

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 an Amendment to a ☐ 1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Mississippi** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of ☐ 1915(c) of the Social Security Act.

B. Program Title:

Intellectual Disabilities/Developmental Disabilities (ID/DD)

C. Waiver Number: MS.0282

Original Base Waiver Number: MS.0282.90.R3

D. Amendment Number:

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

07/01/16

Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

1) Change the LOC determination tool to meet the requirements of the Balancing Incentive Program Core Standardized Assessment

The LOC determination tool will be the Inventory for Client and Agency Planning (ICAP). It contains all but three (3) of the required elements for the core standardized assessment. Those not contained (transferring, mobility in bed, and bathing), are asked to provide information related to a person's need for support but do not impact scoring of the ICAP.

2) Change the LOC requirements for recertification.

3) Add "Economic Self-Sufficiency" to list DD Requirements areas in which a person must have at least 3/7 deficits under LOC. This was inadvertently omitted previously.

4) Change the qualifications of who can conduct LOC determinations for recertification

ID/DD Waiver Support Coordinators will conduct the LOC evaluation for recertification using the ICAP. Additionally, every third year, an independent contractor will conduct the ICAP for resource allocation and LOC. The requirements will be a bachelor's degree in a field related to individuals with intellectual/developmental disabilities and one year experience in said field. A staff person with a Master's degree will no longer have to review the ICAP before submission to BIDD. Initial

ICAPs will always be conducted by the independent contractor. They have a robust quality assurance system in place which trains assessors according to parameters developed by one of the authors of the ICAP and that also requires a 100% review of clinical notes and scoring for assessors by quality consultants before submission of the ICAP data to MS LTSS's scoring system.

5) Take out references to the LOC Re-Evaluation Tool

All references to the LOC Re-Evaluation Tool will be removed as it is being replaced by the ICAP.

6) Change references to the Individual Activity Plan to the Activity Support Plan

The Individual Activity Plan is being changed to the Activity Support Plan which is a part of the Plan of Services and Supports.

7) Change the requirements for two (2) monthly Support Coordination contacts to one(1)

Support Coordinators will now, with the advent of Medicaid's LTSS System, be able to review up to date information from providers, thus negating the need for the additional contact per month. Support Coordinators will also have to be in more constant contact as they monitor the Plan of Services and Supports - setting up meetings and talking with providers. Support Coordinators are still required to have at least a quarterly face-to-face visit with the person, alternating service settings, and having at least one (1) home visit per year if a person does not receive an in-home service such and Respite or Home and Community Supports.

8) Allow reporting of Serious Incidents through Medicaid's Long Term Services and Support System

Medicaid's LTSS System will provide the means for providers to send Reportable Events through the system, allowing for a triage system and response hierarchy that is part of the workflow between DMH staff, Support Coordinators and the Division of Medicaid. Reports can still be phoned or faxed, but will be entered into the system according to its requirements.

9) Develop definitions for the following new services: Shared Supported Living, Intermittent Supported Living, In-Home Respite, Medical Homes, Behavior Homes

10) Revise definitions of Supervised Living, Supported Employment, Job Discovery, Prevocational Services, Crisis Support, Support Coordination, In-Home Nursing Respite and Crisis Intervention services

11) Change the Reserved Capacity amounts

Based on historical information and experience, the Reserved Capacity per year for people being deinstitutionalized will be raised to 150. The Reserved Capacity for people being admitted to the waiver due to crisis situations will be raised to 50. A crisis is defined as homelessness, death of immediate caregiver with no other caregiving options, behavior that exceeds the capacity of the person's control or that severely threatens the safety of the person and/or others.

12) Implement Resource Allocation for individual budgets

BIDD has worked extensively with Human Services Research Institute (HSRI) and Burns and Associates to develop a Resource Allocation model to implement individual budgets based on an objective measure of need - the ICAP.

13) Implement new rates based on a revised Rate Study

New rates for ID/DD Waiver services have been developed based on a rate study by Burns and Associates. The new rate system allows for tiers of services based on ICAP scores. The tiers specify the amount of staff time to be spent with each person as well as staff ratios, based on a person's ICAP score.

14) Include the state's transition plan for the ID/DD Waiver

The state's transition plan for the ID/DD Waiver has been included.

15) Include the requirements of the HCB Settings Final Rule

DMH Operational Standards and definitions of services in the ID/DD Waiver application have been revised to reflect the requirements of the HCB Settings Final Rule, as per the Transition Plan.

16) Change the word "individual" to "person"

17) BIDD/Division of HCBS will no longer approve all applications for initial and recertification. BIDD/Division of HCBS will review a representative sample from each Support Coordination entity.

- 18) Describe Mississippi's Long Term Services and Supports e-system.
- 19) Performance Measures in Appendix B a.i.a and a.i.c. added LTSS as data source
- 20) Deleted Sub assurance (b) in Appendix B
- 21) Changes to the how family members are approved to provide services for Home and Community Supports. Changes to definition of "family member" for Host Homes. Addition of family members as providers for new service In-Home Respite.
- 22) Appendix C(c)(i) – Changes to indicate compliance with Final Rule in the case of larger facilities.
- 23) App D-1-d. Updated language for Final Rule and deleted requirement for Quarterly Provider Reports to be sent to Support Coordinators. LTSS and the person centered planning process allow Support Coordinators to adequately monitor implementation of the PSS and the person's status in reaching his/her outcomes.
- 24) D-1-g – BIDD/Division of HCBS does not review all requests for initial, recertification and changes in service. Only changes in service will be reviewed on a 100% basis; representative samples are reviewed for initial and recertification requests.
- 25) The name "Support Coordination Contact Summaries" was changed to "Support Coordination Service Notes."
- 26) Appendix D-2-b - clarified to state Support Coordination activities are monitored by the state.
- 27) Appendix D – Quality Improvement – deleted Subassurance b. as per guidance from CMS. Revised Subassurance a. to delete measure regarding choice of provider as it is now in e. Added LTSS as a data source.
- 28) Appendix G-1-b – Deleted DMH Quality Management Council. Added LTSS.

3. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input checked="" type="checkbox"/> Appendix A <input type="checkbox"/> Waiver Administration and Operation	A-2(b)
<input checked="" type="checkbox"/> Appendix B <input type="checkbox"/> Participant Access and Eligibility	B-3(c), B-6(d), B-6(f)
<input checked="" type="checkbox"/> Appendix C <input type="checkbox"/> Participant Services	C-1/3, C-2(e), C-4(a)
<input checked="" type="checkbox"/> Appendix D <input type="checkbox"/> Participant Centered Service Planning and Delivery	D-1(c), D-1(d), D-1(e)
<input type="checkbox"/> Appendix E <input type="checkbox"/> Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F <input type="checkbox"/> Participant Rights	F-3(c),
<input checked="" type="checkbox"/> Appendix G <input type="checkbox"/> Participant Safeguards	G-1(b), G-1(d)
<input checked="" type="checkbox"/> Appendix H	H-1(a)(i),
<input type="checkbox"/> Appendix I <input type="checkbox"/> Financial Accountability	
<input checked="" type="checkbox"/> Appendix J <input type="checkbox"/> Cost-Neutrality Demonstration	

- B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- ☐ Modify target group(s)
- ☐ Modify Medicaid eligibility
- ☒ Add/delete services
- ☒ Revise service specifications

- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

1) Medicaid's Long Term Services and Supports System (LTSS) to include include, at a minimum, No Wrong Door System, Conflict Free Case Management, a Core Standardized Assessment instrument, Information and Referral System, Electronic Visit Verification, Reportable Event reporting system, electronic Support Coordination vehicle for developing, maintaining, revising, and tracking Plans of Services and Supports, electronic input of provider Activity Support Plans for monitoring by Support Coordinators and a Quality Improvement Strategy that reaches across all Mississippi's HCBS Waivers.

2) LOC Assessment Tool was changed to the Inventory for Client and Agency Planning (ICAP) in order to align with the Balancing Incentive Program Core Standardized Assessment.

3) LOC criteria was changed to indicate a score of 70 or above on the ICAP will indicate a person may not meet ICF/IID LOC. All person's with an ICAP over 70 will be reviewed by one of the Diagnostic and Evaluation Teams to determine clinical eligibility. If the person is determined to no longer meet ICF/IID LOC requirements, he/she will be transitioned to another more appropriate program such as the IDD Community Support Program (1915i), Targeted Case Management or Community Support Services offered by a Community Mental Health Center.

4) Master's level staff will no longer review LOC criteria for recertification. The ICAP does not require this level of review.

5) Removed references to LOC Re-Evaluation Tool. It has been replaced by the ICAP.

6) Revised Performance Measures to comport with March, 2014 SMD letter.

7) Adding process of setting budget limits by level of support based on ICAP scores.

8) Changed Support Coordinator review requirements from two (2) monthly phone contacts to one (1).

9) Revised Appendix J-2(iv) to include new rates from Rate Study.

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

1. Request Information (1 of 3)

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

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

Intellectual Disabilities/Developmental Disabilities (ID/DD)

C. Type of Request: amendment

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

☐ 3 years ☒ 5 years

Original Base Waiver Number: MS.0282

Draft ID: MS.009.04.10

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/13

Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

☐ **Inpatient psychiatric facility for individuals age 21 and under as provided 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:

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

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

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

1. Request Information (3 of 3)

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

☒ **Not applicable**

☐ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- ☐ A program authorized under §1915(i) of the Act.
- ☐ A program authorized under §1915(j) of the Act.
- ☐ A program authorized under §1115 of the Act.

Specify the program:

H. Dual 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 ID/DD Waiver provides service to people who, but for the provision of services through this waiver would require care in an intermediate care facility for individuals with intellectual disabilities(ICF/IID). Services are available statewide without regard to age.

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

The program proposes to provide the following services:

Supervised Living
 Behavior Support
 Day Services-Adult
 Community Respite
 Prevocational Services
 Supported Employment
 Specialized Medical Supplies
 Support Coordination
 Occupational, Physical and Speech Therapies
 Home and Community Supports
 Intermittent Supported Living
 Shared Supported Living
 Job Discovery
 Crisis Support
 Crisis Intervention
 Host Homes
 Transition Assistance
 Medical Homes
 Behavior Support Homes
 In-Home Nursing Respite
 In-Home Respite

GOALS AND OBJECTIVES: To provide access to meaningful and necessary home and community based services and supports; to provide services in a culturally competent, person-centered manner; to provide services and supports that facilitate a person living as independently as possible in his/her community including the facilitation of community participation to the extent someone not receiving HCBS services would participate and the development of social relationships, natural supports and employment.

ORGANIZATIONAL STRUCTURE – Mississippi’s Division of Medicaid is the single State Medicaid Agency having administrative responsibility in the administration and supervision of the ID/DD Waiver. The Department of Mental Health (DMH), Bureau of Intellectual and Developmental Disabilities (BIDD), Division of HCBS is responsible for the daily operation of the ID/DD Waiver.

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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in ☐ 1902(a)(1) of the Act (*select one*):
 - ☒ **No**
 - ☐ **Yes**

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

 - ☐ **Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of § 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR § 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider

certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver: Public input about the ID/DD Waiver and its operations is continuously sought and obtained by the Division of Medicaid and BIDD/Division of HCBS. The BIDD retains an Advisory Council comprised of parents, self-advocates, providers and advocates. The BIDD Advisory Council provides guidance and advice in setting goals and objectives for the BIDD. Staff from Medicaid and BIDD/Division of HCBS Services attends and present at conferences for advocates, professionals and self-advocates. This arena provides an excellent means of garnering input from a variety of sources. Staff from the BIDD/Division of HCBS has attended MFP Stakeholders meetings where much input about the waiver and waiver services was obtained.
- A series of three (3) statewide listening sessions was conducted. Attendees included advocates, parents, self-advocates, and service providers. Notes were taken at the meetings and the input was considered when developing the waiver application. Additionally, announcements of the meetings were published in all of the state's major newspapers and on the DMH's website.
- Meetings with stakeholders regarding the changes to the rate structure were held in February, 2014.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

Windham

First Name:

Bonlitha

Title:

Office Director, Bureau of Mental Health Programs

Agency:

Mississippi Division of Medicaid

Address:

550 High Street, Suite 1000

Address 2:

Walter Sillers Building

City:

Jackson

State:

Mississippi

Zip:

39201

Phone:

(601) 359-6114

Ext:

☐ **TTY**

Fax:

(601) 359-6294

E-mail:

bonlitha.windham@medicaid.ms.gov

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

Lacoste

First Name:

Ashley

Title:

Director of Home and Community Based Services

Agency:

Mississippi Department of Mental Health

Address:

Robert E. Lee Building, Suite 1101

Address 2:

239 North Lamar

City:

State:**Mississippi****Zip:****Phone:****Ext:****TTY****Fax:****E-mail:**

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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

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:

Changes which could result in some people losing eligibility or being transferred to another 1915(c) Waiver or to the 1915i State Plan Amendment (IDD Community Support Program) are being implemented. These changes involve setting LOC score requirements for the ICAP. Previously, there was not a score to determine recertification of LOC. This change is being made to bring the State into compliance with Balancing Incentive Program's Core Standardized Assessment requirements. People who score above the ICF/IID LOC range for the ID/DD Waiver will be assisted in transferring to another 1915(c) Waiver such as the Elderly and Disabled, Independent Living, TBI/SCI or Assisted Living. Additionally, the State has services (day habilitation, prevocational and Supported Employment) through an approved 1915i State Plan Amendment (IDD Community Support Program). They will not be discharged from ID/DD Waiver services until they are successfully enrolled in one of these programs or choose to decline all other service option. If they are not eligible for another 1915(c) Waiver or the IDD Community Support Program, they will be referred to a local Community Mental Health Center for community services such as Psychosocial Rehabilitation and/or Community Support Services (case management).

In order to ensure people get the amount/type(s) of services they need, no more-no less, the State is implementing individual budget limits based on ICAP scores. The State is working with HSRI to develop service packages for day and living services as well as for people who receive only in-home services such as Respite, Home and Community Supports and In-

Home Nursing Respite. If someone's services are reduced as a result of having an ICAP score that does not support what they currently receive, there will be an exceptions process in place as well as the currently required appeals process. Additionally, the State has attempted, as a supplement to the administration of the ICAP, to identify people who may have exceptional medical and behavioral support needs during the assessment so that services/amounts of service can be adjusted to prevent or lessen the amount of any potential reduction.

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- ☐ **The waiver is operated by the State Medicaid agency.**

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

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Mississippi Department of Mental Health

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Division of Medicaid (DOM) performs the following administrative functions: (1) promulgation of program policies; (2) notification and clarification of policy revisions to the Department of Mental Health (DMH)/Bureau of Intellectual and Developmental Disabilities(BIDD)and waiver providers; (3) monitoring the interagency agreement with DMH/BIDD; and (4) analyzing utilization of services.

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

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

- ☒ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	<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 checked="" type="checkbox"/>
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 checked="" 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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Quarterly report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5% margin of error
<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 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 (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial Certification/Recertification

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Quarterly Report Reserved Capacity

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

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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: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOM monitors the Quality Improvement Strategy (QIS) of the waiver on an ongoing basis through Onsite Compliance Reviews. During the Onsite Compliance Review, if individual problems are discovered, the provider must submit a corrective action plan to DOM for all items cited in the Onsite Compliance Review. A written report of findings is provided to the provider and to the Department of Mental Health.

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; 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 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 type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input 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"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	0		<input checked="" 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:

None

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

- ☒ **Not applicable. There is no maximum age limit**
- ☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- ☐ **Other**

Specify:

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

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

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

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

- ☐ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
☐ **Additional services in excess of the individual cost limit may be authorized.**

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2300
Year 2	2500
Year 3	2700
Year 4	2900
Year 5	3100

- 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	<input type="checkbox"/>
Deinstitutionalization	
Crisis	

Appendix B: Participant Access and Eligibility

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

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

Deinstitutionalization

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

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

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

Crisis

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	30
Year 4	30
Year 5	30

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. Miller Trust State.

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

- ☐ No
☒ Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

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

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

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

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☒ A special income level equal to:

Select one:

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

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- ☐ **Other standard included under the State Plan**

Specify:

- ☐ **The following dollar amount**

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

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

Specify:

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

- ☐ **Other**

Specify:

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

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

Specify:

Specify the amount of the allowance (select one):

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

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

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

Specify:

iii. Allowance for the family (select one):

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

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

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

Specify:

- ☐ **Other**

Specify:

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

- Health insurance premiums, deductibles and co-insurance charges
- 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).

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- ☐ **The following dollar amount:**

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

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

Specify formula:

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

- ☐ **Other**

Specify:

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

Select one:

- ☒ **Allowance is the same**
- ☐ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

- ☐ The State does not establish reasonable limits.
- ☐ The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-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.

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 (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-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 (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).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ☐ **Directly by the Medicaid agency**
- ☒ **By the operating agency specified in Appendix A**
- ☐ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ☐ **Other**
Specify:

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

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

Initial ICAPs for LOC will be conducted by the independent contractor. A robust quality assurance system is in place which trains assessors according to parameters developed by one of the authors of the ICAP and that also requires a 100% review of clinical notes and scoring for assessors by quality consultants before submission of the ICAP data to the scoring system.

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

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

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

OR

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

1. It is attributable to:
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with intellectual disabilities and requires treatment or services similar to those required for these persons; and
2. It is manifested before the person reaches age 22; and
3. It is likely to continue indefinitely; and
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.
 - g. Economic self-sufficiency.

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

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

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

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

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

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

For reevaluation of LOC, the ICAP is administered at least annually by each individual's Support Coordinator or by an independent contractor. All initial ICAPs for LOC are administered by an independent contractor. The independent contractor re-administers the ICAP every three (3) years, or less depending on the individual situation,

to determine LOC. In years the independent contractor does not administer the ICAP for LOC, the person's Support Coordinator administers the ICAP. If there is a request for another ICAP because someone's condition has changed, that is administered by the independent contractor to ensure an unbiased evaluation of the person's LOC requirements.

If there is a significant change in a person's LOC score on the ICAP, a review by the Diagnostic and Evaluation Team may take place to determine any clinical cause.

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

- ☐ Every three months
- ☐ Every six months
- ☒ Every twelve months
- ☐ Other schedule

Specify the other schedule:

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

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

Specify the qualifications:

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

The independent contractor uses staff who meet the same minimum qualifications as those for Support Coordinators. Additionally, the contractor has a robust quality assurance system which trains the contractor's assessors according to parameters developed by one of the authors of the ICAP and that also requires a 100% review of clinical notes and scoring for assessors by quality consultants before submission of the ICAP data to the LTSS scoring system.

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

ID/DD Waiver Support Coordinators are responsible for conducting annual reevaluations of each individual to determine if they continue to require ICF/IID level of care. Reports are generated by LTSS that show the length of time before someone's certification expires. These reports are run at least monthly by Support Coordinators and Support Coordination Directors to determine when the recertification process for each person should begin. Recertification information must be submitted to LTSS before the end of someone's certification period in order to ensure ongoing eligibility for services.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the 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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

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 type="checkbox"/> 100% Review
<input checked="" 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 type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

		<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
<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"/>

- 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:

LOC a.i.b. - Number and percent of waiver participants who received an annual LOC evaluation before the end of their current certification period. N: # of waiver participants reviewed who received an annual LOC evaluation before the end of their certification period. D: # of waiver participants in the sample

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

LTSS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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 = Confidence interval = 95% with +/- 5% error
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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: <div></div>	<input checked="" type="checkbox"/> Annually
	<input 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual record review- monitoring checklist 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin of error
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

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

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Individual monitoring checklist 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin of error
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; 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 black; height: 20px; width: 100%;"></div>

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Individual monitoring checklist LTSS

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMH/BIDD staff will provide technical assistance to the five (5) state-operated Diagnostic and Evaluation Teams (D&E Teams) when it is determined the LOC criteria was not applied as outlined in the waiver. Should a determination be made that an individual does not meet LOC criteria, DMH will notify the Support Coordinators and/or D&E Team and referrals to non-waiver services will be made. At that time, an individual would be informed of their right to appeal the LOC determination.

ii. Remediation Data Aggregation

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

Responsible Party(<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: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></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).

Upon determination of eligibility and again when an person is admitted to the waiver, he/she is informed of his/her ability to choose between services provided in an ICF/IID setting or those provided through the ID/DD Waiver. The person/legal representative indicates his/her choice on the appropriate form and signs the form. During reviews, DMH staff verifies there is documentation the person was offered a choice and chose ID/DD Waiver services.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service	<input type="checkbox"/>	<input type="checkbox"/>
Statutory Service	Day Services-Adults		
Statutory Service	In-Home Nursing Respite		
Statutory Service	In-Home Respite		
Statutory Service	Prevocational Services		
Statutory Service	Shared Supported Living		
Statutory Service	Supervised Living		
Statutory Service	Support Coordination		
Statutory Service	Supported Employment		
Statutory Service	Supported Living		
Extended State Plan Service	Specialized Medical Supplies		
Extended State Plan Service	Therapy Services		
Other Service	Behavior Support Services		

Service Type	Service	<input type="checkbox"/>	<input type="checkbox"/>
Other Service	Community Respite		
Other Service	Crisis Intervention		
Other Service	Crisis Support		
Other Service	Home and Community Supports		
Other Service	Host Home		
Other Service	Job Discovery		
Other Service	Transition Assistance		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Services-Adults

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

**Service Definition (Scope):**

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

The site setting must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Waiver services.

Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact.

Day Services-Adult must have a community component that is individualized and based upon the choices of each person. Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services.

Community integration opportunities must be offered weekly and address at least one of the following: 1. Activities which address daily living skills 2. Activities which address leisure/social/other community activities and events.

Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.

Transportation must be provided to and from the program and for community participation activities.

Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.

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

Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

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

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

Providers may bill for a maximum of 138 hours per month for an individual in a month which has 23 working days, a provider may bill a maximum of 132 hours per month for an individual in a month which has 22 working days.

Providers may only bill for the actual amount of service provided.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Services Adult Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency ▼

Provider Type:

Day Services Adult Agency

Provider Qualifications

License (specify):

Certificate (specify):

DMH certification

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

Initially and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Respite ▼

Alternate Service Title (if any):

In-Home Nursing Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support ▼

Sub-Category 1:

09012 respite, in-home ▼

Category 2:

▼

Sub-Category 2:

**Category 3:**

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

Sub-Category 4:**Service Definition (Scope):**

A. In-Home Nursing Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Nursing Respite staff provides all the necessary care the usual caregiver would provide during the same time period.

B. In-Home Nursing Respite is only available to individuals living in a family home and is not permitted for individuals living independently, either with or without a roommate.

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

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

E. In-Home Nursing Respite cannot be provided in the provider's residence.

F. Nurses may accompany individuals on short community outings but this cannot comprise the entirety of the service. Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan. Allowable activities include:

1. Assistance with personal care needs such as bathing, dressing, toileting, grooming;
2. Assistance with eating and meal preparation for the person receiving services
3. Assistance with transferring and/or ambulation
4. Administration of medical treatments and/or procedures as prescribed by a physician
5. Leisure activities

G. In-Home Nursing Respite is provided by a registered or licensed practical nurse He/she must provide nursing services in accordance with the Mississippi Nursing Practice Act and other applicable laws and regulations.

H. In-Home Nursing Respite is provided for persons who require skilled nursing services, as prescribed by a physician, in the absence of the primary caregiver. The need for administration of medications alone is not a justification for receiving In-Home Nursing Respite services.

I. Individuals must have a statement from their physician/nurse practitioner stating:

1. The treatment(s) and/or procedure(s) the individual needs in order to justify the need for a nurse in the absence of the primary caregiver; and
2. The amount of time needed to administer the treatment(s) and/or procedure(s); and
3. How long the treatment(s) and/or procedure(s) are expected to continue

J. Private Duty Nursing services through EPSDT must be exhausted before waiver services are utilized.

K. In-Home Nursing Respite cannot be provided by family members.

DRAFT

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-Home Nursing Respite Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Nursing Respite

Provider Category:

Agency

Provider Type:

In-Home Nursing Respite Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

DMH certification

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

Initially and every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Respite ▼

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support ▼

Sub-Category 1:

09012 respite, in-home ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

A. In-Home Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Respite staff provides all the necessary care the usual caregiver would provide during the same time period.

B. In-Home Respite is only available to individuals living in a family home and is not permitted for individuals living independently, either with or without a roommate.

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

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

E. In-Home Respite cannot be provided in the provider's residence.

I. Staff may accompany individuals on short community outings but this cannot comprise the entirety of the service. Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan. Allowable activities include:

1. Assistance with personal care needs such as bathing, dressing, toileting, grooming;
2. Assistance with eating and meal preparation for the person receiving services
3. Assistance with transferring and/or ambulation

4. Administration of medical treatments and/or procedures as prescribed by a physician (In-Home Nursing Respite only)
5. Leisure activities

C. Individuals cannot be left unattended at any time during the provision of In-Home Respite Services.

D. Staff providing In-Home Respite cannot accompany individuals to medical appointments.

E. In-home Respite services cannot be billed for while the person is receiving another Medicaid service, except Behavior Support.

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	

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Respite

Provider Category:

Agency

Provider Type:

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid/DMH

Frequency of Verification:

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:**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:****Service Definition (Scope):**

A. Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.

B. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team.

C. People receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment outcomes.

D. Services 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:

1. Ability to communicate effectively with supervisors, coworkers and customers
2. Generally accepted community workplace conduct and dress
3. Ability to follow directions; ability to attend to tasks
4. Workplace problem solving skills and strategies
5. General workplace safety and mobility training
6. Attention span
7. Motor skills
8. Interpersonal relations

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

F. Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations.

G. Community job exploration activities must be offered to each person at least one time per month and be provided individually or in groups of up to three (3) people. Documentation of the choice to participate must be documented in each person's record. People who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.

H. Transportation must be provided to and from the program and for community integration/job exploration.

I. Any person 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 person receiving services 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. Services must be time limited with a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.

J. At least annually, providers will conduct an orientation informing people receiving services about Supported Employment and other competitive employment opportunities in the community. This documentation must be maintained on site. Representative(s) from the Mississippi Department of Rehabilitation Services must be invited to participate in the orientation.

K. Personal care assistance from staff must be a component of Prevocational Services. A person cannot be denied Prevocational Services because he/she requires assistance from staff with toileting and/or personal hygiene.

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

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

N. A person must be at least 18 years of age and have documentation in his/her record to indicate he/she has received either a diploma or certificate of completion if under the age of 22.

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

S. Services must optimize, not regiment personal initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact.

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services Agency

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency ▼

Provider Type:

Prevocational Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

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:

Residential Habilitation ▼

Alternate Service Title (if any):

Shared Supported Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services ▼

Sub-Category 1:

02031 in-home residential habilitation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

A. Shared Supported Living services are for persons age 18 and older and are provided in compact geographical areas (e.g. an apartment complex) in residences either owned or lease by themselves or a provider. Staff supervision is provided at the program site and in the community but does not include direct staff supervision at all times.

1. The amount of staff supervision someone receives is based on tiered levels of support based on a person's score on the Inventory for Client and Agency Planning (ICAP).
2. There must be awake staff on site twenty-four (24) hours per day, seven (7) days per week when people receiving services are present. Staff must be able to respond to requests/need for assistance from anyone receiving services within five (5) minutes at all times people are present at the program site.

B. Nursing services are a component part of ID/DD Waiver Shared Supported Living. They must be provided as-needed, based on each person's individual need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

C. Shared Supported Living provides assistance with direct personal care activities such as:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene

D. Shared Supported Living provides assistance with instrumental activities of daily living which include:

1. Planning and preparing meals
2. Cleaning
3. Transportation
4. Ambulation and mobility
5. Supervision of the person's safety and security
6. Banking
7. Shopping
8. Facilitation of the person's participation in community activities to the same extent as someone not receiving services.
9. Use of natural supports and typical community services available to all people in order to facilitate meaningful days
10. Social Activities
11. Participation in leisure activities
12. Development of socially valued behaviors
13. Assistance with scheduling and attending appointments

E. People receiving services have freedom and support to control their own schedules and activities.

1. A person cannot be made to attend a day program if he/she chooses to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if he/she is ill, or otherwise chooses to remain at home.
2. Staff must be available to support each person's choice.

G. People receiving Shared Supported Living must have access to food at all times.

H. People receiving Shared Supported Living must have control over their personal resources.

I. A person receiving Shared Supported Living must have a key to his/her residence and bedroom. Appropriate staff may also have a key in case of emergency.

J. People receiving waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 Duties of the Landlord (§89-8-23) and Duties of the Tenant (§89-8-25).

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

The amount of staff support provided to each person is based on his/her service level based on his/her ICAP score.

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	Shared Supported Living Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Shared Supported Living

Provider Category:

Agency ▼

Provider Type:

Shared Supported Living Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

DMH Certification

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/Medicaid

Frequency of Verification:

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:

Residential Habilitation ▼

Alternate Service Title (if any):

Supervised Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services ▼

Sub-Category 1:

02011 group living, residential habilitation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

A. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,

B. Supervised Living Services must include the following services as appropriate to each person's support needs:

1. Direct personal care assistance activities such as:

- (a) Grooming
- (b) Eating
- (c) Bathing
- (d) Dressing
- (e) Personal hygiene

2. Instrumental activities of daily living which include:

- (a) Assistance with planning and preparing meals
- (b) Cleaning
- (c) Transportation
- (d) Assistance with ambulation and mobility
- (e) Supervision of the individual's safety and security
- (f) Banking
- (g) Shopping
- (h) Budgeting
- (i) Facilitation of the person's participation in community activities
 - (j) Use of natural supports and typical community services available to everyone
 - (k) Social activities
 - (l) Participation in leisure activities
 - (m) Development of socially valued behaviors

(n) Assistance with scheduling and attending appointments

3. Methods for assisting people arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:

- (a) Assistance with making doctor/dentist/optical appointments;
- (b) Transporting and accompanying individuals to such appointments; and
- (c) Conversations with the medical professional, if the person gives consent.

4. Transporting the person to and from community activities, other places of his/her choice (within the provider's approved geographic region), work, and other sites as documented in the Plan of Services and Supports and Activity Support Plan.

5. If Supervised Living staff members have been unable to participate in the development of someone's Plan of Services and Supports, staff must be trained regarding the person's plan prior to beginning work with that person. This training must be documented.

6. Orientation of the person, to include but not limited to:

- (a) Familiarization with the living arrangement and neighborhood;
- (b) Introduction to support staff and other residents (if appropriate)
- (c) Description of the written materials provided upon admission and
- (d) Description of the process for informing the person/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

C. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from those living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

- (a) Each person must have access to food at any time, unless prohibited by his/her individual plan.
- (b) Each person must have choices of the food they eat.
- (c) Each person must have choices about when and with whom they eat

D. People receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.

E. In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

1. Procedures for setting and collecting fees and/or room and board
2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)
3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)
4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)
5. The written financial agreement must be explained to and reviewed with the person/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.
6. A requirement that the person's record contain a copy of the written financial agreement which is signed and dated by the person/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the person/legal guardian.
7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living services.
8. People receiving waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 Duties of the Landlord (§89-8-23) and Duties of the Tenant (§89-8-25).

F. A person must be 18 years or older to participate in Supervised Living.

G. There must be at least one (1) staff person under the same roof as people receiving services at all times that is able to respond immediately to the requests/needs for assistance from the people in the dwelling.

H. Sites certified after July 1, 2016, can house no more than four (4) people.

I. People have the freedom and support to control their own schedules and activities.

1. A person cannot be made to attend a day program if he/she chooses to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if he/she is ill, or otherwise chooses to remain at home.

2. Staff must be available to support each person's choices/

J. There must be a Supervised Living Program Supervisor for a maximum of four (4) Supervised Living locations.

1. The Supervised Living Program Supervisor is responsible for providing weekly supervision and monitoring at all four (4) sites.

2. Unannounced visits on all shifts, on a rotating basis must take place monthly.

3. All supervision activities must be documented and available for DMH review. Supervision activities include but are not limited to: review of daily Service Notes to determine if outcomes identified on a person's Plan of Services and Supports are being met; review of meals, meal plans and food availability; review of purchasing; review of each person's finances and budgeting; review of each person's satisfaction with services, staff, environment, etc.

K. Each person must have control over his/her personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.

L. Nursing services are a component of Supervised Living services and must be provided in accordance with the MS Nursing Practice Act. They must be provided on an as-needed basis. Only activities within the scope of the Nurse Practice Act and Regulations can be provided. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring, etc.

M. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

N. All sites must have furnishings that are safe, up-to-date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the people currently living in the home.

O. All providers must provide access to a washer and dryer in the residence and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.

P. Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site

2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)

3. Procedures to ensure pets will be kept away from food preparation sites and eating areas

4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Q. Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.

R. All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.

S. The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.

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

Staffing levels are based on the ratios set by a person's service level based on his/her ICAP score.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DMH Certified Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supervised Living

Provider Category:

Agency ▼

Provider Type:

DMH Certified Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

DMH certification

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

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:

Case Management ▼

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:

01 Case Management ▼

Sub-Category 1:

01010 case management ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

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

B. Support Coordinators cannot supervise, provide, or in any way be associated with any other ID/DD Waiver service. Support Coordination Services must be distinctly separate from other ID/DD Waiver service(s) an agency provides.

C. Support Coordinators must adhere to the requirements in the ID/DD Waiver Support Coordination Manual.

D. Support Coordinators coordinate and facilitate the development of the Plan of Services and Supports through a person-centered planning process.

E. Support Coordinators revise/update each person's Plan of Services and Supports at least annually or when changes in the person's circumstances occur or when requests are made by the person/legal guardian.

F. Support Coordinators inform people receiving services/legal guardians about all ID/DD Waiver and non-waiver services.

G. Support Coordinators inform each person/legal guardian about certified providers for the services on his/her approved Plan of Services and Supports initially, annually, if he/she becomes dissatisfied with the current provider, when a new provider/site is certified, or if a provider's certification status is affected.

H. Support Coordinators assist the person/legal guardian with meeting/interviewing agency representatives and/or arranging tours of service sites until the person chooses a provider.

I. Support Coordinators are responsible for entering required information in Medicaid's LTSS System.

J. Support Coordinators are responsible for notifying each person of:

1. Approval for initial enrollment
2. Approval/denial of requests for additional services
3. Approval/denial of requests for increases in services
4. Approval of requests for annual recertification
4. Approval for requests for readmission.
5. Reduction in service(s)
6. Termination of service(s)

K. Support Coordinators inform and provide the person/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services.

L. Support Coordinators educate each person, legal guardian and family on rights and the procedures for reporting instances of abuse, neglect and exploitation.

M. Support Coordinators perform all necessary functions for the person's annual recertification of ICF/IID level of care.

N. Support Coordinators are responsible for ongoing monitoring and assessment of the person's Plan of Services and Supports that must include:

1. Information about the person's health and welfare, including any changes in health status
2. Information about the person's satisfaction with current service(s) and provider(s) (ID/DD Waiver and others)
3. Information addressing the need for any new services (ID/DD Waiver and others) based upon expressed needs or concerns or changing circumstances and actions taken to address the need (s)
4. Information addressing whether the amount/frequency of service(s) listed on the approved Plan of Services and Supports remains appropriate
5. Review of Activity Support Plans developed by agencies which provide ID/DD Waiver services to the person
6. Ensuring all services a person receives, regardless of funding source, are coordinated to maximize the benefit and outcome for the person.
7. Follow-up activities regarding issues/needs identified during monthly or quarterly contacts or those reported by providers.

O. Support Coordinators monitor service provision/implementation monthly through onsite face-to-face visits, telephone contacts and review of the monthly service utilization.

P. Support Coordinators address issues related to a person's Plan of Services and Supports with his/her provider (s). If a provider is not responsive, the Support Coordinator is responsible for reporting the issue as a grievance through DMH's established grievance reporting procedures through the Office of Consumer Support.

Q. Speaking with a person and/or the legal guardian at least one (1) time per month or more frequently as determined by the Plan of Services and Supports or seeing the person during a face-to-face contact. The following items must be addressed monthly:

1. Determine if needed supports and services in the Plan of Services and Supports have been provided
2. Review implementation of Activity Support Plans to ensure specified outcomes are being met
3. Review the person's progress and accomplishments
4. Review the person's satisfaction with services and providers
5. Identify any changes to the person's needs, preferences, desired outcomes, or health status

6. Identify the need to change the amount or type of supports and services or to access new waiver or non-waiver services

7. Identify the need to update the Plan of Services and Supports

R. Support Coordinators conduct face-to-face visits with each person and speak to the legal guardian at least once every three (3) months, rotating service settings and talking to staff. For people who receive only day services, at least one (1) visit per year must take place in the person's home.

S. The following items must be addressed during quarterly visits:

1. Determine if needed supports and services in the Plan of Services and Supports have been provided
2. Review implementation of Activity Support Plans to ensure specified outcomes are being met
3. Review the person's progress and accomplishments
4. Review the person's satisfaction with services and providers
5. Identify any changes to the person's needs, preferences, desired outcomes, or health status
6. Identify the need to change the amount or type of supports and services or to access new waiver or non-waiver services
7. Identify the need to update the Plan of Services and Supports

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	DMH Regional Program

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Support Coordination

Provider Category:

Agency ▼

Provider Type:

DMH Regional Program

Provider Qualifications

License (specify):

Certificate (specify):

DMH certification

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMH

Frequency of Verification:

Initially and every 3 years thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

03 Supported Employment ▼

Sub-Category 1:

03010 job development ▼

Category 2:

03 Supported Employment ▼

Sub-Category 2:

03021 ongoing supported employment, individual ▼

Category 3:

03 Supported Employment ▼

Sub-Category 3:

03022 ongoing supported employment, group ▼

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

▼

Service Definition (Scope):

A. Before a person can receive Supported Employment services, he/she must first be referred by his/her Support Coordinator to the Department of Rehabilitation Services to determine his/her eligibility for services from that agency. Documentation must be maintained in the record of each person receiving Supported Employment Services that verifies the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

B. Supported Employment is the ongoing support to people who, because of their disabilities, will need intensive, ongoing support to obtain and maintain a job in competitive, or self-employment.

C. Employment must be in an integrated work setting in the general workforce for where a person 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 people without disabilities.

D. Providers must work to reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. This is decided on a personalized basis dependent on the amount of support recommended by the employer, the Department of Rehabilitation Services and the person's team.

E. Supported Employment Services are provided in a work site where people without disabilities are employed; therefore, payment is made only for adaptations, supervision, and training required by people receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

F. Other workplace supports may include services not specifically related to job skills training that enable the person to be successful in integrating into the job setting.

G. Each person must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.

H. Providers must be able to provide all activities that constitute Supported Employment: Job Seeking and Job Coaching.

1. Job Seeking – Activities that assist a person in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours. Additional hours may be approved if a person wishes to find another job. Job seeking includes:

- (a) Completion of IDD Employment Profile
- (b) Person Centered Career Planning which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches
- (c) Job Development
 - (i) What environment does the person enjoy
 - (ii) In what environments has the person experienced success
 - (iii) What work and social skills does the person bring to the environment
 - (iv) What environments are their skills viewed as an asset
 - (v) What types of work environments should be avoided
- (d) Employer research
- (e) Employer needs assessment
 - (i) Tour the employment site to capture the requirements of the job
 - (ii) Observe current employees
 - (iii) Assess the culture and the potential for natural supports
 - (iv) Determine unmet needs
- (f) Negotiation with prospective employers
 - (i) Employer needs are identified
 - (ii) Job developer acts as a representative for the job seeker

2. Job Coaching – Activities that assist an individual to learn and maintain a job in the community. The amount of Job Coaching a person receives is dependent upon individual need, team recommendations, and employer evaluation. Job coaching includes:

- (a) Meeting and getting to know co-workers and supervisors
- (b) Learning company policies, dress codes, orientation procedures, and company culture

- (c) Job and task analysis
 - (i) Core work tasks
 - (ii) Episodic work tasks
 - (iii) Job related tasks
 - (iv) Physical demands
 - (v) Sensory and communication demands
 - (vi) Academic demands
- (d) Systematic instruction
 - (i) Identification and instructional analysis of the goal
 - (ii) Analysis of entry behavior and learner characteristics
 - (iii) Performance Objectives
 - (iv) Instructional strategy
- (e) Identification of natural supports
 - (i) Personal associations and relationships typically developed in the community that enhance the quality and security of life
 - (ii) Focus on natural cues
 - (iii) Establish circles of support
- (f) Ongoing support and monitoring

I. If a person moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during Job Seeking or Job Discovery (if applicable).

J. Transportation will be provided between the individual's place of residence for job seeking as well as between the site of the individual's job or between habilitation sites as a component part of Supported Employment. Transportation cannot comprise the entirety of the service.

K. Supported Employment may also include services and supports that assist the person in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include:

1. Assisting the person to identify potential business opportunities
2. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and starting a business (e.g. internet and telephone service, website development, advertising, incorporation, taxes, etc.).
3. Identification of the supports that are necessary for the person to operate the business
4. Ongoing assistance, counseling and guidance once the business has been launched.
5. Up to fifty-five (55) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product
6. Up to thirty-five (35) hours per month for assistance in the community by a job coach.

L. Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be developed with the Mississippi Department of Rehabilitation Services. There must be documentation of the referral in the person's record.

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

N. Individuals cannot receive Supported Employment and Job Discovery.

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

P. Supported Employment does not include volunteer work, career exploration or internships.

Q. Providers are prohibited from making incentive payments to an employer to encourage or subsidize the employer's participation in the Supported Employment Program and/or passing payments through to users of

Supported Employment Services.

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

S. A person must be at least 18 years of age to participate in Supported Employment and have documentation in their record to indicate he/she has received either a diploma or certificate of completion if he/she is under the age of 22.

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

A individual may receive a maximum amount of Job Seeking of 90 hours. Additional hours may be approved if needed to find another job.

For self employment, the following limits apply: Up to fifty-five(55) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product and up to thirty-five (35) hours per month for assistance in the community by a job coach.

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

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

Supported Employment does not include volunteer work.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency ▼

Provider Type:

Supported Employment Agency

Provider Qualifications

License (specify):

Certificate (specify):

DMH certification

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/Medicaid

Frequency of Verification:

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:

Residential Habilitation ▼

Alternate Service Title (if any):

Supported Living

HCBS Taxonomy:**Category 1:**

08 Home-Based Services ▼

Sub-Category 1:

08010 home-based habilitation ▼

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

**Category 3:**

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

Sub-Category 4:**Service Definition** (*Scope*):

A. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living services are provided in a homelike setting where people have access to the community at large to the same extent as people who do not have a serious mental illness and/or IDD.

B. Supported Living Services are for individuals age 18 and above.

C. Four (4) or fewer people may live in a residence.

D. A maximum of eight (8) hours of Supported Living may be received in a twenty-four (24) hour period.

E. Supported Living provides assistance with the following, depending on each person's support needs:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene.

F. Supported Living provides assistance with instrumental activities of daily living which include assistance with:

1. Planning and preparing meals
2. Transportation or assistance with securing transportation
3. Assistance with ambulation and mobility
4. Supervision of the individual's safety and security
5. Banking
6. Shopping
7. Budgeting
8. Facilitation of the individual's participation in community activities
9. Use of natural supports

G. Providers must develop methods, procedures and activities to provide meaningful days and independent living choices about activities/services/staff for the individual(s) served in the community.

H. Procedures must be in place for individual(s) to access any other needed services as well as typical community services available to all people in order to facilitate meaningful days and development of natural supports.

I. Supported Living services for community participation activities may be shared by up to three (3) individuals

who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

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

K. Supported Living services cannot be provided in a hospital, ICF/IID or any other Medicaid, Medicare, or private insurance funded facility. This includes rehabilitation facilities.

L. Nursing services are a component part of ID/DD Waiver Supported Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

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

The maximum amount of Supported Living that someone may receive is 8 hours per twenty-four (24) hour period.

Supported Living is not available to individuals receiving Supervised Living, Host Home services, In-Home Nursing Respite, Home and Community Supports, or Community Respite.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Living

Provider Category:

Agency ▼

Provider Type:

Supported Living Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH certification

Other Standard *(specify):*

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMH/Medicaid

Frequency of Verification:

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:**Service Title:**

Specialized Medical Supplies

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

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

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The DOM fiscal agent.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service ▼

Service Title:

Therapy Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services ▼

Sub-Category 1:

11090 physical therapy ▼

Category 2:

11 Other Health and Therapeutic Services ▼

Sub-Category 2:

11080 occupational therapy ▼

Category 3:

11 Other Health and Therapeutic Services ▼

Sub-Category 3:

11100 speech, hearing, and language therapy ▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

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

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

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

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

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

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

Therapy services must be approved on the individuals approved Plan of Care (POC).

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

Maximum of 3 hours per week of physical therapy. Maximum of 3 hours per week of speech therapy. Maximum of 2 hours per week of occupational therapy.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOM Approved Agency
Individual	Physical Therapist, Occupational Therapist and Speech-Language Pathologist (Speech Therapist)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Agency ▼

Provider Type:

DOM Approved Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Therapy Services

Provider Category:

Individual ▼

Provider Type:

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

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Behavior Support Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services ▼

Sub-Category 1:

10040 behavior support ▼

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Behavior Support provides systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for people whose behaviors are significantly disrupting their progress in habilitation, self-direction or community participation and/or are threatening to require movement to a more restrictive setting. This service also includes consultation and training provided to families and staff working with the individual. The desired outcome of the service is long term behavior change.

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

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

Direct Behavior Support services cannot be provided in a school setting. The consultant may observe a person in the school setting to assess behaviors in that area, but not provide any direct services.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Support Agency

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

Service Type: Other Service

Service Name: Behavior Support Services

Provider Category:

Agency ▼

Provider Type:

Behavior Support Agency

Provider Qualifications**License (specify):****Certificate (specify):**

DMH Certification

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service ▼

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

Service Title:

Community Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support ▼

Sub-Category 1:

09011 respite, out-of-home ▼

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

▼

Category 3:

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

Sub-Category 4:**Service Definition (Scope):**

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

The site setting must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving Home and Community Based Services (HCBS) services.

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

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

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

Community Respite cannot be provided overnight.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Respite Agency

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

Service Type: Other Service

Service Name: Community Respite

Provider Category:

Agency

Provider Type:

Community Respite Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

DMH Certification

Other Standard (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH/Medicaid

Frequency of Verification:

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:

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

Service Title:

Crisis Intervention

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

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

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

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

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

Crisis Intervention is authorized for up to 24 hours per day in 7 day segments with the goal of being a phased out service.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Intervention Agency

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

Service Type: Other Service

Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Crisis Intervention Agency

Provider Qualifications

License (specify):

Certificate (specify):

DMH Certification

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH/Medicaid

Frequency of Verification:

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:

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

Service Title:

Crisis Support

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:**

Sub-Category 4:

Service Definition (Scope):

Crisis Support services are provided in an ICF/IID and are used when an individual's behavioral or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention/Behavior Support. Crisis Support is time limited in nature and provides the individual with the behavioral and emotional supports necessary to allow the individual to return to his/her living arrangement. Crisis Support is not billed to the State Plan; it is a waiver service. The DMH reviews and approves all requests for admission to ICF/IIDs; therefore the Crisis Support provider cannot admit an individual to their ICF/IID program without prior approval from the DMH.

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

There is a maximum of 30 days per stay. Additional days must be prior authorized by BIDD.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	ICF/IID

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

Service Type: Other Service
Service Name: Crisis Support

Provider Category:

Agency

Provider Type:

ICF/IID

Provider Qualifications**License (specify):**

ICF/IID

Certificate (specify):

Medicaid certified

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

MS Department of Health

Frequency of Verification:

At least annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

Home and Community Supports

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

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

Home and Community Supports may be shared by up to three individuals who have a common direct service

provider agency. Individuals may share Home and Community Supports staff when agreed to by the participants and the health and welfare can be assured for each participant. The shared staff must be reflected on the participants' Plans of Services and Supports.

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

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

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

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

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

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

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

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

- ☐ Legally Responsible Person
☒ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DMH Certified Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Community Supports

Provider Category:

Agency ▼

Provider Type:

DMH Certified Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

DMH certification

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/Medicaid

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Host Home

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services ▼

Sub-Category 1:

02023 shared living, other ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

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

Host Home Services include assistance with personal care, leisure activities, social development, family

inclusion, community participation to the extent someone not receiving services would be afforded, and access to medical services. Natural supports are encouraged and supported. Supports are to be consistent with the person's skill level, identified outcomes, and interests.

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Host Home Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency ▼

Provider Type:

Host Home Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

DMH certification

Other Standard (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH/Medicaid

Frequency of Verification:

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:

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

Service Title:

Job Discovery

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:

Sub-Category 4:

Service Definition (Scope):

Job Discovery includes, but is not limited to, the following types of person-centered services: Assisting the individual with volunteerism, self-determination and self-advocacy, identifying wants and needs for supports, developing a plan for achieving integrated employment, job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, employment preparation (i.e. resume development, work procedures), and business plan development for self-employment. Job discovery is intended to be time-limited. The initial discovery process should result in the development of a person-centered career profile and employment goal or career plan. Individual staff must receive or participate in at least 8 hours of training on Customized Employment before providing Job Discovery services.

Persons eligible for Job Discovery include:

1. Someone who is an adult (age 21) and has never worked.
2. Someone who has previously had two (2) or more unsuccessful employment placements.
3. Someone who is leaving a nursing facility or ICF/IID.
4. Someone who has been in a Prevocational or Work Activity Program and has never had community employment.
5. Someone with multiple disabilities who has previously or never been successful in obtaining community employment.
6. Someone who cannot represent him/herself without assistance and who has previously or never been successful in obtaining community employment.

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

Job Discovery should not exceed 20 hours of service over a three (3) month period and will result in the development of a career profile and employment goal or career plan. Additional monthly increments/hours must be justified and prior authorized by the BIDD.

Individuals who are currently employed may not receive Job Discovery.

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

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

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	Job Discovery Agency

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

Service Type: Other Service
Service Name: Job Discovery

Provider Category:

Agency ▼

Provider Type:

Job Discovery Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

DMH Certification

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/Medicaid

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service ▼

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

Service Title:

Transition Assistance

HCBS Taxonomy:**Category 1:**

17 Other Services ▼

Sub-Category 1:

17010 goods and services ▼

Category 2:

▼

Sub-Category 2:

**Category 3:**

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

Sub-Category 4:**Service Definition** (*Scope*):

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

To be eligible:

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

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

Examples of expenses that may be covered include:

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

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Transition Assistance services shall not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes such as televisions, cable TV access or VCRs or DVD players.

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

An individual's whose ICF/IID or NF stay is acute or is for rehabilitative purposes is not eligible for this service.

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

☐ Participant-directed as specified in Appendix E

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Agency
Agency	Supervised Living Agency
Agency	Host Home Agency
Agency	Shared Supported Living Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Assistance

Provider Category:

Agency ▼

Provider Type:

Supported Living Agency

Provider Qualifications

License (specify):

Certificate (specify):

DMH Certification

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

Initially and every 3 years thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Assistance

Provider Category:

Agency ▼

Provider Type:

Supervised Living Agency

Provider Qualifications

License (specify):

Certificate (specify):

DMH certification

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transition Assistance****Provider Category:**Agency **Provider Type:**

Host Home Agency

Provider Qualifications**License (specify):****Certificate (specify):**

DMH certification

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMH

Frequency of Verification:

Initially and every 3 years thereafter.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transition Assistance****Provider Category:**Agency **Provider Type:**

Shared Supported Living Agency

Provider Qualifications**License (specify):****Certificate (specify):**

DMH Certification

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMH/Medicaid

Frequency of Verification:

Annual

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(f) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services**C-2: General Service Specifications (1 of 3)**

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

☐ **No. Criminal history and/or background investigations are not required.**

☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All providers are certified for a three year period. During the three year period, DMH staff conducts on-site monitoring visits two out of the three years, based on a rotating schedule, to ensure compliance with DMH Operational Standards. Part of the on-site monitoring process includes reviewing personnel records of staff providing services. One of the elements reviewed is whether the criminal history/background investigation was conducted and returned indicating no criminal activity before the staff person began providing services. If it is found that a criminal history/background check was not conducted for a particular staff member or member(s),

the staff member(s) are prohibited from providing services and the provider is required to develop a corrective action plan. In order for the staff member(s) to return to service delivery, the provider must provide evidence to DMH that a criminal history/background investigation has been conducted. The maximum length of time for the submission of a corrective action plan is 30 days, which may be altered by DMH given the nature and severity of the concern. Plans must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Review Committee reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. Should a Plan not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☐ **No. The State does not conduct abuse registry screening.**
- ☒ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

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

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

- ☐ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ☒ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Adult Group Home	<input type="checkbox"/>

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

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

The DMH Operational Standards and monitoring process ensure the following:

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
In-Home Respite	<input type="checkbox"/>
Day Services-Adults	<input type="checkbox"/>
Therapy Services	<input type="checkbox"/>
Behavior Support Services	<input type="checkbox"/>
Shared Supported Living	<input type="checkbox"/>
In-Home Nursing Respite	<input type="checkbox"/>
Host Home	<input type="checkbox"/>
Supported Living	<input type="checkbox"/>
Supervised Living	<input checked="" type="checkbox"/>
Job Discovery	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Transition Assistance	<input type="checkbox"/>
Support Coordination	<input type="checkbox"/>
Crisis Intervention	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Crisis Support	

Waiver Service	Provided in Facility
	<input type="checkbox"/>
Community Respite	<input type="checkbox"/>
Specialized Medical Supplies	<input type="checkbox"/>
Home and Community Supports	<input type="checkbox"/>

Facility Capacity Limit:

6

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

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

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

A. The following types of family members are excluded from being providers of In-Home Respite:

1. Anyone who lives in the same home with the individual, regardless of relationship
2. Those that are parents/step-parents of the individual receiving the services
3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services

B. Providers seeking approval for a family member to serve as In-Home Respite staff, regardless of relationship or qualifications, must maintain the following documentation in each staff's personnel record in addition to the requirements in Standard 11.2 and Chapter 12:

1. Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address.
2. Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide HCS.
3. Family members must receive the same training as non-family members and submit to background checks.

C. Family members providing HCS and In-Home Respite will only be authorized to provide a maximum of up to 172 hours per month (40 hours per week).

D. Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:

1. Observation of the family member's interactions with the person receiving services
2. Review of the Plan of Services and Supports and Service Notes to determine if outcomes are being met and
3. Review of utilization to determine if contents of Service Notes support the amount of service provided.

☐ **Other policy.**

Specify:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Certification Database

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

collection/generation (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 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 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 type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Certification Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 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 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 type="checkbox"/> Annually

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial provider applications submitted to fiscal agent

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Fiscal agent

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
--	--	--

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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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:

The state does not have non-licensed or non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input 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 = <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
<input checked="" type="checkbox"/> Other Specify: N/A	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: N/A
	<input checked="" type="checkbox"/> Other Specify: N/A	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Written Reports of Findings

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 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 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 type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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: <div style="border: 1px solid black; 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 black; 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 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.

People on and applying for the ID/DD Waiver will be assigned to an aggregate budget limit for certain services based on their level of need, age, and living situation.

The State will use the Inventory for Client and Agency Planning (ICAP), which measures "the service intensity required by an individual, considering both adaptive and maladaptive behavior." Assessments for

resource allocation are conducted by an independent contractor hired by the State on a 3 year rotating cycle.

Based on statistical analyses conducted as part of the national norming of the ICAP, the instrument produces a Service Score to reflect the level of care, supervision, and training that a person needs. The Service Scores range from 0 to 100, with lower scores indicating more significant needs. The Service Scores are then combined into nine service levels. The State, in turn, has further collapsed the ICAP service levels into five levels of need, with Level 1 including people with the relatively fewest needs (ICAP Service Scores of 90 or greater), and Level 5 including people with the greatest needs (ICAP Service Scores below 30).

The State also considers age and living situation when grouping people together. Four living situations have been defined: adults receiving full-time residential support (Supervised Living, Shared Supported Living, and Host Home), adults living at home with family, youth living at home with family, and adults living independently. Adults are defined as individuals who are 21 years of age or older.

Based on five levels of need and four age/ living situation categories, there are 18 defined groups (note that there are not groups established for people living independently and assigned to Levels 4 and 5; instances in which a person with significant needs wishes to live independently will be reviewed on a case-by-case basis). There is a budget limit for each of these 18 groups. The budget limit is the same for each person in a given group.

The budget limits apply to the following 'core budget' services: Home and Community Supports, Supported Living, Job Discovery, Supported Employment, Day Services, Prevocational, In-Home Respite. Any other required service is authorized in addition to a person's budget limit.

The budget limits are calculated based on 'model service packages' that are assumptions regarding the types and amounts of supports that people in each group require to be safe and successful in their communities. These service assumptions are then costed out using the Waiver fee schedule to calculate the budget limits. People with more significant needs are assumed to require more supports (often at higher provider payment rates) and, thus, receive higher budget limits.

The service-level assumptions in the model service packages are not themselves limits. People are required to remain within their budget limits, but have the flexibility to choose to access more hours of a given service than assumed in the model service packages (although they would need to use fewer hours than assumed for another service in order to accommodate the higher spending for the given service).

The assumptions included in the model service packages were developed based on several factors. First, the State considered detailed utilization data for people in each group. This data included the number and percent of people in each group who used a given service, the range of service usage, and similar information. Then, policy goals were considered. For example, each model service package includes an assumption that people will use Individual Supported Employment, although few people are currently utilizing this service (in practice, people may choose not to use Supported Employment and instead use more hours of Day Services or some other service). Finally, the State will conduct a validation study in which a sample of actual case files will be reviewed, as well as the individual budget to which each member would be assigned, to determine whether the budget would be sufficient to meet the needs of that person.

The budget limits do not vary based on geography. A person in a given group (level of need, age, living situation) will receive the same budget limit regardless of where in the State they reside.

The model service packages and resulting budget limits will be available for public inspection on the Department of Mental Health's website. The model service packages will detail the specific assumptions regarding services and rates, allowing the budget limit to be revisited as necessary. For example, if provider rates are increased, the model service packages will be re-priced to calculate new budget limits.

Provisions for adjusting or making exceptions to the limit based on a person's health and welfare needs include an exceptional needs review process. BIDD staff review requests for exceptional needs that could cause a person to exceed their budget limit yet have no change in ICAP score. To assist in identifying

these people, the state has added two (2) Supplemental Questions to the assessment process that address exceptional medical and behavioral needs. Definitions for exceptional medical and behavioral needs have been established. ICAP assessors employed by the independent contractor ask these questions of the respondents to the ICAP. Additionally a person's PSS team can submit requests through the Support Coordinator to the state to request a review of the assigned allocation. The team must provide supporting documentation for the request that might lead to an adjustment in the allocation limit. Reviews are conducted by BIDD staff based on established criteria and recommendations. Requests for exceptional needs can be on a short term or long term basis. Each year, before the person's PSS meeting, he/she and the PSS team are notified of the individual budget allocation. Therefore, decisions can be made at the PSS meeting regarding the services and supports that best meet the person's needs to ensure they remain at home and in the community.

- ☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

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

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

Specify qualifications:

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

- ☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each person is meaningfully and actively engaged in the development and maintenance of the Plan of Services and Supports in several ways. The person, either alone or with assistance from a chosen representative, chooses the people he/she would like to attend the development/review of the Plan of Services and Supports. It is held at a time and place convenient for the person. The person, through a person-centered planning process, determines the outcomes he/she would like to happen as a result of receiving ID/DD Waiver services. Additionally, he/she requests the types and amounts of services he/she would like to receive, within his/her resource allocation, as well as the provider(s) he/she would like to have render the services.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) The development of the Plan of Services and Supports is driven by the person centered planning process. The person or legal representative (if applicable), the Support Coordinator, provider staff and others of the person's choosing participate in the development of the Plan of Services and Supports. The Plan of Services and Supports must be revised at least annually or when changes in support needs arise.

(b) Before initial enrollment in the ID/DD Waiver, people have to first be evaluated by one of the state's five Diagnostic and Evaluation Teams. The information from the evaluation is used as part of the basis for the development of the initial Plan of Services and Supports. After the initial assessment, the person-centered planning meeting that leads to the development of the Plan of Services and Supports is considered to be part of the assessment. A person's needs are continually being assessed through monthly and quarterly contacts with him/her, the legal representative, if applicable, and with his/her providers. Adjustments to the Plan of Services and Supports and/or Activity Support Plans are made when the person requests such. The State of Mississippi is participating in the Balancing Incentive Program. As part of that, the state has chosen the ICAP as the Core Standardized Assessment to be used to assess functional needs.

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

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

Support Coordinators are also required to inquire about each person's health care needs and changes in such during monthly and quarterly contacts. Additionally, the Division of Medicaid provides a Monthly Utilization Report to Support Coordinators that lists all Medicaid services a person receives each month. This is one tool the Support Coordinator can use to determine if the person has been to the doctor, been hospitalized, or changed medications.

Health care needs are also addressed with providers. Providers are contacted at least quarterly to ascertain how their services are assisting the person in meeting stated outcomes. One of the questions is to review any changes in the person's health status.

(e) The coordination of waiver and other services is a constant activity for Support Coordinators. Through at least monthly contacts, the Support Coordinator is able to determine which services are being utilized, what new services

may be needed and what services may need to be reviewed for effectiveness. Through at least quarterly face-to-face contacts in the person's service settings, Support Coordinators are able to observe the person, talk with him/her and talk with staff to ensure all services he/she receives are adequate and appropriate.

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

(f) The Support Coordinator is responsible for ensuring all services are implemented as approved on the person's Plan of Services and Supports. This is accomplished through monitoring service provision during monthly phone contacts, onsite and face-to-face visits, and Utilization Reports from Medicaid.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Support Coordinators must, in conjunction with the person and his/her service providers, complete The Risk Assessment Tool. The tool identifies mitigation and emergency back-up strategies. The Risk Assessment Tool is completed at least annually by the Support Coordinator with input from the person, others important to the person and all providers. The information gathered is included in the PSS.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ Medicaid agency
- ☐ Operating agency
- ☐ Case manager
- ☒ Other

Specify:

All Plans of Services and Supports are entered electronically in LTSS. Medicaid, BIDD/Division of HCBS and Support Coordinators have access to the PSS at any time, based on staff roles.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Support Coordinators monitor implementation of the Plan of Services and Supports as well as individual health and welfare on a monthly basis. Support Coordinators also speak with individuals/legal representatives at least one (1) time per month or more frequently as determined by the Plan of Services and Supports or see the individual during a face-to-face contact. Detailed documentation of all contacts is maintained in the ID/DD Waiver Support Coordination Service Notes. During monthly contacts, the Support Coordinator talks with the person to:

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

services

g. Identify the need to update the Plan of Services and Supports

Throughout the month, Support Coordinators conduct any identified follow-up activities that may be needed, based on information gathered during monthly and/or quarterly contacts. Follow-up activities are documented in the Support Coordination Service Notes.

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

The effectiveness of back up plans is monitored by the Support Coordinator. Monitoring methods include talking with the person at least one (1) time per month to determine if back-up plans have been needed and if so, how were they utilized, did the plan work appropriately, and what changes, if any, need to be made to the back-up plan. Additionally the use of back up plans is monitored through quarterly contact with providers to determine if the plan has been used and if any changes/modifications are necessary to increase efficiency and effectiveness.

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

People are afforded a choice of providers when the Plan of Services and Supports is initially developed, annually at the Plan of Services and Supports meeting, when new providers are certified or at any time they become unhappy with a current provider(s). Support Coordinators are responsible for informing people about all certified providers for the services listed on the Plan of Services and Supports and for routinely assessing a person's satisfaction with services and providers (at least one (1) monthly phone contact and quarterly face-to-face visits). The DMH also maintains an electronic database on its website that allows individuals to search for providers by county.

b. Monitoring Safeguards. Select one:

- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

The entities that provide Support Coordination may also provide other direct waiver services to a person; however, those entities do not monitor the provision of Support Coordination activities. Support Coordination is monitored by staff from DMH's Division of Certification, BIDD and Medicaid.

A person receiving services can, at any time request another Support Coordinator.

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

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

In addition to person level discovery and remediation that occurs as a responsibility of Support Coordinators, DMH's Division of Certification, BIDD, and Medicaid are also responsible for discovery related to person level remediation. Through DMH's on-site monitoring process, which includes Support Coordination record reviews of individual people receiving supports, issues are identified for remediation and are addressed through a Written Report of Findings from the DMH Division of Certification to the provider. Person level discovery and remediation also occurs through DMH's serious incident reporting/tracking processes and grievance process. Data from the results of Support Coordination monitoring, serious incidents, and grievances is available on a person, a Support Coordination provider or system level basis.

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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:

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

N: # of Plans of Services and Supports reviewed in which services and supports align with identified needs D: # of Plans of Services and Supports reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual record review- monitoring checklist

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with +/- 5% margin of error
<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 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 type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

National Core Indicators- Consumer Survey

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin of error
<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 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 checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual record review - monitoring checklist

Responsible Party for 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 type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = Confidence Interval = 95% with +/- 5% margin of error
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<input type="text"/>		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"/>

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

National Core Indicators Consumer Survey Results

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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 = Confidence Interval = 95% with +/- 5% margin of error
<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 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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual record review - monitoring checklist; 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5 % margin of error
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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

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"/> 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:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Individual record review- monitoring checklist; 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin or error
<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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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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
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; 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 black; height: 20px; width: 100%;"></div>

- 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:

SP a.i.d(1) Number and percent of services and supports that were provided in the type, scope, amount, duration and frequency as defined in the POC N: # of Plans of Services and Supports reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the Plans of Services and Supports D: All Plans of Services and Supports reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

LTSS

Responsible Party for data		Sampling Approach (check each that applies):
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collection/generation (check each that applies):	Frequency of data collection/generation (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% margin of error
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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:

SP a.i.e. (1) Number and percent of individuals who were given a choice between/among service providers. N: Number of people given a choice D: All people in the sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual record review- monitoring checklist

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin of error
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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
<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:

SP a.i.e (2) Number and percent of people given an choice between/among waiver services. N: Number of people given a choice D: Number of people in the sample

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

DMH Monitoring checklist

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% with +/- 5% margin of error
<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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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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 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party(<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: <div style="border: 1px solid black; 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 black; 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 Service Plans that are currently non-operational.

☒ No

☐ Yes

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services**E-1: Overview (1 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (2 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (3 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (4 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (5 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (6 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (7 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (8 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (9 of 13)**

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

Appendix E: Participant Direction of Services**E-1: Overview (10 of 13)**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

If, upon initial evaluation it is determined that a person does not meet LOC requirements, the person/legal guardian is sent a notice within 10 business days of the ineligibility determination for ICF/IID Level of Care and the Intellectual Disabilities Waiver. This notice outlines the procedures for appealing this decision, supporting documentation required and to whom to send the information.

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

1. The person applying for services will be notified in writing with 10 business days of the denial of eligibility for LOC and, thus, his/her ineligibility for ID/DD Waiver services.
2. The person/legal representative has 30 calendar days from the date of the "Notice of Ineligibility for ICF/IID Level of Care" to submit an appeal to the Director of the BIDD. The appeal must be in writing. If the person/legal representative so desires, he/she may submit additional justification with the appeal, other than the reports from evaluators, to support his/her request. The "Notice of Ineligibility for ICF/IID Level of Care" must be included in the appeal.
3. The Director of BIDD must respond in writing within 30 calendar days of receipt of the appeal by BIDD. If sufficient justification was not submitted with the appeal, the Director may request additional information before making a decision, thus extending the 30 day time line.
4. If the Director of BIDD disagrees with the denial of eligibility for ICF/IID LOC, he/she will notify the D&E Team in writing and send a copy of the decision to the person/legal representative. At that point, the person's application for ID/DD Waiver services can be processed.
5. If the Director of BIDD agrees with the determination of ineligibility for ICF/IID LOC, the person has the right to appeal the decision to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director by the date indicated in the letter.
6. The Executive Director of the DMH will respond in writing, within 30 calendar days. If he/she feels additional information is required to make a decision he/she will request such, thus extending the 30 day time line.
7. The decision of the Executive Director of the DMH is final.

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

If a person requests a service on his/her initial Plan of Services and Supports, an increase in the amount of previously approved services, or an additional service and the BIDD/Division of HCBS denies the request, he/she can appeal to the Director of the BIDD. If BIDD/Division of HCBS staff determines a service on a person's Plan of Services and Supports is no longer appropriate and terminates the service, the person can appeal the decision to the Director of the BIDD. The person/legal representative must submit the appeal to the Director of the BIDD within 30 calendar days of the date provided in the response. The appeal must be in writing. If the person/legal representative so desires, he/she may submit additional justification, other than what has already been received by the BIDD/Division of HCBS, to support the appeal. During the pendency of the appeal, the services on the Plan of Services and Supports remain the same as before the appeal. The same timelines as listed above for ICF/IID appealing denial of eligibility for Level of Care are used in this process.

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

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

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

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

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

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

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

All records that pertain to adverse actions, the opportunity to request a fair hearing, appeal documentation and final determinations are filed in LTSS by the appropriate party.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ☒ **No. This Appendix does not apply**
☐ **Yes. The State operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Mississippi Department of Mental Health

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- ☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

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

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

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

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

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

Upon receipt of a serious incident report, DMH's Director of the Office of Incident Management categorizes the incident by type, assigns the incident a level and enters the information into LTSS. Serious incidents are assigned Levels I-III.

Level I incidents have been resolved at the service provider level. No further action is required by DMH Staff. Level II incidents require inquiry by DMH staff. Additional information is needed for resolution and/or to establish whether or not a pattern is being/has been established. Inquiry may include the submission of requested information or an on-site visit.

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

The DMH Office of Incident Management is responsible for analyzing data to identify trends and patterns. Serious incidents are analyzed by type of incident, level of incident, participant involved, staff involved, time of incident, time of reporting and cause of incident. Trends and patterns are reported to BIDD and the Office of Certification for review during on-site visits, or before, if warranted.

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

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

annually thereafter, people are also provided information, in writing and orally, about the procedures for filing a grievance.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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

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

Upon receipt of a serious incident report, DMH's Director of the Office of Incident Management categorizes the incident by type, assigns the incident a level and enters the information into LTSS. Serious incidents are assigned Levels I-III.

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

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

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

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

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DMH is responsible for overseeing the reporting and follow up to serious incidents that affect people enrolled in the waiver. Oversight is conducted on an ongoing basis through the process outlined in b-d above. As the operating agency for the waiver, DMH provides the Division of Medicaid quarterly summary reports of the categories of serious incidents related to people enrolled in the waiver.

Appendix G: Participant Safeguards

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

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

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

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

☒ **The 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).

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

Crisis Support Services providers follow all applicable state and federal ICF/IID regulations related to the use of seclusion or restraint. The state ICF/IID regulations can be viewed by going to the following website: http://www.msdf.state.ms.us/msdfsite/_static/resources/119.pdf.

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

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

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

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

Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:

- (a) A physical restraint is personal restriction that immobilizes or reduces the ability of a person to move his or her arms, legs, or head freely. Such term does not include a physical escort.
- (b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a person who is acting out to walk to a safe location.

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

Time out may not be used by waiver providers.

The following are practices employed to ensure the health and safety of people receiving services:

- A. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.
- B. Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition.
- C. Providers must ensure that all staff who may utilize physical restraint/escort successfully Mandt® training.
- D. Providers must maintain a listing of all staff members who have successfully completed required training and demonstrate competency in utilization of physical restraint.
- E. Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:
 - 1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
 - (a) A physical restraint is personal restriction that immobilizes or reduces the ability of a person to move his or her arms, legs, or head freely. Such term does not include a physical escort.
 - (b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a person who is acting out to walk to a safe location.
 - 2. Requirements that in emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the person from injuring himself/herself or others. An emergency is defined as a situation where the person's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the person being served, others served by the program, or staff.
- F. Requirements that physical restraints/escorts are used as specified in the Behavior Support Plan only when all other less restrictive alternatives have been determined to be ineffective to protect the person or others from harm. The utilization of other less restrictive alternatives must be documented in the person's case record.
- G. Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, a person must not be restrained for more than sixty (60) minutes at any one time. He/she must be released after those sixty (60) minutes. A face-to-face assessment must take place at least every twenty (20) minutes while the person is being restrained.
- H. Providers must establish and implement policies and procedures specifying that physical restraint (s)/escort must be in accordance with a written modification to the comprehensive Plan of Services and Supports and/or Crisis Intervention or Behavior Support Plan of the person being served as well as all of the following:
 - 1. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;

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

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

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

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

- 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:

The DMH is responsible for analyzing data to identify trends and patterns and improvement strategies.

At the state level, data is collected directly from the standardized data elements that are contained in DMH's serious incident reporting form and LTSS. Each data element is recorded into the LTSS by the Director of the Office of Incident Management. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined.

At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

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

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

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

1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:

- (a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
- (b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

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

Physical restraints/escort are implemented in the least restrictive manner possible. Physical restraints/escort are in accordance with safe, appropriate restraining techniques as taught in the Mandt System®. Physical restraints/escort are ended at the earliest possible time (i.e. when the individual's behavior has de-escalated and that individual is no longer in danger of harming him/herself or others).

Physical restraints/ escort is not used as a form of punishment, coercion or staff convenience. Supine and prone restraints are prohibited

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

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

a. First use of non-aversive methods;

De-escalation techniques, touch (ask permission to touch, touch only when necessary, know how to touch, know where to touch, relax and slowly touch), assisting, (stance and balance, body mechanics, body positioning) and re-direction. (Mandt System ® pages 48, 222-223)

b. Methods to detect unauthorized use of restrictive interventions;

The unapproved use of restrictive interventions is monitored through the reporting of serious incidents and grievances and the DMH on-site monitoring process. Additionally, Support Coordinators speak with each individual/legal representative at least two times per month and have quarterly face-to-face contact in which the unauthorized use of restrictive interventions can be detected and reported.

c. Required documentation for each use of restrictive interventions; and

A Behavior Management Log is maintained in the individual's case record. The log must include:

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

d. Required education and training of personnel involved in authorization and administration of restrictive interventions.

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

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

The DMH Quality Management Council is responsible for analyzing data to identify trends and patterns and support improvement strategies. The DMH Quality Management Council is responsible for providing status reports regarding the quality of care being provided by DMH certified providers and making recommendations regarding quality management functions and activities to the Bureau of

Quality Management, Operations and Standards. Data sources include the serious incident tracking database, Refer© for the tracking of grievances, DMH Written Reports of Findings, and client level data reported by certified providers. Data sources are analyzed dependent upon the data elements. All sources can be analyzed by provider. Serious incidents, including the use of restraints, can be analyzed by type of incident, level of incident, participant involved, staff involved, time of incident, time of reporting and cause of incident. Grievances can be analyzed by type of grievance, level of grievance, and participant involved. Information from each data source is shared with the Quality Management Council to identify emerging trends or patterns based on a comparison of the data.

At the state level, data are collected directly from the standardized data elements that are contained in DMH's serious incident reporting form. Each data element is recorded into the serious incident tracking database by DMH's Incident Review Coordinator and a scanned copy of the reported incident is attached in that database to create a historical record. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined. Serious incident data is reviewed quarterly by DMH's Quality Management Council to provide oversight to the incident management process.

At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH BQMOS staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

At the state level, data are collected directly from the standardized data elements that are contained in DMH's serious incident reporting form. Each data element is recorded into the serious incident tracking database by DMH's Incident Review Coordinator and a scanned copy of the reported incident is attached in that database to create a historical record. Serious incidents are reviewed to ensure that the cause of the reported incident has been identified or is being determined. Serious incident data is reviewed quarterly by DMH's Quality Management Council to provide oversight to the incident management process.

At the provider level, each provider is required to have a Quality Management Committee that reviews and analyzes their reported serious incidents. During on-site monitoring, DMH BQMOS staff reviews this process to ensure analysis is taking place and strategies to prevent re-occurrence are being put in place.

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

- a. Applicability.** Select one:

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

- b. Medication Management and Follow-Up**

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

DOM is responsible for oversight of medication management and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for people enrolled in Supervised Living is vested in a licensed physician. Each Supervised Living, Supported Living, and Shared Supported Living provider must employ appropriately trained or professionally qualified staff to administer medications if a person requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to people receiving services have daily and ongoing responsibility for medication monitoring to ensure that medications are correctly administered and that medication administration is appropriately documented in accordance with DOM requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DOM on-site compliance reviews.

First line responsibility for monitoring a person's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Supervised Living, Supported Living or Shared Supported Living setting. Staff monitoring focuses on areas identified by the physician and /or pharmacist which may be of concern. If a person is using a behavior modifying medication (psychotropic medication), the DOM program nurse will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; and (2) the person or his/her family member or guardian/conservator was provided information about the risks and benefits of the medication. Staff observations regarding the behavior which the medication has been prescribed to reduce are reported to the provider. Each waiver provider must have policies and procedures that identify the frequency of monitoring. People receiving services have a choice of physicians and pharmacies, but are encouraged to be consistent in their use of these professionals in order to ensure continuity of care and to prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated with another medication prescribed.

Additionally, the Division of Medicaid makes available an eScript information system so that prescribing

physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries. The system integrates prescription drug formularies to alert providers to adverse drug reactions.

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

All treatment shall be provided by, or provided under the direction or supervision, of professionally qualified staff. Medication is reviewed by appropriately qualified staff. Appropriately qualified staff includes physicians, physician assistants, and advanced registered nurse practitioners acting within the scope of their professional licensure.

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

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

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

DOM is responsible for oversight of medication management. DOM employs a licensed nurse who makes annual reviews of Supervised Living, Supported Living and Shared Supported Living providers to ensure they are following required procedures regarding the medication regimen of people who require such. During annual on-site compliance reviews, DOM reviews the person's Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. During annual on-site compliance reviews, the DOM program nurse reviews a sample of service recipient Medication Administration Records to identify potentially harmful practices and to ensure compliance with medication administration documentation requirements. Medication error reports are also reviewed. Provider medication management policies and practices are reviewed to ensure that:

- a. The Medication Administration Record correctly lists all medications taken by each person;
- b. The Medication Administration Record is updated, signed, and maintained in compliance with DOM medication administration documentation requirements;
- c. All medications are administered in accordance with physician's orders;
- d. Medications are administered by appropriately trained staff;
- e. Medications are kept separated for each person and are stored safely, securely, and under appropriate environmental conditions.

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

Providers are required to complete a reportable incident form for medication errors. If the medication error caused, or is likely to cause, harm, the provider must submit a copy of the Reportable Incident Form to the

Division of Medicaid. The DOM program nurse reviews medication error incident forms for completeness and determination of the nature of the incident. Provider agencies are responsible for identifying medication error trends.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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:

DMH Office of Incident Management, Division of Medicaid, and appropriate licensure boards

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

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

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

Medications given to wrong person, overdoses, missing medications

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state 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:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Monitoring checklist

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% margin of error
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

HW a.(2) The proportion of individuals who report that they feel safe in their home, neighborhood, workplace and day program/ other daily activities. N: # of individuals who report feeling safe in their home, neighborhood, workplace and day program/other daily activities D: # of individuals in survey sample

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Naitonal Core Indicators- Consumer Survey

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

collection/generation (check each that applies):		
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" 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% margin of error
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

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

Performance Measures

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

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

Performance Measure:

HW b. (1) Number and percent of serious incidents reported to DMH Office of Incident Management within timelines N: # of serious incidents received within timelines D: # of serious incidents reported

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Incident Reporting System and 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 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="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 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"/>

Performance Measure:

HW b. (2) Number and percent of serious incidents that received an inquiry as required. N: # of serious incidents that received an inquiry as required D: # of serious incidents subject to inquiry

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Incident Management System and 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 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 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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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
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; 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 black; height: 20px; width: 100%;"></div>

Performance Measure:

HW b. (3) Number and percent of serious incidents that included follow-up action that was completed as a result of inquiry N: # of serious incidents completed that included follow up action D: 3 of serious incidents requiring follow-up action

Data Source (Select one):**Other**

If 'Other' is selected, specify:

DMH Written Report of Findings

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<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 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"/>

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

Performance Measures

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

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

Performance Measure:

HW c. (1) Number and percent of people with whom restrictive intervention was utilized and that use was in compliance with DMH Operational Standards N: # people with whom restrictive intervention was utilized and that use was in

compliance with DMH Operational Standards D: # of people who had restrictive interventions**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

Individual Record Review, DMH Serious Incident Reporting System and 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 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 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 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 type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

Performance Measures

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

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

Performance Measure:

HW d. (1) The proportion of people who report having a primary care doctor N:

of people reporting having a primary care doctor D: # of people in survey sample

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<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 checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

HW d. (2) Proportion of people who have had a routine dental exam in the past year N: # of people who have had a routine dental exam in the past year D: # of people in survey sample

Data Source (Select one):**Other**

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		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 checked="" type="checkbox"/> Annually
	<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.

N/A

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- Individual problems related to the health and welfare of people enrolled in the waiver are discovered through several mechanisms – Support Coordinators identify concerns through ongoing contact, DMH review of records, serious incidents, and grievances. The method of addressing the problems is dependent upon the discovery mechanism. As individual problems are identified by Support Coordinators, Support Coordinators work with the person/legal guardian and/or provider to modify the Plan of Services and Supports to ensure health and welfare concerns are addressed in a timely manner. Individual problems identified through DMH review of records, serious incidents and/or grievances, are subject to the DMH process of requiring a provider to develop plans that must be approved by DMH. The maximum length of time for the submission

of a corrective action plan is 30 days, which may be altered by DMH given the nature and severity of the concern. Plans must address each problem, how each problem was remediated and the provider agency's plan for continued compliance with the DMH Operational Standards along with timelines for each remedial activity. DMH's Review Committee reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. DMH does provide technical assistance provider agencies to assist them with developing an acceptable Plan. Should a Plan not be acceptable or implemented as approved, DMH may exercise its authority to suspend or terminate a provider agency's DMH certification.

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

ii. Remediation Data Aggregation

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

Responsible Party(<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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; 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 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

- Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Mississippi has systems in place to measure and improve performance in meeting the six specific waiver assurances. Continuous quality improvement is based on the processes of discovery and remediation and the aggregated data produced by those activities. Quality improvement takes place on the individual, provider and system wide levels.

Quality improvement at the individual level is focused on monitoring and improving care and outcomes for the individual. The individual's Support Coordinator is primarily responsible for quality improvement at the

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

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

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

Quality improvement at the systemic level is designed to improve the overall system's delivery of care. System level discovery incorporates data from multiple sources to develop a comprehensive view of service provision. Data from the discovery processes at the individual and provider levels is utilized for system level quality improvement activities.

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

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring 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 type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

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

System improvements and design changes are targeted at three levels – individual, provider and systemic. In order for system improvements and evaluation of those improvements to take place, many parties are involved.

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

At the provider level, providers are responsible for the reporting of serious incidents. Quality Management Committees at the provider level are responsible for reviewing serious incidents and putting action(s) in place to prevent future occurrence. DMH's Office of Incident Management is responsible for tracking data related to the type of incident, individuals involved in the incident and remedial action taken. Serious incident tracking data is utilized to determine whether or not remedial actions put in place at the provider level are effective in mitigating future incidents. Should serious incidents be identified that are suspected to jeopardize the health and/or welfare of a waiver participant, DMH notifies the Support Coordinator of the incident and begins an immediate inquiry. This may include engaging the support of other entities charged with protecting vulnerable persons, such as the MS Attorney General's Office or the MS Department of Human Services. DMH staff remain involved in an incident until there is resolution of the incident or adequate investigation has been concluded.

At the systemic level, the Division of Certification maintains a database which includes citations for all providers. Data can be drilled down to the individual standards being cited to determine the need for any revisions or changes in interpretation. Additionally, trends and patterns for providers can be identified through continued citations on specific standard(s) and failure to implement their plan of compliance. Should there not be cooperation in implementing quality improvement activities, the Division of Certification will inform the DMH Review Committee to engage their assistance in determining adequate consequences related to certification status for repeated failure to properly implement approved plans of compliance.

System design changes are based on data from grievance, serious incidents and site visits. Changes are based on identified trends and patterns that may indicate the need for additional standards, clarification in standards or changes to current standards. These changes are communicated through a variety of methods. Since most system design changes require changes to DMH Operational Standards, those changes are communicated through the state's administrative procedures rules that include the public posting of changes with required public comment periods. In addition to following the administrative rules process, system design changes are also communicated to the BIDD Advisory Council that includes self advocates, advocates, providers and families.

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

The quality improvement strategy is continuously evaluated to ensure the strategy is accomplishing the intended goal of improving outcomes for people receiving waiver services.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Mississippi Division of Medicaid operates two audit units to assure provider integrity and proper payment for Medicaid services rendered. The Program Integrity Bureau investigates any suspicion of fraud or abuse reported or identified through the surveillance and utilization reporting (SURS) program. The Compliance and Financial Review Bureau conducts routine monitoring of cost reports and contracts with other agencies. Payments will be monitored through monthly reports by the Office of Mental Health Programs. In addition, these waiver services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the waiver programs to identify areas of misuse.

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (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:

**FA a.i. (1) Number and percent of claims for which payment was made where the service was included in the individual's Plan of Services and Supports. N: # of claims paid that were included in the individual's Plan of Services and Supports
D: # of total claims paid**

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

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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 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 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
<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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Procedure expense report

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

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"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

MMIS system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of provider payment rates that are consistent with rate methodology in the approved waiver application or subsequent amendment. N: # and percent of provider payment rates that are consistent with rate methodology in approved waiver application or subsequent amendment. D: Total number of payments.

Data 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

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

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

ii. Remediation Data Aggregation

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

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

DMH engaged Burns & Associates, Inc., a national consultant experienced in developing provider reimbursement rates, in 2014 to establish independent rate models that are intended to reflect the costs that providers face in delivering a given service. Specific assumptions are made for each of the category of costs outlined below. These assumptions, however, are not prescriptive and providers have the flexibility within the total rate to design programs that meet people's needs consistent with service requirements and each person's individual support plan.

The rate-setting process included:

- Conducting a series of focus groups with providers for each category of services (for example, there was a series of groups for residential habilitation providers, for case management providers, etc.)
- Inviting all providers to complete a survey related to their service design and costs
- Identification of benchmark data, including Bureau of Labor Statistics cross-industry wage and benefit data as well as rates for comparable services in other CMS Region 4 states
- Development of rate models that include the specific assumptions related to the cost of delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration
- Incorporating Inventory for Client and Agency Planning assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs
- Emailing proposed rate models and supporting documentation, inviting the parties to submit comments, preparing written responses to all comments received, and revising the rates based on these comments

Rate models were developed for all waiver services with a few exceptions. Rates for Crisis Support and Nursing Respite were maintained at previous levels, based on an earlier rate study. Therapy services and medical supplies rates are aligned with the rates paid for those services in other Medicaid programs. Transition services are reimbursed based on actual costs.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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

Appendix I: Financial Accountability

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

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

- ☒ **No. State or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- ☒ **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:

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

- ☒ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ☐ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ☐ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

⬆
⬇

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

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

⬆
⬇

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ☒ **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:

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

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:




Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- ☐ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- ☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ☐ **The following source(s) are used**
- Check each that applies:*
- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ☐ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:




Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- ☒ No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- ☐ Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:




Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		2606.00	2606.00	108197.00	2405.00	110602.00	107996.00
2		2736.00	2736.00	113606.00	2525.00	116131.00	113395.00
3		2843.00	2843.00	119286.00	2651.00	121937.00	119094.00
4	39751.24	2985.00	42736.24	125250.00	2784.00	128034.00	85297.76
5	37855.42	3134.00	40989.42	131512.00	2923.00	134435.00	93445.58

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		
		ICF/IID		
Year 1	2300		2300	
Year 2	2500		2500	
Year 3	2700		2700	
Year 4	2900		2900	
Year 5	3100		3100	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was determined by the 372 reports for this waiver for FY 2011. Based on that report the ALOS was 361 days. The State recognized this is an average and averages change based on individual consumption of services. The estimated average of 361 from historical data does not preclude anyone from receiving hospital services and therefore falling below the expected average. The State recognizes the average length of stay is long, but that is in part due to the fact there were few hospitalizations for the high number of participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates of Factor D for each year are derived by projecting the average number of users for each service, the average number of units per beneficiary and the rate set for each service. The number of users and average units per user are projected using the 372 lag report for the state fiscal year 2011.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' equals the average per capita annual costs for all other Medicaid services (ancillary) to HCBS DD Waiver beneficiary (excluding HCBS DD Waiver services cost). These estimates are based on actual costs from claims data in our MMIS system for SYF 2012 projected out with a 5% growth factor over the duration of the waiver renewal. The Factor D' assumptions are from the cost of all State Plan services while the participant was on the HCBS DD Waiver excluding drug cost.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G for each waiver year are derived using the average per diem rate for ICF/IID for SFY 2011. Future years are derived by projecting growth using 5% with is the five year average increase in rates for ICF/IID provider type in Mississippi.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates for State Plan services utilization for inpatient intermediate care facility, sub-acute and hospital level of care are derived from experience as reported in MS claims data for SFY 2012. The calculations are projected out with a growth factor of 5% over the horizon of the renewal of the waiver. The assumptions used for obtaining the aggregate Factor G' are the cost of all state plan services furnished during the beneficiary institutional stay in an ICF/IID facility. The Medicare Part D drug costs are not included in the Factor G' estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	<input type="checkbox"/>
Day Services-Adults	
In-Home Nursing Respite	
In-Home Respite	
Prevocational Services	
Shared Supported Living	
Supervised Living	
Support Coordination	
Supported Employment	
Supported Living	
Specialized Medical Supplies	
Therapy Services	
Behavior Support Services	
Community Respite	
Crisis Intervention	
Crisis Support	
Home and Community Supports	

Waiver Services	C
Host Home	
Job Discovery	
Transition Assistance	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						
Low Support	15 minutes	355	4800.00	3.57	6083280.00	
Medium Support	15 minutes					
High Support	15 minutes					
In-Home Nursing Respite Total:						4465000.00
In-home Nursing Respite	15 minutes	250	2000.00	8.93	4465000.00	
In-Home Respite Total:						
Short Term	15 minutes					
Long Term	15 min					
Short Term 2-person	15 min					
Long Term 2-person	15 min					
Short Term 3 person	15 min					
Long Term 3 person	15 min					
Prevocational Services Total:						
Low Support	hour	875	1000.00	12.52	10955000.00	
Medium Support	hour					
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2300
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Support	hour					
Shared Supported Living Total:						
Low Support	day					
Medium Support	day					
High Support	day					
Supervised Living Total:						
4-person or fewer, low support	day	300	325.00	101.91	9936225.00	
4-person or fewer, medium support	day					
4-person or fewer, high support	day					
5-person or more, low support	day					
5 person or more, medium support	day					
5 person or more, high support	day					
Medical Home	day					
Behavioral Home	day					
Support Coordination Total:						4928112.00
Support Coordination	monthly	2100	12.00	195.56	4928112.00	
Supported Employment Total:						
Job Development	15 minutes	230	240.00	6.25	345000.00	
Job Maintenance	15 min					
Supported Living Total:						
Intermittent 1-person	15 minutes	27	960.00	5.19	134524.80	
Intermittent 2-person						
Intermittent 3-person						
Specialized Medical Supplies Total:						1018877.00
Underpads					212520.00	
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2300
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	each	253	1000.00	0.84		
Disposable briefs	each	460	1800.00	0.72	596160.00	
Catheters	each	23	740.00	12.35	210197.00	
Therapy Services Total:						73525.00
Physical Therapy	15 minutes	20	100.00	25.65	51300.00	
Speech Therapy	15 minutes	5	100.00	17.80	8900.00	
Occupational Therapy	15 minutes	5	100.00	26.65	13325.00	
Behavior Support Services Total:						
Evaluation < 6 hours						
Evaluation > 6 hours						
Behavior Support Specialist - 15 min						
Behavior Support Consultant - 15 min						
Community Respite Total:						44012.80
Community Respite	15 minutes	46	260.00	3.68	44012.80	
Crisis Intervention Total:						
Intermittent - 15 min	day	1	10.00	410.40	4104.00	
Daily						
Crisis Support Total:						58080.00
Crisis Support	day	22	10.00	264.00	58080.00	
Home and Community Supports Total:						
Short Term	15 minutes	1311	3000.00	5.19	20412270.00	
Long Term						
Short Term, 2-person						
Long Term, 2 person						
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2300
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Short Term, 3-person						
Long Term, 3 person						
Host Home Total:						13750.00
Host Home	day	1	250.00	55.00	13750.00	
Job Discovery Total:						9136.00
Job Discovery	15 minutes	10	80.00	11.42	9136.00	
Transition Assistance Total:						8000.00
Transition Assistance	lifetime	10	1.00	800.00	8000.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: 2300 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 361						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						
Low Support	15 minutes	475	4800.00	3.74	8527200.00	
Medium Support	15 minutes					
High Support	15 minutes					
In-Home Nursing Respite Total:						5142500.00
In-home Nursing Respite	15 minutes	275	2000.00	9.35	5142500.00	
In-Home Respite Total:						
Short Term	15 minutes					
GRAND TOTAL: Total Estimated Unduplicated Participants: 2500 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 361						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term	15 min					
Short Term 2-person	15 min					
Long Term 2-person	15 min					
Short Term 3 person	15 min					
Long Term 3 person	15 min					
Prevocational Services Total:						
Low Support	hour	1150	1000.00	13.07	15030500.00	
Medium Support	hour					
High Support	hour					
Shared Supported Living Total:						
Low Support	day					
Medium Support	day					
High Support	day					
Supervised Living Total:						
4-person or fewer, low support	day	450	300.00	130.00	17550000.00	
4-person or fewer, medium support	day					
4-person or fewer, high support	day					
5-person or more, low support	day					
5 person or more, medium support	day					
5 person or more, high support	day					
Medical Home	day					
Behavioral Home	day					
Support Coordination Total:						6016800.00
Support Coordination	month	2500	12.00	200.56	6016800.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: 2500 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						
Job Development	15 minutes	275	360.00	6.50	643500.00	
Job Maintenance	15 min					
Supported Living Total:						
Intermittent 1-person	15 minutes	37	960.00	5.45	193584.00	
Intermittent 2-person						
Intermittent 3-person						
Specialized Medical Supplies Total:						1184330.00
Underpads	each	275	1000.00	0.90	247500.00	
Disposable briefs	each	500	1800.00	0.77	693000.00	
Catheters	each	25	740.00	13.18	243830.00	
Therapy Services Total:						77265.00
Physical Therapy	15 minutes	20	100.00	26.15	52300.00	
Speech Therapy	15 minutes	5	100.00	18.55	9275.00	
Occupational Therapy	15 minutes	6	100.00	26.15	15690.00	
Behavior Support Services Total:						
Evaluation < 6 hours						
Evaluation > 6 hours						
Behavior Support Specialist - 15 min						
Behavior Support Consultant - 15 min						
Community Respite Total:						52000.00
Community Respite	15 minutes	50	260.00	4.00	52000.00	
Crisis Intervention Total:						
Intermittent - 15 min	day	3	10.00	430.00	12900.00	
Daily						
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2500
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Support Total:						190080.00
Crisis Support	day	24	30.00	264.00	190080.00	
Home and Community Supports Total:						
Short Term	15 minutes	1425	3000.00	5.45	23298750.00	
Long Term						
Short Term, 2-person						
Long Term, 2 person						
Short Term, 3-person						
Long Term, 3 person						
Host Home Total:						28875.00
Host Home	day	2	250.00	57.75	28875.00	
Job Discovery Total:						14400.00
Job Discovery	15 mintes	15	80.00	12.00	14400.00	
Transition Assistance Total:						16000.00
Transition Assistance	lifetime	20	1.00	800.00	16000.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: 2500 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						
Low Support	15 minutes	513	4800.00	3.93	9677232.00	
Medium Support	15 minutes					
High Support	15 minutes					
In-Home Nursing Respite Total:						5833080.00
In-home Nursing Respite	15 minutes	297	2000.00	9.82	5833080.00	
In-Home Respite Total:						
Short Term	15 minutes					
Long Term	15 min					
Short Term 2-person	15 min					
Long Term 2-person	15 min					
Short Term 3 person	15 min					
Long Term 3 person	15 min					
Prevocational Services Total:						
Low Support	hour	1242	1000.00	11.55	14345100.00	
Medium Support	hour					
High Support	hour					
Shared Supported Living Total:						
Low Support	day					
Medium Support	day					
High Support	day					
Supervised Living Total:						
4-person or fewer, low support	day	486	300.00	136.50	19901700.00	
4-person or fewer, medium support	day					
4-person or fewer, high support	day					
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2700
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
5-person or more, low support	day					
5 person or more, medium support	day					
5 person or more, high support	day					
Medical Home	day					
Behavioral Home	day					
Support Coordination Total:						6498144.00
Support Coordination	month	2700	12.00	200.56	6498144.00	
Supported Employment Total:						
Job Development	15 minutes	297	240.00	7.16	510364.80	
Job Maintenance	15 min					
Supported Living Total:						
Intermittent 1-person	15 minutes	47	960.00	5.72	258086.40	
Intermittent 2-person						
Intermittent 3-person						
Specialized Medical Supplies Total:						1106670.60
Underpads	each	297	100.00	0.96	28512.00	
Disposable briefs	each	540	1800.00	0.82	797040.00	
Catheters	each	27	740.00	14.07	281118.60	
Therapy Services Total:						92025.00
Physical Therapy	15 minutes	22	100.00	27.05	59510.00	
Speech Therapy	15 minutes	7	100.00	19.40	13580.00	
Occupational Therapy	15 minutes	7	100.00	27.05	18935.00	
Behavior Support Services Total:						
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						2700
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Evaluation < 6 hours						
Evaluation > 6 hours						
Behavior Support Specialist - 15 min						
Behavior Support Consultant - 15 min						
Community Respite Total:						42822.00
Community Respite	15 minutes	54	260.00	3.05	42822.00	
Crisis Intervention Total:						
Intermittent - 15 min	day	5	10.00	451.50	22575.00	
Daily						
Crisis Support Total:						205920.00
Crisis Support	day	26	30.00	264.00	205920.00	
Home and Community Supports Total:						
Short Term	15 minutes	1539	3000.00	5.72	26409240.00	
Long Term						
Short Term, 2-person						
Long Term, 2 person						
Short Term, 3-person						
Long Term, 3 person						
Host Home Total:						45480.00
Host Home	day	3	250.00	60.64	45480.00	
Job Discovery Total:						20160.00
Job Discovery	15 minutes	20	80.00	12.60	20160.00	
Transition Assistance Total:						16000.00
Transition Assistance	lifetime	20	1.00	800.00	16000.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						2700 361

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						15879840.00
Low Support	15 minutes	339	4800.00	3.78	6150816.00	
Medium Support	15 minutes	275	4800.00	4.10	5412000.00	
High Support	15 minutes	193	4800.00	4.66	4317024.00	
In-Home Nursing Respite Total:						12323400.00
In-home Nursing Respite	15 minutes	230	6000.00	8.93	12323400.00	
In-Home Respite Total:						1881015.00
Short Term	15 minutes	200	1200.00	5.33	1279200.00	
Long Term	15 min	100	1200.00	4.07	488400.00	
Short Term 2-person	15 min	25	600.00	3.33	49950.00	
Long Term 2-person	15 min	15	900.00	2.55	34425.00	
Short Term 3 person	15 min	10	900.00	2.66	23940.00	
Long Term 3 person	15 min	5	500.00	2.04	5100.00	
Prevocational Services Total:						10190000.00
Low Support	hourly	600	1000.00	12.00	7200000.00	
Medium Support	hour	200	800.00	13.00	2080000.00	
High Support	hour	100	650.00	14.00	910000.00	
Shared Supported Living Total:						7232112.50
GRAND TOTAL:						115278597.85
Total Estimated Unduplicated Participants:						2900
Factor D (Divide total by number of participants):						39751.24
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Low Support	day	200	200.00	116.66	4666400.00	
Medium Support	day	100	150.00	147.27	2209050.00	
High Support	day	25	75.00	190.22	356662.50	
Supervised Living Total:						22554060.00
4-person or fewer, low support	day	200	300.00	184.89	11093400.00	
4-person or fewer, medium support	day	100	300.00	203.17	6095100.00	
4-person or fewer, high support	day	40	100.00	239.73	958920.00	
5-person or more, low support	day	50	325.00	168.53	2738612.50	
5 person or more, medium support	day	5	325.00	178.99	290858.75	
5 person or more, high support	day	5	225.00	199.87	224853.75	
Medical Home	day	10	150.00	302.23	453345.00	
Behavioral Home	day	10	150.00	465.98	698970.00	
Support Coordination Total:						6850032.00
Support Coordination	month	2800	12.00	203.87	6850032.00	
Supported Employment Total:						6984875.00
Job Development	15 minutes	225	2500.00	8.35	4696875.00	
Job Maintenance	15 min	125	2080.00	8.80	2288000.00	
Supported Living Total:						513200.00
Intermittent 1-person	15 min	50	1500.00	6.34	475500.00	
Intermittent 2-person	15 min	10	750.00	3.97	29775.00	
Intermittent 3-person	15 min	5	500.00	3.17	7925.00	
Specialized Medical Supplies Total:						1566214.60
Underpads	each	319	1000.00	1.02	325380.00	
Disposable briefs					918720.00	
GRAND TOTAL:						115278597.85
Total Estimated Unduplicated Participants:						2900
Factor D (Divide total by number of participants):						39751.24
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	each	580	1800.00	0.88		
Catheters	each	29	740.00	15.01	322114.60	
Therapy Services Total:						122695.00
Physical Therapy	15 minutes	25	100.00	28.99	72475.00	
Speech Therapy	15 minutes	10	100.00	21.23	21230.00	
Occupational Therapy	15 minutes	10	100.00	28.99	28990.00	
Behavior Support Services Total:						818829.00
Evaluation < 6 hours	unit	50	6.00	310.64	93192.00	
Evaluation > 6 hours	unit	50	12.00	321.27	192762.00	
Behavior Support Specialist - 15 min	15 min	25	250.00	12.70	79375.00	
Behavior Support Consultant - 15 min	15 m in	50	500.00	18.14	453500.00	
Community Respite Total:						39660.40
Community Respite	15 minutes	58	260.00	2.63	39660.40	
Crisis Intervention Total:						101429.35
Intermittent - 15 min	15 min	20	600.00	6.92	83040.00	
Daily	day	5	7.00	525.41	18389.35	
Crisis Support Total:						594000.00
Crisis Support	day	75	30.00	264.00	594000.00	
Home and Community Supports Total:						27419525.00
Short Term	15 minutes	1200	3500.00	6.18	25956000.00	
Long Term	15 min	100	2500.00	4.35	1087500.00	
Short Term, 2-person	15 min	50	1500.00	3.87	290250.00	
Long Term, 2 person	15 min	10	1250.00	2.72	34000.00	
Short Term, 3-person	15 min	15	1000.00	3.09	46350.00	
GRAND TOTAL:					115278597.85	
Total Estimated Unduplicated Participants:					2900	
Factor D (Divide total by number of participants):					39751.24	
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term, 3 person	15 min	5	500.00	2.17	5425.00	
Host Home Total:						143070.00
Host Home	day	10	150.00	95.38	143070.00	
Job Discovery Total:						44640.00
Job Discovery	15 min	50	80.00	11.16	44640.00	
Transition Assistance Total:						20000.00
Transition Assistance	lifetime	25	1.00	800.00	20000.00	
GRAND TOTAL:						115278597.85
Total Estimated Unduplicated Participants:						2900
Factor D (Divide total by number of participants):						39751.24
Average Length of Stay on the Waiver:						361

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services-Adults Total:						16432800.00
Low Support	15 minutes	350	4800.00	3.78	6350400.00	
Medium Support	15 minutes	285	4800.00	4.10	5608800.00	
High Support	15 minutes	200	4800.00	4.66	4473600.00	
In-Home Nursing Respite Total:						4107800.00
In-home Nursing Respite	15 minutes	230	2000.00	8.93	4107800.00	
In-Home Respite Total:						2287765.00
Short Term	15 minutes	250	1200.00	5.33	1599000.00	
Long Term					610500.00	
GRAND TOTAL:						117351807.20
Total Estimated Unduplicated Participants:						3100
Factor D (Divide total by number of participants):						37855.42
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	125	1200.00	4.07		
Short Term 2-person	15 min	30	600.00	3.33	59940.00	
Long Term 2-person	15 min	15	300.00	2.55	11475.00	
Short Term 3 person	15 min	10	200.00	2.66	5320.00	
Long Term 3 person	15 min	5	150.00	2.04	1530.00	
Prevocational Services Total:						6362500.00
Low Support	hourly	300	1000.00	12.00	3600000.00	
Medium Support	hour	200	800.00	13.00	2080000.00	
High Support	hour	75	650.00	14.00	682500.00	
Shared Supported Living Total:						11107218.75
Low Support	day	250	250.00	116.66	7291250.00	
Medium Support	day	125	175.00	147.27	3221531.25	
High Support	day	25	125.00	190.22	594437.50	
Supervised Living Total:						27743958.75
4-person or fewer, low support	day	225	300.00	184.89	12480075.00	
4-person or fewer, medium support	day	125	300.00	203.17	7618875.00	
4-person or fewer, high support	day	75	100.00	239.73	1797975.00	
5-person or more, low support	day	50	325.00	168.53	2738612.50	
5 person or more, medium support	day	5	325.00	178.99	290858.75	
5 person or more, high support	day	5	225.00	199.87	224853.75	
Medical Home	day	15	225.00	302.23	1020026.25	
Behavioral Home	day	15	225.00	465.98	1572682.50	
Support Coordination Total:						7583964.00
Support Coordination					7583964.00	
GRAND TOTAL:						117351807.20
Total Estimated Unduplicated Participants:						3100
Factor D (Divide total by number of participants):						37855.42
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	monthly	3100	12.00	203.87		
Supported Employment Total:						8943825.00
Job Development	15 minutes	275	2500.00	8.35	5740625.00	
Job Maintenance	15 min	175	2080.00	8.80	3203200.00	
Supported Living Total:						903675.00
Intermittent 1-person	15 minutes	50	2400.00	6.34	760800.00	
Intermittent 2-person	15 min	25	1200.00	3.97	119100.00	
Intermittent 3-person	15 min	15	500.00	3.17	23775.00	
Specialized Medical Supplies Total:						1777068.80
Underpads	each	341	1000.00	1.09	371690.00	
Disposable briefs	each	620	1800.00	0.93	1037880.00	
Catheters	each	31	740.00	16.02	367498.80	
Therapy Services Total:						132905.00
Physical Therapy	15 minutes	25	100.00	31.33	78325.00	
Speech Therapy	15 minutes	10	100.00	23.25	23250.00	
Occupational Therapy	15 minutes	10	100.00	31.33	31330.00	
Behavior Support Services Total:						937244.80
Evaluation < 6 hours	unit	60	6.00	310.64	111830.40	
Evaluation > 6 hours	unit	60	12.00	321.27	231314.40	
Behavior Support Specialist - 15 min	15 min	30	250.00	12.70	95250.00	
Behavior Support Consultant - 15 min	15 min	55	500.00	18.14	498850.00	
Community Respite Total:						39660.40
Community Respite	15 minutes	58	260.00	2.63	39660.40	
Crisis Intervention Total:						140578.70
GRAND TOTAL:						117351807.20
Total Estimated Unduplicated Participants:						3100
Factor D (Divide total by number of participants):						37855.42
Average Length of Stay on the Waiver:						361

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intermittent - 15 min	15 min	25	600.00	6.92	103800.00	
Daily	daily	10	7.00	525.41	36778.70	
Crisis Support Total:						594000.00
Crisis Support	day	75	30.00	264.00	594000.00	
Home and Community Supports Total:						27944825.00
Short Term	15 minutes	1225	3500.00	6.18	26496750.00	
Long Term	15 min	100	2500.00	4.35	1087500.00	
Short Term, 2-person	15 min	50	1500.00	3.87	290250.00	
Long Term, 2 person	15 min	10	1250.00	2.72	34000.00	
Short Term, 3-person	15 min	10	1000.00	3.09	30900.00	
Long Term, 3 person	15 min	5	500.00	2.17	5425.00	
Host Home Total:						238450.00
Host Home	day	10	250.00	95.38	238450.00	
Job Discovery Total:						53568.00
Job Discovery	15 minutes	60	80.00	11.16	53568.00	
Transition Assistance Total:						20000.00
Transition Assistance	lifetime	25	1.00	800.00	20000.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:					117351807.20 3100 37855.42 361	