1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Habilitation Services – Day Habilitation Services, Prevocational Services and Supported Employment Services

2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
☑	The State plan HCBS benefit is operated by *(name of agency)*		
	Mississippi Department of Mental Health (DMH)		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

3. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the

entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☐	☐
6 Qualified provider enrollment	☑	☑	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

2, 3, 4, 5, 6, 9, 10

(By checking the following boxes the State assures that):

4. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

DMH's Diagnostic and Evaluation (D&E) Teams perform the evaluations, reevaluations and assessments for medical eligibility. DMH provides Targeted Case Management (TCM) Services to coordinate and facilitate Person-Centered Planning to develop individualized plans of care for individuals receiving HCBS.

1915(i) State Plan services will only be provided by DMH or DMH operated facilities if there are no other qualified providers in a geographic location. Although DMH facilities may provide services in specific circumstances neither the D&E team nor TCM coordinator will provide any 1915(i) State Plan services.

5. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

6. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	11/01/2013	06/30/2014	2,000
Year 2	07/01/2014	06/30/2015	2,000
Year 3	07/01/2015	06/30/2016	2,000
Year 4	07/01/2016	06/30/2017	2,000
Year 5	07/01/2017	06/30/2018	2,000

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. ☐ In addition to providing State plan HCBS to individuals described in item 1 above, the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, Pages XXXX and XXXX of the state plan.

3. **Medically Needy** (Select one):

☑ The State does not provide State plan HCBS to the medically needy.
○ The State provides State plan HCBS to the medically needy. (Select one):
○The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, medically needy individuals only receive 1915(i) services ○ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
☑	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	DMH

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The D&E Team conducts the evaluation/reevaluations for eligibility. Each D&E Team consists of at least a psychologist and social worker. Additional team members may be utilized, dependent upon the needs of the individual being evaluated such as physical therapists, dieticians, etc. All members of the D&E Teams are licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluation/reevaluating needs-based eligibility for State plan HCBS involves a review of current pertinent information in the individual's record, such as medical, social and psychological evaluations, and standardized instruments to measure intellectual functioning, the individual service plan, progress notes, case management notes and other assessment information. The review verifies the determination that the individual meets the needs-based eligibility criteria including the existence of significant functional limitations in three or more areas of major life activity including: receptive/expressive language, learning, self-care, mobility, self-direction, capacity for independent living and economic self-sufficiency.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibilityreevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Based on evaluation/reevaluation, individuals who participate in State plan HCBS must have a need for assistance demonstrated by a need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.) to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands.

The individual must also have a likelihood of retaining new skills acquired through habilitation over time.

Individual must have a condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require planning and coordination of services to assist the individual in achieving maximum potential that continues or can be expected to continue, indefinitely.

In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis:

• Is unemployed or employed in a sheltered setting, or has markedly limited skills and a poor or non-existent work history.
• Shows severe inability to establish or maintain a beneficial, meaningful personal social support system.
• Requires help in basic Instrumental Activities of Daily Living (IADL) such as money management, housekeeping, meal planning and preparation, shopping for food, clothing and other essential items, communicating by phone or other media, and traveling around and participating in the community.
• Exhibits inappropriate social behavior that results in the need for intervention.
• Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Based on evaluation/reevaluation, individuals who participate in State plan	For an individual to qualify for the Elderly and Disabled, Independent Living,	For an individual to currently be eligible for services in an ICF/IID, the	Mississippi does not have any hospital waivers.

HCBS must have a need for assistance demonstrated by a need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.) to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands. The individual must also have a likelihood of retaining new skills acquired through habilitation over time. Individual must have a condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require planning and coordination of services to assist the individual in achieving maximum potential that continues or can be expected to continue, indefinitely. In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria	Traumatic Brain/Spinal Cord and Assisted Living waivers, the individual must be assessed and score 50 or less on a standardized preadmission screening tool designed and tested to determine whether the individual meets nursing home level of care. Additionally, the physician must certify level of care. For participation in the Traumatic Brain or the Independent Living waivers, the individual must have either a specific condition or diagnose which requires specialized services to meet the unique needs of the waiver participant. The Traumatic Brain Injury waiver requires the individual to have a diagnosed traumatic brain/spinal cord injury to qualify for services. The Independent Living waiver requires the individual to have either a neurological	individual must have an intellectual disability or developmental disability with associated deficits in adaptive functioning and have a need for active treatment. In order to receive a diagnosis of mental retardation (an intellectual disability), an individual must have an IQ score of approximately70 or below and confirmation of deficits in adaptive behavior. Both must exist and originate prior to the age of 18. A developmental disability includes multiple types of disabilities that are brought about by either a physical impairment, mental impairment, or both before the age of 22 that is likely to continue for an indefinite period of time and results in limitations in functioning in 3 or more areas: self-care, receptive and expressive language, learning, mobility, self-direction,	

on a continuing or intermittent basis: • Is unemployed or employed in a sheltered setting, or has markedly limited skills and a poor or non-existent work history. • Shows severe inability to establish or maintain a beneficial, meaningful personal social support system. • Requires help in basic Instrumental Activities of Daily Living (IADL) such as money management, housekeeping, meal planning and preparation, shopping for food, clothing and other essential items, communicating by phone or other media, and traveling around and participating in the community. • Exhibits inappropriate social behavior	or orthopedic condition with impairment resulting in the need for nursing home level of care. The Assisted Living waiver requires an individual to have a diagnosed traumatic brain injury with complicating behavioral issues resulting in the need for specialized care to qualify for the traumatic brain injury residential services offered through this waiver.	capacity for independent living, and economic self-sufficiency.	

that results in the need for intervention. • Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

The state is targeting Individuals with Intellectual Disabilities (IID). Commencing November 1, 2013, in addition to the needs identified above, the individual must also have a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.

(By checking the following boxes the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The state attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets home and community-based setting requirements as defined by the state and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the home and community-based setting requirements that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity;
- Each individual has privacy in their sleeping or living unit:
- Units have lockable entrance doors, with appropriate staff having keys to doors;
- Individuals share units only at the individual's choice; and
- Individuals have the freedom to furnish and decorate their sleeping or living units;
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
- Individuals are able to have visitors of their choosing at any time; and
- The setting is physically accessible to the individual.
- The setting is integrated in, and facilitates the individual's full access to, the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities;
- The setting is selected by the individual among all available alternatives and is identified in the person-centered service plan;
- Personal rights of privacy, dignity and respect and freedom from coercion and restraint are protected;
- Initiative, independence in making life choices re daily activities, physical environment and with whom to interact are optimized (not regimented);
- Individual choice regarding services and supports and who provides them is facilitated; and
- The home and community-based settings are not a nursing facility, institution for mental disease, ICF/IID, hospital or any other location that have the qualities of an institutional setting.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent who is independent and qualified;
- A person-centered process and guided by best practice and research on effective strategies that result in improved health and quality of life outcomes;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan;

- An examination of the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the person-centered service plan, a caregiver assessment;
- If the state offers individuals the option to self-direct state plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☑ Based on the independent assessment, the individualized person-centered service plan:

- Is developed with a person-centered process jointly with the individual and if applicable, the individual's authorized representative, and others chosen by the individual. The person-centered planning process:
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Is timely and occurs at times and locations of convenience to the individual.
- Relfects cultural considerations of the individual;
- Includes strategies for solving conflict or disagreement with the process, including clear conflict of interest guidelines for all planning participants;
- Offers choices to the individual regarding the services and supports they receive and from whom;
- Includes a method for the individual to request updates to the plan, as needed; and
- Records the alternative home and community-based settings that were considered by the individual.
- Reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
- Reflect that the setting in which the individual resides is chosen by the individual.
- Reflects the individual's strengths and preferences.
- Reflects clinical and support needs as identified through an assessment of functional need.
- Includes individually identified goals and desired outcomes.
- Reflects the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
- Identifies the individual and/or entity responsible for monitoring the plan.
- Is finalized and agreed to, with the informed consent of the individual, in writing by the individual and signed by all individuals and providers responsible for its implementation.
- Is distributed to the individual and other people involved in the plan.
- Includes those services, the purchase or control of which the individual elects to self-direct.
- Prevents the provision of unnecessary or inappropriate services and supports.
- Is reviewed at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Each D&E Team consists of at least the following: psychologist, and social worker.

Additional team members, such as physical therapists, dieticians, etc. may be utilized depending upon the needs of the individual being evaluated. All members of the D&E Teams are licensed and/or certified through the appropriate State licensing/certification body for their respective discipline.

4. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Case Managers responsible for the development of the plan of care must have a minimum of a Bachelor's degree in a mental health/IDD related field and be credentialed by the MS Department of Mental Health or be a Qualified Mental Retardation Professional (QMRP)/Qualified Developmental Disabilities Professional (QDDP). Additionally, Case Managers must complete training in Person-Centered planning and demonstrate competencies associated with that process. The individualized plan of care must be reviewed at least every 12 months and when there is a significant change in the individual's circumstances that may affect his/her level of functioning and needs.

5. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The active involvement of individuals and their families and/or legal guardians are essential to the development and implementation of a plan of care that is person-centered and addresses the outcomes desired by the individuals. Individuals participating in HCBS and/or their family members and legal representatives will have the authority to determine who is included in their planning process. Case managers will work with the individuals and their families and/or legal guardians to educate them about the person-centered planning process itself and encourage them to identify and determine who is included in the process. Case Managers will encourage the inclusion of formal and informal providers of support to the individuals in the development of a person-centered plan.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Case Managers will assist the individuals in selecting qualified providers of the 1915(i) services. A qualified provider must be a Medicaid provider and be certified by DMH to provide the services. During the development of the plan of care, case managers will educate the individual about the qualified providers certified to provide the services in the area the individual lives as identified on the plan of care. Should additional qualified providers be identified, the Case Managers will inform the individuals of the new qualified provider of service. DMH, Division of Certification, is the entity responsible for notifying the Case Managers regarding providers who have received DMH certification to provide services.

7. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

Each plan of care is initially reviewed by DMH to verify the HCBS services are:

1. Addressed,
2. Appropriate and adequate to ensure the individual's health and welfare, and
3. Delivered by a DMH certified provider.

DMH then forwards the Plan of Care to DOM for review and approval.

On an annual basis, DMH, in conjunction with DOM, will verify through a representative sample of beneficiaries POCs to ensure all service plan requirements have been met. POCs are housed Document Management System allowing both agencies capability of accessing POCs at any time.

8. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☑	Operating agency	☑	Case manager
☐	Other (*specify):*				

Services

b. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Day Habilitation Services
Service Definition (Scope)*:*	
Day Habilitation Services are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports to enhance an individual's acquisition of skills, appropriate behaviors and personal choice. Day Habilitation activities must aim to improve skills needed for the individuals to function as independently as possible. Day Habilitation will be provided based on a person centered approach with supports tailored to the individual desires and life plan of the individual participant. Day Habilitation Services take place in a non-residential setting that is separate from the residence of the individuals receiving the service. Services cannot exceed five (5) hours a day and must be delivered at least four (4) hours one (1) day per week and are based on the individual's plan of care. A minimum staffing ratio of 1 staff member to every 8 individuals receiving the service will be in place.	

Individuals will be able to choose their provider of Day Habilitation Services from those certified by the MS Department of Mental Health to provide the service.			
Additional needs-based criteria for receiving the service, if applicable *(specify):*			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*			
☐	Categorically needy *(specify limits):*		
☐	Medically needy *(specify limits):*		
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Day Habilitation Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:			
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*		Frequency of Verification *(Specify):*
Day Habilitation Providers	Division of Medicaid		Annually
Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Prevocational Services
Service Definition (Scope)*:*	
Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Individuals receiving Prevocational Services must have employment related goals in their Plans of Care; the general habilitation activities must be designed to support such employment goals.	

Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of Prevocational Services. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

Services are intended to develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples include, but are not limited to,:

Ability to communicate effectively with supervisors, coworkers and customers

Generally accepted community workplace conduct and dress

Ability to follow directions; ability to attend to tasks

Workplace problem solving skills and strategies

General workplace safety and mobility training

Attention span

Motor skills

Interpersonal relations

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

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

Services provided cannot exceed six (6) hours per day.

Individuals may be compensated in accordance with applicable Federal Laws.

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

Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by

someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

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

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Prevocational Services Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Prevocational Services Providers	Division of Medicaid	Annually
Service Delivery Method. *(Check each that applies)*:	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supported Employment

Service Definition (Scope)*:*

Supported Employment is the ongoing support to individuals who, because of their disabilities, need intensive, ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment. Employment must be in an integrated work setting in the general workforce for whom an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Providers must reduce the number of hours of staff involvement over the first few weeks of employment as the supported employee becomes more productive and less dependent on paid supports. The plan for reduction in services is based on the individual's identified need for support as established in the Plan of Services and Supports and must be documented in the individual's record.

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

Each individual must have an Activity Plan that is developed based on his/her Plan of Care.

Providers must provide all activities that constitute Supported Employment including assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction, and ongoing job support and monitoring.

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

Supported Employment includes services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include: aiding the individual to identify potential business opportunities; assistance in the development of a business plan which includes searching for potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment are made through the Mississippi Department of Rehabilitation Services (MDRS). Documentation of the referral must be in the record.

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

Service hours cannot exceed forty (40) hours per month.

Supported Employment does not include volunteer work.

Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in the Supported Employment program or payments passed through to users of Supported Employment Services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supported Employment Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supported Employment Provider	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

3. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; I the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

HCBS are provider managed services. Providers are prohibited from allowing relatives, legally responsible individuals and legal guardians from providing State plan HCBS.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

N/A

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
N/A	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

☑	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ Participant–Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment, a person-centered process produces a person-centered service plan for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

☑	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.

	☐	**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.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

☑	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):*
	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):*

Quality Improvement Strategy

(Describe the state's quality improvement strategy in the tables below):

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915 (i) participants, are updated annually, and document choice of service services and providers.	1. Number and percent of individual service plans in which the services and supports align with assessed needs Numerator (N): # of individual service plans reviewed in which the services and supports align with assessed needs Denominator (D): # of individual service plans reviewed	1. Data Source – DMH/DOM review of individual service plan prior to implementation Sample – 100%	1. DMH/DOM	1. Discovery is continuous and ongoing	1. DMH/DOM	1. Quarterly
	2. Number and percent of 1915 (i) participants who were afforded a choice of providers. N:	2. Data Source – DMH Written Report of Findings	2. DMH	2. Discovery is continuous and ongoing	2. DMH	2. Quarterly

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	# of sampled participants who were afforded choice of provider. D: # number of participants sampled.					
	3. The proportion of participants reporting that Case Managers (CM) help them get what they need. N: # of individuals who report CM helps them get what they need. D: # of individuals included in survey sample	3. Data Source – National Core Indicators – Consumer Survey	3. DMH	3. Annually	3. DMH	3. Annually
	4. Number and percent of services and supports that were provided in	4. Data Source – DMH Written Report of Findings	4. DMH	4. Continuous and ongoing	4. DMH	4. Quarterly

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	the type, scope, amount, duration and frequency as defined in the individual service plan. N: # of individual service plans reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the individual service plan. D: number of individual service plans in review sample					
Providers meet required qualifications	1. Number and percent of provider agencies that initially meet DMH certification requirements prior to service delivery. N: # of	1. Data Source - DMH Provider Management System; Sample – 100%	1. DMH	1. One time upon initial certification.	1. DMH	1. Annually

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	provider agencies meeting initial certification requirements prior to service delivery. D: # of provider agencies seeking initial DMH certification.	of initial applicants for DMH certification				
	2. Number and percent of 1915 (i) provider agencies that continue to meet DMH requirements for certification. N: # of 1915 (i) provider agencies who continue to meet certification requirements D: # of 1915 (i) agencies	2. Data Source – DMH Written Reports of Findings	2. DMH	1. At least twice during the three year certification period.	2. DMH	2. Continuous and Ongoing
	3. Number and percent of provider agencies that initially meet Medicaid	3. Initial provider applications submitte	3. DOM	3. One time upon enrollment.	3. DOM	3. Continuous and Ongoing

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	provider requirements prior to service delivery. N: # of provider agencies meeting initial Medicaid provider requirements. D: # number of provider agencies seeking initial Medicaid Provider Status.	d to DOM fiscal agent.				
	4. Number and percent of provider agencies that continue to meet Medicaid provider requirements. N: # of 1915 (i) provider agencies who continue to meet Medicaid provider requirements. D: # of 1915 (i) provider agencies	4. DOM Fiscal Agent	4. DOM	4. Annually	4. DOM	4. Continuous and Ongoing
Settings meet the home and	Number and percent of service	Data Source	DMH	Continuous and	DMH	Continuous and Ongoing

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
community-based setting requirements as specified in the SPA.	settings that meet item 9 requirements. N: # of settings approved as community-based settings. D: # of total settings reviewed	– DMH Written Report of Findings		Ongoing		
The SMA retains authority and responsibility for program operations and oversight.	Number and percent of individuals who are certified/recertified to receive 1915 (i) services who meet Medicaid eligibility requirements. N: # of individuals who are certified/recertified to receive 1915 (i) services who meet Medicaid eligibility requirements D: # of individuals certified/recertified by DMH to receive 1915 (i) services	Data Source – Individual Record Review Sample Size – 100% at initial certification/ annual recertification	DOM	Continuous and Ongoing	DOM	Continuous and Ongoing
The SMA maintains financial accountability	Number of and percent of claims for each payment was made for services	Source is MMIS system. Data are claims paid for	DOM	Continuous and Ongoing	DOM	Quarterly

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
through payment of claims for services that are authorized and furnished to 1915 (i) participants by qualified providers.	included in the beneficiary's plan of care. N: # of claims paid that were included in the individuals plan of care. D: # of total claims paid.	1915(i) services.				
The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Number and percent of waiver individuals whose records document information of Rights and Options, which include the right to be free from abuse, in addition to procedures for reporting grievances (inclusive of serious incidents). N: # of records that indicate	1. Data Source – Individual Record Review – DMH Written Reports of Findings Sample Size – less than 100% review – confidence interval = 95 +/- 5% margin of error	1. DMH	1. Continuous and Ongoing	1. DMH	1. Quarterly

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	acknowledgement of Rights and Options and grievance procedures (inclusive of serious incidents) D: # of records reviewed.					
	2. Number and percent of serious incidents reported to DMH within timelines. N: # of serious incidents received within timelines. D: # of serious incidents reported.	2. Data Source – DMH Serious Incident Management System – Sample – 100%	2. DMH	2. Continuous and Ongoing	2. DMH	2. Quarterly
	3. Number and percent of serious incidents received and inquiry was required. N: # of serious incidents that received an inquiry as required. D: # of	3. Data Source – DMH Serious Incident Management System – Sample – 100%	3. DMH	3. Continuous and Ongoing	3. DMH	3. Quarterly

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	serious incidents subject to inquiry.					
	4. Number and percent of serious incident that included follow up action that was completed as a result of inquiry. N: # of serious incidents that include completed follow up action. D: # of serious incident requiring follow up action	4. Data Source – DMH Serious Incident Management System – Sample – 100%	4. DMH	4. Continuous and Ongoing	4. DMH	4. Quarterly
	5. The proportion of individuals who report that they feel safe in their home, neighborhood, workplace and day program/other daily activities. N: # of individuals who	5. Data Source – National Core Indicators – Consumer Survey – Sample – less than 100% review –	5. DMH	5. Annually	5. DMH	5. Annually

Requirement	Discovery Evidence (performance measure)	Discovery Activity (data source and sample)	Monitoring Responsibilities	Frequency	Remediation Responsibilities	Frequency of Analysis and Aggregation
	report feeling safe in their home, neighborhood, workplace and day program/other activities. D: # of individuals in survey sample	confidence interval = 95 +/- 5% margin of error				

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Data is gathered via on-site visits and administrative reviews conducted by DMH. DMH analyzes data against stated performance measures and prioritizes the needs for system improvement based on data gathered. Through Plans of Compliance, Remediation is required of all providers when requirements are not met. All Plans of Compliance are reviewed by the DMH Bureaus of Quality Management, Operations and Standards (BQMOS) and the Bureau of Intellectual/Developmental Disabilities for completeness and appropriateness. Recommendations for approval/disapproval are made to DMH Review Committee which is comprised of DMH's Executive Leadership Team. Trends and patterns are analyzed and aggregated on both the provider and system level to identify areas of needed improvement and possible changes in DMH	DMH's BQMOS is responsible for the agency's quality assurance activities such as the development of provider certification standards and monitoring adherence to those standards. BQMOS will primarily be responsible for ensuring quality assurance reviews are conducted, data collection and analysis. Trends and patterns will be identified by BQMOS, the agency's Quality Management Council and the DMH BIDD.	Data is aggregated and analyzed at least annually.	To determine if number of instances of remediation in identified areas decreases based on changes made to implement systems improvement. Remediation activities are monitored by the BQMOS.

Operational Standards, data collection and reporting methods, or records management practices.			

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Day Habilitation Services $10.80 per hour Prevocational Services $12.52 per hour Supported Employment Services $25.00 per hour
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i.