medical Equipment & Supplies Total:							8912400.00
Specialized Medical Equipment & Supplies	<input type="checkbox"/>	item	1400	2.00	3183.00	8912400.00	
Transition Assistance Services Total:							160000.00
Transition Assistance Services	<input type="checkbox"/>	1-time	200	1.00	800.00	160000.00	
GRAND TOTAL:							159293480.80
Total: Services included in capitation:							
Total: Services not included in capitation:							159293480.80
Total Estimated Unduplicated Participants:							3600
Factor D (Divide total by number of participants):							44248.19
Services included in capitation:							
Services not included in capitation:							44248.19
Average Length of Stay on the Waiver:							11