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:
Elderly and Disabled (E&D)

C. Waiver Number:MS.0272
Original Base Waiver Number: MS.0272.90.R1

D. Amendment Number:MS.0272.R04.03

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/15

Approved Effective Date: 07/01/15
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Refine the process for waiver enrollment through an improved assessment instrument, utilize an algorithm for level of care (LOC)determination, reduce 100% nurse review requirement for approval of LOC reassessments and Plans of Services and Supports (PSS), remove the requirement that a physician certify a LOC determination, and update quality measures to reflect quality review based on random samples.

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)
☐ Waiver Application	
☑ Appendix A – Waiver Administration and Operation	7.
☑ Appendix B – Participant Access and Eligibility	B3-f, B-6-b, c,d,f,i,j;
☑ Appendix C – Participant Services	D-1 a,b,c,d,e,f,g,i
☑ Appendix D – Participant Centered Service Planning and Delivery	D-2 a,b; PM1, PM2,l
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	G-2 c
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

Component of the Approved Waiver	Subsection(s)

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:
Remove the requirement that a physician certify a LOC determination. Reduce 100% nurse review requirement for approval of LOC reassessments and PSS in favor of quality review samples. Update terminology in affected sections to "person" instead of participant or individual and references of plan of care to "Plan of Services and Supports (PSS)". This is being done to decrease wait time for services, to fully develop the quality strategy, and incorporate the process of person centered planning in the development of the PSS.

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*):
Elderly and Disabled (E&D)

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.0272
Waiver Number:MS.0272.R04.03
Draft ID: MS.005.04.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/12

1. Request Information (2 of 3)

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

- ☐ **Hospital**

  Select applicable level of care

  - ○ **Hospital as defined in 42 CFR §440.10**

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

  - ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- ☑ **Nursing Facility**

  Select applicable level of care

  - ◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
    The State additionally limits the waiver to individuals who are aged and/or disabled. Individuals must be 21 and over.

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

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

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

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

- [ ] **§1915(b)(1) (mandated enrollment to managed care)**
- [ ] **§1915(b)(2) (central broker)**
- [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
- [ ] **§1915(b)(4) (selective contracting/limit number of providers)**

- [ ] **A program operated under §1932(a) of the Act.**

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the E&D Waiver is to allow Medicaid eligible individuals who require nursing facility (NF)level of care to receive medical and social services in their homes or a community-based setting instead of in a NF. If not for the services provided by this waiver, the participants would otherwise be institutionalized. The goal of the waiver is to provide the highest quality of care possible to assure the waiver participants can attain and maintain life in a home and community based setting.

Waiver participants must be 21 years or older and must be aged and/or disabled. Services provided under the E&D Waiver are case management, personal care services, adult day care, in-home respite, institutional respite, home delivered meals, transition assistance, physical therapy, speech therapy, and extended State Plan home health care services.

The E&D Waiver is administered by the State Medicaid agency, which exercises administrative discretion in the supervision of the waiver and issues policies, rules and regulations related to the waiver.

The State has case management agencies that serve as the primary point of entry into the E&D Waiver. Under a provider agreement with DOM, the case management agencies are responsible for case management services for all E&D Waiver participants. The main objective of case management is continuity of care. Case management provides the comprehensive assessment by which a waiver participant's needs, preferences and goals for services are determined and arranges for those services in an organized and coordinated manner. Periodic monitoring and reevaluation of the individualized service plan is also performed by the case management agency.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level (s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Second Amendment effective 7/1/2015 - This amendment is to address process change as a result of years of input regarding administrative processes. In addition, MAC 2.0 quarterly stakeholder meetings have included this topic in discussions. Much input was received on the current processes during the implementation of the LTSS changes and many efficiencies were identified. The State notified the Mississippi Band of Choctaw Indians Health Administration via written notice regarding the waiver amendment 60 days prior to submission of the waiver amendment in order to provide an opportunity for their input. The Tribe had no comments. Public notice of the proposed changes was published on the Division of Medicaid's website. No comments were received.

2012- Public input was sought through meetings with stakeholders and providers who actively participated with recommendations for waiver changes. The primary requests were to provide Personal Care Service and to increase the amount of allowable units for in-home respite services. The Personal Care Service was requested to allow for easier transition to the E&D Waiver for those waiver applicants who had previously participated in the State's Independent Living (IL) Waiver, but was discharged due to failure to meet clinical eligibility. As a result of the Stakeholder's input, the waiver services were evaluated for efficacy and quality of care. From the extensive review, the decision was made to replace the homemaker services with Personal Care Service to more efficiently and effectively provide for the needs of the waiver participant.

Mississippi also obtains public input through the E&D Waiver review and audit process. A Medicaid review team regularly audits each E&D Waiver case management agency and service providers. This process includes home visits of a sample population for waiver participants served across the state. During the home visit, direct feedback is received from the waiver participant and/or their family members regarding the participant's satisfaction with their services, their case management, and any comments related to additional beneficial services. This feedback is then utilized to improve and/or further develop waiver services.

Another mechanism through which public input is obtained is from telephone correspondence with participants, family members or applicants regarding inquiries, complaints, or appeals.

The State notified the Mississippi Band of Choctaw Indians Health Administration via written notice regarding the waiver renewal greater than 60 days prior to submission of the waiver in order to provide an opportunity for their input. Copies of the draft were provided to the Mississippi Band of Choctaw Indians prior to waiver submission to CMS. A face-to-face meeting was held with representatives of the Tribe to discuss the waiver renewal and changes.

The State accepts any input from the provider community, advocacy groups, Medicaid beneficiaries and waiver participants at any given time.

Stakeholder meetings were held beginning six (6) months prior to submission of the renewal draft to The Centers for Medicare and Medicaid Services.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Johnson

First Name: Paulette

Title: Nurse Office Director, Long Term Care

Agency: Mississippi Division of Medicaid

Address: Walter Sillers Building, Suite 1000

Address 2: 550 High Street

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-5514 **Ext:** ☐ **TTY**

Fax: (601) 359-9521

E-mail: Paulette.Johnson@medicaid.ms.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with 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: Margaret Wilson

State Medicaid Director or Designee

Submission Date: Jun 20, 2016

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

Last Name: Wilson

First Name: Margaret

Title: Nurse Office Director

Agency: Division of Medicaid, Office of the Governor

Address: 550 High Street, #1000

Address 2:

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-5248 **Ext:** ☐ **TTY**

Fax: (601) 359-6294

E-mail: margaret.wilson@medicaid.ms.gov

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:

Third Amendment effective 7/1/2015- This amendment only changes the internal process for State Agency approval and will not result in reduced services.

2012- Personal Care Service will replace homemaker services that were provided in the previous waiver. Personal Care Service will provide similar care as the homemaker services with the added benefit of promoting continuity of care and assisting the waiver participant while out in the community. Personal Care Service will also provide for an easier transition of waiver applicants who are transitioning from other State waivers.

Transitioning Personal Care Service will involve a phase in and phase out process. Waiver participants currently receiving homemaker services will continue to receive these services until their first annual recertification. During recertification, if Personal Care Service is determined to meet the needs of the waiver participant, Personal Care Service will be added to the plan of care (POC) replacing homemaker services. The amount and frequency of Personal Care Service will be determined based on the needs of the waiver participant. If and when additional hours are needed to be increased or reduced, the POC will be updated by the case manager. Participants who are not due for an annual recertification will have the option to have Personal Care Service added as needs are reevaluated on an ongoing and continuous basis. New waiver participants will receive Personal Care Service according to their assessed needs.

During transition to Personal Care Service the State will assure that the health and welfare of the waiver participants will not be compromised. The case managers will provide essential information to the waiver participants to provide for an easy transition. The transition period will take approximately 12 months from July 1, 2012 to complete.

Medicaid's NET services will be utilized in place of Escorted Transportation service. Case managers, participants and caregivers can assist the participant with arranging NET transportation. NET is established statewide in Mississippi with adequate means to care for the waiver participants previously assisted by escorted transportation.

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.

Third Amendment effective 7/1/2015.

Mississippi assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in Mississippi's approved Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Background

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, effective March 17, 2014, which amends the requirements for qualities of home and community-based (HCB) settings. These requirements reflect CMS's intent that individuals receive services and supports in settings that are integrated in and support full access to the greater community. The final rule requires the use of a person-centered planning process to develop a person's annual Plan for Services and Supports (PSS). A summary of the requirements included in the final rule is provided below. The complete set of federal regulations for the final regulations can be found on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. The setting must:
• Be integrated in and support full access to the greater community;
• Be selected by the individual from among setting options;
• Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
• Optimize autonomy and independence in making life choices; and
• Facilitate choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include that the individual:
• Has a lease or other legally enforceable agreement providing similar protections;
• Has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
• Has Control over his/her own schedule including access to food at any time;
• Can have visitors at any time; and
• Has Physical access to the setting.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The Division of Medicaid developed and submitted Transition Plans to CMS on October 21, 2014, for Mississippi's 1915(c) Home and Community-Based (HCB) programs to ensure compliance with the requirements specified in 42 CFR § 441.30(c)(4). The final rule provides the Division of Medicaid the opportunity for the continued development and implementation of the Statewide Transition Plan by March 1, 2019.

Overview of Mississippi's 1915(c) HCBS Programs

Mississippi's 1915(c) HCB programs use a person directed, person focused planning process in determining the type and level of supports to incorporate each person's unique desires and wishes in the HCB services they receive. The goal is to provide supports for persons to receive services in settings that meet the requirements of the final rule. Persons are able to choose non-disability specific settings to receive services.

3. 1915(c) Elderly and Disabled (E&D) Waiver:
Adult Day Care services are provided in a non-residential setting which must meet the requirements of the HCB settings. Adult Day Care services provide a structured, comprehensive program with a variety of health, social and related supportive services during the daytime and early evening hours. It is designed to meet the needs of aged and disabled individuals through an individualized person centered plan of services and supports.

E&D Waiver services provided in the person's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:
• Case management,
• Home-delivered meals,
• Personal care services,
• Institutional respite services,
• In-home respite,
• Transition Assistance, and
• Expanded home health visits.

E&D services provided in a setting which is considered a non-HCB setting include:
• Institutional respite services.

The October 21, 2014, submission to CMS of the Transition Plan for HCB settings consisted of the required elements listed below:

1. Two (2) public notices were published on September 17, 2014, and September 24, 2014, in the Clarion Ledger which notified the public of public hearings which were held at the following times:
• Elderly and Disabled (E&D) Waiver – 11 a.m.
2. Two (2) Public Hearings held on September 26, 2014, at the Woolfolk Building in Jackson, MS, with teleconference, and October 3, 2014, at the War Memorial Building in Jackson, MS,
3. Comments received during the thirty (30) day comment period September 17 – October 17, 2014 were:
• The Arc of Mississippi requested the Personal Outcome Measures as either a substitute for or accompaniment to the NCI for data collection for measuring quality.
Response: The Division of Medicaid has not elected to use the Personal Outcome Measures for data collection for measuring quality for the E&D waiver because the Division of Medicaid is using the NCI performance measure for the IDD population. To use the POM would be a duplication of efforts. The Division of Medicaid currently is expanding the NCI data collection for the Aged and Disabled population which will achieve the same result.
• Beth Porter with Disability Rights Mississippi commented that the MS Statewide Transition Plan was not accessible to the constituents being served and the plan needed to be more accessible.
Response: Ms. Porter was referred to the Division of Medicaid's website and the location of the transition plans as well as instructed her to contact the Division of Medicaid to obtain a copy of the transition plan if unable to download and print. The Mississippi Division of Medicaid strives to reasonably accommodate all target audiences through communications tools, including the external website at http://medicaid.ms.gov. The website was developed with a variety of audiences in mind and includes tools to address issues for non-English speaking, aged, disabled and impaired such as font size buttons, a Google language translator tool, prominent search features, a site map and it is built on a response website frame within a content management system. The Division of Medicaid also routinely performs Web Content Accessibility Guidelines checks to ensure adherence to web standard guidelines, as well as HTML validation to be in line with W3C standards.
• Beth Porter with Disability Rights Mississippi commented "Under Section 3, Quality Management Provider Monitoring it doesn't look like you're doing any changes. It just says annually. You're just going to leave it annually instead of changing any of that? I think that should be changed -- well, that's my comment. I think that should be changed to quarterly. Thank you."
Response: The Division of Medicaid presently does not have the staffing capacity to perform quarterly monitoring. However, a committee consisting of stakeholders will be formed and will meet by June 30, 2015, to assist in evaluating the feasibility of performing quarterly or biannual monitoring activities.
CMS Review and Revised Statewide Transition Plan

On February 6, 2015, the Mississippi Division of Medicaid received a review from CMS of the October 21, 2014, submission of the Transition Plans which requires the following revisions to the Transition Plans for HCB settings.

1. The combination of each of the four (4) individual Transition Plans into one (1) Revised Statewide Transition plan. See attached Revised Statewide Transition Plan Timeline.

2. Two (2) public notices published on Wednesday, March 11, 2015, and Sunday, March 15, 2015, in the following newspapers: Clarion Ledger, Commercial Appeal and the Sun Herald. The public notices contained the dates, times and locations of three (3) additional public hearings and how the public could submit comments via a teleconference number during the public hearings, e-mail or standard mail. See attached public notices. Additionally, the Division of Medicaid broadcasted radio announcements regarding the public hearings and availability of the Revised Statewide Transition Plan.

3. Availability of the 1915(c) and 1915(i) HCB settings public notice, Revised Statewide Transition Plan, public comments and the Division of Medicaid's responses on the Division of Medicaid's website homepage at www.medicaid.ms.gov, and for those individuals without electronic/internet access, at each Medicaid Regional Office, at each Mississippi State Department of Health clinic, and at the Issaquena Department of Human Services office, at each Assisted Living facility, at each Adult Daycare facility, and Case Management agency. To request a copy be mailed or e-mailed contact the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi, 39201 or by calling 601-359-5248 or by e-mailing at Margaret.wilson@medicaid.ms.gov. Additionally, the Division of Medicaid notified the following stakeholders of the Revised Statewide Transition Plan, the public notice and public hearings and requested them to assist in notifying their constituents, including, but not limited to:

• Disability Rights of Mississippi,
• The Arc of Mississippi,
• Mississippi Council on Developmental Disabilities,
• The Five DMH IDD Regional Centers,
• The Ten Planning and Development Districts (PDDs),
• DMH, and
• Mississippi Access to Care (MAC) stakeholders.

4. A thirty (30) day comment period from March 11, 2015, through April 10, 2015:
a. Verbal and written comments will be received at the following three (3) public hearings and teleconferences:
1) Thursday, March 19, 2015, at 2:30 and 6:30 p.m. at the Hattiesburg Regional Office, 6971 Lincoln Road Extension, Hattiesburg, MS 39402. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
2) Tuesday, March 24, 2015 at 2:30 and 6:30 p.m. at the Grenada Regional Office, 1109 Sunwood Drive, Grenada, MS 38901-6601. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
3) Thursday, March 26, 2015, at 2:30 and 6:30p.m., at the Jackson Regional Office, 5360 I-55 North, Jackson, MS 39211 To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
b. Written comments will be received via:
1) Mail at the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi, 39201, or
2) E-mail to Margaret.Wilson@medicaid.ms.gov.

5. Comments received during the 30 day comment period from March 11, 2015, through April 10, 2015:
• Pandora Redmond with Professional Staffing Solutions, Greenville, Mississippi, Adult Daycare Center commented: In all due respect, with all the requirements that are asked and all the changes that have been made, we have been in compliance with a lot and we are working on enforcing some of the things that have been implemented. But one of the concerns we have had in the past is the expense of doing a lot of things, especially with the meals having variety. We do cater to the diet each client is supposed to have according to their doctor. My question is; with all the requirements, it's going to incur an expense. This is more of an expense for the daycare centers or whatever facility that is, especially if you have a lower census than most of the ones that have been in business for years. And my question is; will there be an increase in compensation to these centers for the types of services that you're offering? We are in compliance, but like I said, in order to make it even a greater individualized plan of care, we have a limited budget. And most of these clients that we serve do have some type of deficit in their care. I'm a registered nurse and I have two LPNs on staff, as well as two RNs, and that is an expense by itself. To give the care that is needed, like I said, we will have to have more compensation for the services.
Response: The Division of Medicaid will take into consideration the new requirements when the fee schedule is reviewed by the actuary firm.
• Carrol Hudspeth with Runnels Creek commented: Is there a new set of regulatory minimum standards issued for Adult Day Care Services to comply with the transition? If so, how may I get an updated copy?
Response: The Division of Medicaid is in the process of reviewing our policies, procedures and The Mississippi Administrative Code Title 23 Division of Medicaid to ensure compliance with the CMS Final Rule for Home and Community-Based Settings. New policies, procedures and/or administrative code rules will be published on our website as they are updated. Additionally, the new minimum federal regulatory requirements can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).
• Beth Porter with Disability Rights Mississippi commented: In general, DRMS would like to express its concern that person centered planning be provided to all waiver participants, not just those who live in residential settings. The plan should be clear that person centered planning will be provided to all who may live independently in the community, such as IL and TBI/SCI waiver participants. In addition, we express our concern that the plan is still too general and should include transportation if needed, for all waiver participants to have access to fully integrated activities in the community.
Response: The Person-Centered Planning process is required for all waiver persons, including in the Independent Living (IL) and Traumatic Brain Injury/Spinal Cord Injury(TBI/SCI) waivers. An update to Mississippi's Statewide Transition Plan will be made to reflect that Person Centered Planning is required throughout each of the 1915(C) and 1915(i) HCB waivers. Please see response below to question regarding transportation.
• Specific Issues related to the Currently Proposed Statewide Transition Plan received from Disability Rights of Mississippi on April 10, 2015.

o We are disappointed in the relatively non-specific nature of the plan. We would like to see a much greater level of detail and more specific tasks.
Response: The purpose of the Statewide Transition Plan is to describe how the state will bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements at 42 CFR §441.301(c)(4)(5) and § 441.710(a)(1)(2). CMS provided a HCBS Basic Element Review Tool for Statewide Transition Plans Version 1.0 to describe the level of detail required for the Statewide Transition Plan. The Division of Medicaid used this review tool to ensure that the required level of detail was present in the Revised Statewide Transition

Plan in order to successfully bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements

o The plan is not clear as to whether any of the compilations of information, such as the compilations of self-assessment results, assignment of providers to categories, or written report of findings, will be available to the public. We believe that they should be. It is important that such information be transparent, so that the public can offer the State information as to the accuracy of the conclusions. There should be similar transparency in regard to the plans of correction. The disability community has direct experience with and knowledge of these settings and how they operate on a day-to-day basis, often from the perspective of the participants. We ask that the state make the assessment results and information publicly available, and that it provide a period of public comment so the community may offer information as to the accuracy of the classification of the settings or other information. There should be similar transparency in regard to the plans of correction. We also request that any determination that a setting should be submitted to heightened scrutiny be publicly posted, along with information providing the justification for this decision. The community should be allowed to comment on this information and decision before it is submitted to CMS for heightened scrutiny.

Response: The category in which each provider falls into will be posted to the Division of Medicaid website. The Division of Medicaid understands the importance of the public's notice of and input on the Statewide Transition Plan and will continue to comply with all state and federal regulations during the implementation of the Statewide Transition Plan.

o We have a growing concern about the decision to make the waiver agents responsible for performing assessments.

Response: CMS has offered guidance in regard to complying with 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2) which states that providers can "self-assess" their compliance with the Federal requirements. The Division of Medicaid has used this guidance by including self-assessments as part of the Revised Statewide Transition Plan. Additionally, the Revised Statewide Transition Plan also includes an action item in which the persons/legal representatives assess the settings and the Division of Medicaid conducts on-site visits to assess the settings.

o It is critical that HCBS participants be educated throughout this process, as their settings may be undergoing changes, which they need to understand. They should also know what their experience in the HCBS programs is supposed to be, so they can self-advocate and complain to the appropriate people or entities. The plan does not identify a process for a person to complain about a setting's adherence to the rules, but there should be a clearly identified entity responsible for receiving complaints about a setting and the process through which they respond to an individual's complaint. We appreciate that there is some indication of education for participants and families in the timeline (p. 18), but these groups are not included in the education mentioned in the narrative (p. 11). We ask that the plan clearly describe educational activities to participants, families, and community members, and that the State plan do so at points throughout implementation.

Response: The Division of Medicaid, with guidance from CMS, will train state level and field staff of the Division of Medicaid as well as persons, families and other stakeholders about the requirements of the final rule to correct non-compliance issues. The Division of Medicaid will require case managers/Support Coordinators to provide a handout to currently enrolled persons and/or legal representatives that lists the specific requirements of HCB settings as outlined in federal regulations including the ways of submitting a complaint about a setting's adherence to the rules and will require that this handout also be included in the person's admission process.

o The plan does not mention Mississippi's plans to evaluate the current system at the point of the 2017 revision to determine the gaps in the provider system, and evaluate the need to develop new providers or settings to ensure the choices that an individual is supposed to have in the person-centered planning process, and to ensure that individuals will have providers to switch to after the 2018 notices of noncompliance. We commend the State for providing at least one year of advance notice and due process protections to individuals who need to switch settings, but are concerned that the date is very close to the end of the transition period, and there may not be sufficient time to develop sufficient settings to meet the need. We encourage the State to include an analysis of need early on in the transition process, so new providers can be developed.

Response: The Division of Medicaid implements an ongoing provider enrollment process which includes education and outreach that will continue to be used to meet person needs.

o It is not clear from Mississippi's plan how the different state agencies are working together and whether the same surveys are being used. It is important that there be overarching supervision so that there is consistency in assessment and implementation across the different agencies running the HCBS programs.

Response: The same surveys are being utilized for residential and non-residential settings by each appropriate state agency. The Division of Medicaid understands the need for consistency in the evaluation process and will develop a uniform set of standards for surveying. The Division of Medicaid will provide staff training to ensure consistency during the assessment and implementation process.

o Transportation is a barrier to community integration in the HCBS program. Transportation is a barrier to integration for individuals on the waivers. The review of the services provided by the waiver needs to look at how well the waiver services are accomplishing the stated goals, and whether the funding of the service is sufficient to meet the community integration requirement—e.g., whether the rate of pay is sufficient and policies are sufficiently lenient to attract well-qualified personal care assistants who
would be willing and able to assist in community integration activities, such as community outings, errands, etc. When evaluating the community nature of any setting, transportation from that setting should be evaluated, as should how or whether the setting overcomes the lack of readily available transportation with other services. Transportation is an important piece of community integration, because a person needs to be able to get to activities and places in the community; therefore, it should be a constant consideration when evaluating settings, services, and the overall effectiveness of the State's various HCBS programs.

Response: The Division of Medicaid requires all providers to comply with federal and state regulations regarding access to transportation in HCB settings. The Administrative Code will be revised to include requirements regarding access to transportation.

o There appears to be a lack of opportunity for input from the numerous disability agencies and organizations that constitute the disability advocacy community. There is no mention of disability advocacy organizations being involved in the vetting process for the statewide assessment tool or other pieces of this plan. The plan is largely centered on providers, assistance to providers, and provider compliance. We ask that the State more equally include all relevant stakeholders throughout implementation of the plan. We ask that the State establish a Transition Plan Stakeholder committee with a fair representation of advocacy organizations that will be allowed to review information and provide comment. We think this would be helpful to the State and ease implementation.

Response: A Statewide Transition Plan stakeholder committee will be formed and will meet no later than June 30, 2015.

o CMS officials have confirmed that any comment period for a transition work plan, or for an interim transition plan, does not lessen a state's obligation to solicit and accept public comment on a final substantive transition plan. We expect that the State will clearly announce when updates to the plan are available, and will do so in such a way that the
information will reach all stakeholders, including specific efforts to reach participants and their families. Relying on electronic notices or mechanisms used to communicate with provider networks is insufficient, and the State should make a communication plan that will ensure reliable dissemination of information in an accessible way. We would also suggest that, for the next iteration of the transition plan, the State hold information sessions across the state that can be accessed by telephone, so that the plan may be explained to participants, families, providers and community members. We also suggest that the state take comments at these sessions by making note of the questions and concerns raised at the meetings, rather than requiring that people formally comment at the meetings.
Response: The Division of Medicaid has complied with 42 CFR 441.301(c)(4) regarding public input and notice requirements for the transition plan. The public notice for the four (4) Transition Plans for HCB settings, submitted to CMS on October 21, 2014, consisted of two public notices in the Clarion Ledger, two public hearings, and a thirty (30) day comment period. The public notice for the Revised Statewide Transition Plan, to be submitted to CMS on April 24, 2015, consisted of two public notices which were published in three different newspapers, three public hearings at three separate locations throughout the state of Mississippi, a radio announcement regarding the public hearings and availability of the Revised Statewide Transition Plan, availability of the Revised Statewide Transition Plan at, at www.medicaid.ms.gov, and for those individuals without electronic/internet access, paper copies at the public hearings, at each Medicaid Regional Office, at each Mississippi State Department of Health clinic, and at the Issaquena Department of Human Services office, at each Assisted Living facility, at each Adult Daycare facility, and Case Management agency. The public was notified of the opportunity to request a copy be through standard mail or e-mail. Additionally, the Division of Medicaid notified the following stakeholders of the Revised Statewide Transition Plan, the public notice and public hearings and requested them to assist in notifying their constituents, including, but not limited to:
• Disability Rights of Mississippi,
• The Arc of Mississippi,
• Mississippi Council on Developmental Disabilities,
• The Five DMH IDD Regional Centers,
• The Ten Planning and Development Districts (PDDs),
• DMH, and
• Mississippi Access to Care (MAC) stakeholders.
The public was also given the opportunity to give comments on the Revised Statewide Transition plan at the three public hearings, via email and via standard mail.
The Division of Medicaid understands the importance of the public's notice of and input on the Statewide Transition Plan and will continue to comply with all state and federal regulations during the implementation of the Statewide Transition Plan.

CMS Review and Revised Statewide Transition Plans

6. The comprehensive assessment was completed on November 20, 2015, and includes the following:

The following waiver is silent on the settings requirements as required in the final rule: Appendix C and D:
• E&D - Appendix C and D,

The Miss. Admin. Code Title 23: Division of Medicaid, Part 208: Home and Community- Based Services Long-term Care will be filed with the Mississippi Secretary of State's Office with an effective date of August 1, 2016, with the following changes:

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.1:General

Rule Content:
A. Medicaid covers certain home and community based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D).
B. The E & D Waiver is administered and operated by the Division of Medicaid.

Determination:

Current language is in compliance with and supports the Final Rule but is silent on the following verbiage which will be added to Rule 1.1.A.:
1. Waiver persons must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.
2. The Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or on the grounds of or adjacent to institutions.

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.3:Provider Enrollment

Rule Content:

C. Provider Qualifications:
1. All providers of E&D waiver services must ensure that all employees who have direct participant contact receive an annual physical examination, including a TB skin test.
2. Providers of Adult Day Care, Personal Care Services, and In-Home Respite must satisfy the applicable qualifications to render services.

3. Qualifications for Adult Day Care Services:
a) Adult day care services must be provided by an established, qualified facility/agency.
b) Each adult day care service must meet the following requirements:
1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.
2) The facility must meet the requirements of the American Disabilities Act of 1990.
3) The facility must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.

Determination:

Current language is in compliance with and supports the Final Rule.

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.4: Freedom of Choice

Rule Content:

A. Medicaid waiver participants have the right to freedom of choice of Medicaid providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
B. Each individual found eligible for the Elderly and Disabled (E&D) waiver must be given free choice of all qualified providers. Medicaid persons have the right to freedom of choice of providers for Medicaid covered services.
Each individual found eligible for the E&D waiver must be given free choice of qualified providers.

Determination:

Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 1.4.C.:
C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.6:Covered Services

Rule Content:

2. Adult Day Care Services
a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled participants through an individualized care plan that includes the following:
1) Personal care and supervision,
2) Provision of meals as long as meals do not constitute a full nutritional regimen,
3) Provision of limited health care,
4) Transportation to and from the site, with cost being included in the rate paid to providers, and
5) Social, health, and recreational activities.
b. Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the participant’s assigned case manager.
c. To receive Medicaid reimbursement the participant must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the participant to and from the facility.

Determination:

Current language is in compliance with and supports Final Rule except the verbiage in the following which will be revised:

Rule 1.6.A.2.a)2) is revised as follows:
2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs which includes, at a minimum:
(a) A mid-morning snack,
(b) A noon meal, and
(c) An afternoon snack.

Rule 1.6.A.2.c. is in conflict with 42 CFR § 441.301(c)(4)(iv). The four (4) hour minimum requirement for provider reimbursement will be removed with the July 2017 E&D Waiver renewal to be submitted by March 2017. There will no longer be a minimum amount of hours required for reimbursement.

The following verbiage from 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5) will be added as Rule 1.6.A.2.d. and 1.6.A.2.e.:
d. Adult Day Care settings must be physically accessible to the person and must:
1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek

employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community , to the same degree of access as individuals not receiving Medicaid HCBS.
2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5) Facilitate individual choice regarding services and supports, and who provides them.
e. Adult Day Care settings do not include the following :
1)A nursing facility,
2)An institution for mental diseases,
3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
4)A hospital, or
5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.11: Due Process Protection

Rule Content:

A. The Case Manager must provide written notice to the participant when any of the following occur:
1. Services are reduced,
2. Services are denied, or
3. Services are terminated.
B. The recourse/appeal procedure notice, E&D Waiver or Notice of Action, must contain the following information:
1. The dates, type, and amount of services requested,
2. A statement of the action to be taken,
3. A statement of the reason for the action,
4. A specific regulation citation which supports the action,
5. A complete statement of the participant/authorized representative’s right to request a fair hearing,
6. The number of days and date by which the fair hearing must be requested,
7. The participant’s right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesperson, and
8. The circumstances under which services may be continued if a hearing is requested.
C. Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the participant must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

Determination:

Current language is in compliance with and supports the Final Rule.

Admin. Code Title 23: Division of Medicaid, Part 208, Chapter 1: 1915c Elderly and Disabled Waiver, Rule 1.12: Hearing and Appeals

Rule Content:

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.
B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change.

Determination:

Current language is in compliance with and supports the Final Rule.

1915(c) HCBS Waiver: MS.0272.R04.01 Elderly and Disabled Waiver Rule Content Determination, Appendix C: Participant Services, C-1/C-3: Service Specification:
1915c Elderly and Disabled Waiver

Rule Content:

A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant. The ADC must be open to provide services during normal business hours and must be open for at least eight continuous hours per day

Determination:

Current language is in compliance with and supports Final Rule but is in conflict with the following verbiage which will be revised with the July 2017 waiver renewal to say: Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment and personal preferences.

Appendix D:Participant-Centered Planning and Service Delivery D-1: Service Plan Development
1915c Elderly and Disabled Waiver

Rule Content:

The plan of care, otherwise known as the service plan, is the fundamental tool by which the State assures the health and welfare of waiver participants participating in the E&D Waiver. The State's process for developing a waiver participant's plan of care requires the plan to be based on a comprehensive preadmission screening process. A registered nurse and a licensed social worker along with the waiver participant and interested parties as requested by the participant are jointly responsible for determining the waiver participant's needs preferences and goals. The assessed information is gathered and synthesized for development of the plan of care. The plan of care includes a comprehensive emergency preparedness plan specific to meet the participant's needs.

Determination:

Current language is in compliance with and supports the Final Rule.
Appendix F: Participant – Rights, F-2: Additional Dispute Resolution
1915c Elderly and Disabled Waiver

Rule Content:

b. The informal dispute resolution process is initiated with the case management agencies at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants address disputes by first reporting to their case management team, which is composed of a registered nurse and a licensed social worker. The case management team responds to the participant within 24 hours. If a resolution is not reached within 72 hours the case management team reports the issue to the case management supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the client’s satisfaction with the new case management team within the following month and notifies DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the case management agency at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.
At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process
Determination:

Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added with the July 2017 waiver renewal: Ensures an individual’s rights to privacy, dignity and respect and freedom from coercion and restraint.

Appendix F: Participant – Rights, F-3: State Grievance/Complaint
1915c Elderly and Disabled Waiver

Rule Content:

c. The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints /grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Waiver participants must first address any complaints/grievance by reporting it to their case management team which is composed of a registered nurse and a licensed social worker. The case management team begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case management team reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the participant’s satisfaction with the new case management team

within the following month and notifies DOM of the final resolution. Upon admission to the waiver, the participant receives a written copy of their bill of rights which addresses disputes, complaints/grievances and hearings. Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Medicaid
Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process.

Determination:

Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added with the July 2017 waiver renewal: Ensures an individual's rights to privacy, dignity and respect and freedom from coercion and restraint.
Safeguards

G-1: Response to Critical Events or Incidents 1915c Elderly and Disabled Waiver

Rule Content:

Upon entry into the waiver, case managers will provide the waiver participant/and/or caregiver education and information concerning the State's protection of the waiver participant against abuse, neglect and exploitation including how participants may notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation.
When participants are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains monthly contact with each participant by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or participant representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.

Determination:

Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added with the July 2017 waiver renewal: Ensures an individual's rights to privacy, dignity and respect and freedom from coercion and restraint.

Appendix G: Participant Safeguards, G-2: Safeguards Concerning Restraints and Restrictive Interventions
1915c Elderly and Disabled Waiver

Rule Content:

The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and the quality of waiver services provided.

Determination:

Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added with the July 2017 waiver renewal: Ensures an individual's rights to privacy, dignity and respect and freedom from coercion and restraint.

Identified HCB setting requirements are located in the following documents and guidance contains specific qualities of home and community based settings:

• Consent to Receive Services
• Rights of Individuals Receiving Services
• Consent to Obtain/Release Information
• Telephone/Visitation Agreement
• Plan of Services and Supports Guidance

Additional documents and guidance included in the comprehensive assessment are the Provider Reference Guide, On-Site Compliance Review (OSCR) processes, and HCB settings monitoring procedures. The revisions to these documents will be completed by the Division of Medicaid and other respective state agencies by August 1, 2016, to incorporate the Administrative Code changes listed above.

7. A sequential timeline which includes the completion and validation of the provider self-assessment tool. The provider self-assessment tool was developed by the Division of Medicaid for residential and non-residential HCB settings based on the Exploratory Questions issued by CMS.

The provider self-assessments are to be completed and returned to the Division of Medicaid by the April 15, 2015, via Survey Monkey and hard copy. The provider self-assessments will help providers and the Division of Medicaid determine the extent providers currently meet the final rule, will be able to meet the final rule with modifications, or cannot meet the final rule. Training for providers on how to complete the provider self-assessment tool was held during December 15-31, 2014. The results of the provider self-assessments will be compiled by the Division of Medicaid by June 30, 2015.

Each provider's self-assessment will be checked for validity by the validation review committee which consists of the Division of Medicaid, Offices of Long-Term Care and Mental Health. The validation process will include an on-site validation visit of each provider's setting(s) and a "per setting" random sample of person surveys during October 1, 2015 through December 31, 2017. The random sample is selected on-site from those persons/beneficiaries attending the program when the validation process occurs.

The Division of Medicaid is prioritizing site visits in the order of how many persons are receiving services in a particular setting, largest number of facilities in a particular setting, and providers who self-identified as not meeting the requirements in the final rule.

The validation review will include a review of the CMS Exploratory Questions, , Miss. Admin. Code Title 23, Part 208, licensing reports, MSDH surveys, the provider's policies and procedures, review of a sample of person records, review of the residential and non-residential physical location and operations to ensure proximity to community resources and supports in practice, environment and safety reviews, personnel training and requirements including staffing patterns, staff qualifications, staff training, and the provider's responses to reported grievances and serious incidents. Persons' surveys will be conducted by e-mail, hard copy mailings and/or phone surveys to a sample of persons asking about their experiences in the HCB settings in order to validate provider self-assessments. The persons' surveys will be cross walked against specific setting criteria to provide their experiences in the settings during the on-site validation visit for comparison to the provider self-assessment.

The results of the validation review will determine each provider's category: Category I: Provider is in full compliance with the final rule; Category II: Provider is not in full compliance with the final rule and will require modifications; Category III: Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals; or Category IV: Provider is presumptively non-HCB. The outcome of the validation reviews will determine what, if any, remediation strategies are needed to bring each provider into compliance. Providers will be notified of their assigned category based on the completion of the validation review process by the Division of Medicaid by the end of 2017. New providers seeking to provide HCBS who do not meet the HCB setting requirements in the final rule will not be approved as a Medicaid provider or receive DMH certification.

By December 31, 2017, the Division of Medicaid will submit an amended Statewide Transition Plan that includes the number of settings within each of the following categories consisting of Adult Day Services, that: 1) fully align with the Federal requirements; 2) do not comply with the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or relocation of individuals; 4) are presumptively nonHCB, but for which the State will provide a date in which evidence and justification will be submitted to CMS to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings for evaluation by CMS through the heightened scrutiny process. These heightened scrutiny settings include the following:

• Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

• Settings in a building on the grounds of, or immediately adjacent to, a public institution;

• Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

The Division of Medicaid received on May 6, 2016 a Geographical Information System (GIS) locator which is being analyzed to determine sites that may require heightened scrutiny. Any sites identified will be reviewed for accuracy of the GIS mapping during the validation review process. Those providers determined to meet the heightened scrutiny criteria after the validation review process will receive a Written Report of Findings (WRF) for non-compliance with the final rule.

8. The process for non-compliant providers to submit a written Plan of Compliance (POC) based on results of the validation of the provider self-assessment. Non-compliance of HCB settings is determined during the validation of the provider self-assessment as described in #5 above. Providers determined to be non-compliant with the final rule will receive a Written Report of Findings (WRF) from the Division of Medicaid within forty five (45) days of the completion of the on-site validation visit. The Division of Medicaid began the validation process on July 1, 2015, and anticipates completion of each of the 423 setting sites by December 31, 2017.

Providers who receive a WRF must submit of a POC to the Division of Medicaid detailing changes in HCB settings validated as non-compliant and the timelines the provider will be in full compliance with the final rule. Providers must have their completed POC submitted within forty five (45) days of receipt of the WRF. The Division of Medicaid will review all submitted POCs for approval or request for additional information, if necessary, within forty five (45) days of receipt. A compilation list showing which category each provider falls into and the reasons for being placed into that category will be posted on the Division of Medicaid's website for public information. All non-compliant providers will be re-assessed through an on-site validation visit and a sample of person re-surveys according to their submitted POC during the calendar year 2017 to determine if they have met the requirements of their POC. If the provider is still assessed to be non-compliant the provider will receive another WRF. Another POC must be completed and submitted to the Division of Medicaid within forty five (45) days after the receipt of the WRF. The Division of Medicaid will review the submitted POC for approval or request for additional information if necessary within forty five (45) days of receipt. A second on-site validation visit will be conducted following receipt the receipt of the POC during the calendar year 2017.

No later than June 1, 2018, providers who do not meet the HCB settings requirements of the final rule following a second on-site validation visit of their second POC will be notified of failure to meet HCB settings' requirements by the Division of Medicaid and that as of March 1, 2019, they will no longer be an approved Medicaid HCBS provider through the 1915(c) HCBS programs. Accordingly, the Division of Medicaid will terminate the provider agreement. The provider has the right to appeal this decision in accordance with Part 300 of the Division of Medicaid's

Administrative Code.

Persons and/or their legal representatives will be notified by the Division of Medicaid in writing no later than June 1, 2018, if the person receives HCBS in HCB settings not in compliance with the federal regulations. The person will be required to choose an alternative HCB setting which meets federal regulations to receive their HCBS before March 1, 2019. This will allow persons one (1) years' time to make an informed choice of alternate HCB settings and HCBSs which are in compliance with the federal rule. The notification will include the Division of Medicaid's appeal process according to Miss. Admin. Code Title 23, Part 300. The person's case manager will convene a person-centered planning meeting with the person and/or their legal representative, including all other individuals as chosen by the person, to address the following:

• Reason the person has to relocate from a residential or non-residential setting and the process, including timelines for appealing the decision,
• Person's options including choices of an alternate setting that aligns, or will align, with the federal regulation, other providers in compliance of the final rule, including, but not limited to, Adult Day Care centers,
• Critical supports and services necessary/desired for the person to successfully transition to another HCB setting or provider,
• Individual responsible for ensuring the identified critical supports and services are available in advance and at the time of the transition, including, Targeted Case Manager, family, natural supports, and
• Timeline for the relocation or change of provider and/or services.

Non-compliant providers will receive ongoing technical assistance, training and follow-up on-site validation visits to determine progress toward meeting their POC. The technical assistance includes the final rule requirements via webinars, distribution of handouts by case managers to persons and families, presentations to the Adult Day Care (ADC) Association, Person Centered Thinking training to staff, collaboration with other agencies for training, invitation to national speakers for meetings and on-site/hands-on technical assistance especially to those non-compliant providers. The Division of Medicaid, with guidance from CMS, will train state level and field staff of the Division of Medicaid, as well as persons, families and other stakeholders about the requirements of the final rule to correct non-compliance issues. The Division of Medicaid will require case managers to provide a handout to currently enrolled persons and/or legal representatives that lists the specific requirements of HCB settings as outlined in federal regulations including the ways of submitting a complaint about a setting's adherence to the rules and will require that this handout be included in the person's admission process. During Calendar Year 2017, the Division of Medicaid will conduct follow-up on-site validation visits for those providers determined to continue to be non-compliant of the final rule. This timeline allows providers two (2) years to meet the HCB setting requirements of the final rule.

By December 31, 2017, the Division of Medicaid will submit an amended Statewide Transition Plan that includes a detailed remediation plan on the systemic regulatory standards and policy assessment findings that detail the dates and actions that will need to occur to assure compliance for all 1915(c) HCB programs. The Division of Medicaid will identify in the amended Statewide Transition Plan the number of individuals that will need to be re-located.

9. The process for monitoring for provider compliance. Provider compliance monitoring includes annual or every three (3) years certification reviews by the State's licensing and/or certifying agencies for residential and non-residential settings. Monitoring also encompasses annual On-Site Compliance Reviews (OSCR), on-site investigations, waiver person and/or their legal representative survey results, provider records, person records, staff licensing requirements and qualifications, and case management/support coordination visit reports.

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:
   Long Term Care, Division of Elderly and Disabled Waiver Program
   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The DOM Utilization Management/Quality Improvement Organization (UM/QIO)is contracted to make licensed physicians available for secondary review of LOC determinations that cannot be approved by the LOC algorithm or the DOM nurse. No denials will be issued other than by a physician.

   ○ **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:
DOM Health Services is responsible for contract monitoring of the services performed by the DOM UM/QIO.

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:
Monthly reports are provided to DOM by the contractor and reviewed by Health Services staff.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure 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.

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. During the QIS review, if individual problems are identified, DOM evaluates the problem to determine the root cause and how it might affect the waiver participants or the overall operation of the waiver. The QIS is reviewed annually. The review consists of analyzing aggregated reports and progress toward meeting 100% of the sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the QIS is necessary, a collaborative effort between DOM and the fiscal agent is made to meet waiver reporting requirements. The Quality Assurance (QA) nurses will utilize the QIS during all levels of QA activities.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	21	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

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

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

Specify:

The State does not employ a maximum age limit on the waiver participants. The web application does not allow the option to select "no maximum age limit" for the disabled (physical) target group.

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	19000
Year 2	19500
Year 3	20000
Year 4	20500
Year 5	21000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Transition of Participants from Nursing Home to Community
Transition individuals who have been discharged from the Independent Living Waiver

Appendix B: Participant Access and Eligibility

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

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

Transition of Participants from Nursing Home to Community

Purpose *(describe):*

The purpose for reserved capacity is to provide nursing home residents with an opportunity to transition to a home and community based setting utilizing E&D Waiver services.

Describe how the amount of reserved capacity was determined:

The number was determined by analyzing data of nursing home residents who were transitioned to the E&D Waiver as a result of a "yes" response to item Q0500B of the MDS 3.0. The targeted populations are the elderly and the physically disabled.

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	115
Year 3	130
Year 4	145
Year 5	160

Appendix B: Participant Access and Eligibility

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

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

Transition individuals who have been discharged from the Independent Living Waiver

Purpose *(describe):*

This transition occurs when individuals have been discharged from the Independent Living waiver because they no longer are able to self-direct their care. If not for the services offered in the Elderly and Disabled waiver, these individuals would be admitted to an institution for long term care support.

Describe how the amount of reserved capacity was determined:

The number was determined by analyzing the number of discharges received from the Independent Living Waiver over a period of two years.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Mississippi Division of Medicaid Administrative Code, Title 23: Medicaid Part 208, Chapter 1: Home and Community Based Services (HCBS) Elderly and Disabled Waiver and the CMS approved (and subsequent amendments to)Elderly and Disabled Waiver Document.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

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

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

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

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

  Select one:

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

    Specify percentage: [ ]

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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

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

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

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

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

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

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

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage: [ ]

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

Specify dollar amount: [ ]

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

Specify percentage: [ ]

○ **Other standard included under the State Plan**

Specify:

[ ]

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

[ ]

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

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

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

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

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

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

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

      Specify dollar amount: [ ]
  - ○ **A percentage of the Federal poverty level**

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

    Specify:

    [ ]
- ○ **The following dollar amount**

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

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

  Specify:

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

- ( ) **Other**

  Specify:

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

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

  Specify:

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

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

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

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

    Specify:

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

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

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

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

  Specify:

- ( ) **Other**

  Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ( ) **The following dollar amount:**

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

  Specify formula:

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

Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

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

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

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

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

Specify the entity:

- **Other**
  Specify:

  A provider agreement exists between Medicaid and the case management agencies for the provision of case management services. The case management agencies are responsible for performing assessments and reassessments of the level of care of individuals.

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 staff performing the initial assessment are part of a case management team that consists of a Mississippi licensed social worker (LSW) and a Mississippi registered nurse (RN). The case managers must meet all provider qualification requirements outlined in Appendix C. The case managers must have received training and certification as a qualified assessor on the assessment instrument as designated by the State.

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.

Level of care for the Elderly & Disabled Waiver is determined through the application of the comprehensive long term services & supports (LTSS) assessment instrument encompassing activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. The LTSS assessment data is entered into a scoring algorithm to generate a numerical score. The score is compared to a numerical threshold for level of care, with those at or above the threshold deemed clinically eligible. Applicants/participants scoring below the threshold may qualify for a secondary review by a DOM nurse and a tertiary review by a physician before waiver services are denied.

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:

During the recertification process, a Case Manager, who is a certified assessor, performs the level of care reassessment. The LTSS Assessment is submitted to the electronic LTSS(eLTSS), which uses a scoring algorithm to indicate whether the person meets the scoring threshold or falls below, triggering secondary review. The scoring algorithm determines whether the person continues to meet LOC requirement. DOM nurses review application packets, including the assessment and the plan of services and supports (PSS), when the LOC falls below the designated threshold or when the services requested on the PSS do not align with the needs identified on the assessment.

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

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

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

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

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

Each case management agency has a procedure for monitoring when the participant's recertification is due. In the newly implemented eLTSS system, a recertification packet is initiated and the case manager is sent an alert 90 days prior to the expiration of the current certification period. DOM provides the case management agencies with a monthly Eligibility Report, which includes participant's name, the end date of the certification period,and the end date for Medicaid financial eligibility. These three processes ensure timely recertification.

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

The case management agencies are required to keep a copy of all paper documents generated, including those with original signatures, for the period of time specified under current federal laws. The eLTSS system maintains an electronic record of all assessments and application packets, which is accessible by the DOM and the case management agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
1)PM: Number and percent of waiver applicants who receive an assessment conducted by the case management agency prior to the receipt of waiver services. N: Number of waiver applicants who receive an assessment conducted by the case management agency prior to the receipt of services. D: Total number of applicants.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
2)PM: Number and percent of waiver participants who receive a recertification assessment conducted by the case management agency within 365 days. N: Number of participants that received a recertification assessment conducted by the case management agency within 365 days. D: Total number of participants who received a recertification assessment conducted by the case management agency.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Omnitrack/eLTSS

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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:
4)The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine LOC. N: Number of reviewed LOC evaluations completed in accordance with state policies and procedures. D: Number of LOC evaluations reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure (PM) 1): Upon discovery of non-compliance, DOM obtains correct documentation; 2. The case manager conducts assessment; 3. If the individual is determined ineligible, the individual is dis-enrolled (Case managers would explore other State plan services as a possiblity for care); 4. Recoup provider payment

PM 2): 1.Upon discovery of a non-compliance, the Provider is required to complete and submit an assessment; 2. The Case management agency is required to continue services on the PSS until such time that the assessment is recieved, and/or explore other State plan services as an alternate means of care until re-enrollment is complete; 3) DOM conducts provider training on recertification process.

PM 4): 1. If problem is identified in the process, education will occur at the nurse reviewer level and/or the case management agency level, wherever the problem is identified. 2. For systemic issues that are repeated across Case Management Agencies during the monitoring process, DOM will initiate focused provider training directed to those issues. 3. For cases where a person was enrolled in the waiver and the process and procedures were not followed, DOM may request information that was lacking or updated information in order to determine if the person meets the criteria for the waiver.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The application process requires the participant or their legal representative to sign and attest to their choice of placement on an Informed Choice form. During this portion of the application process, long term care program options are explained by the case manager and the participant indicates their choice of waiver services or institutional services by evidence of their signature and service choice indicated.

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

The Case Management providers maintain original paper copies of the Freedom of Choice (Informed Choice) forms, if generated at the case management agency. The eLTSS system maintains copies of the Informed Choice forms within an electronic database which is available to DOM and the case management agency.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State subscribes to a language line service that provides interpretation services for incoming calls. The subscribed interpretation services provide access in minutes to persons who interpret English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code.
A Limited English Proficient (LEP) Policy has been established. All essential staff has received training on the use of the Language Line Service. All necessary steps have been taken to ensure that staff understand the established LEP policy and are capable of carrying it out.
The key to the telephone language interpreter service is to provide meaningful access to benefits and services for LEP persons and to ensure that the language assistance provided results in accurate and effective communication between DOM and applicants/beneficiaries about the type of services and/or benefits available and about the applicants' or beneficiaries' circumstances.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Care**		
Statutory Service	**Case Management**		
Statutory Service	**In-Home Respite**		
Statutory Service	**Personal Care Service**		
Extended State Plan Service	**Extended Home Health Services**		
Other Service	**Home Delivered Meals**		
Other Service	**Institutional Respite Care**		
Other Service	**Physical Therapy Services**		
Other Service	**Speech Therapy Services**		
Other Service	**Transition Assistance Service**		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

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):*

Adult day care (ADC) services are defined as services for aged and disabled individuals and consist of the provision of services for part of a day at a day care program site. Adult day care is the arrangement of a structured, comprehensive program which provides a variety of health, social and related supportive services in a protective setting during the daytime and early evening hours. This community-based service is designed to meet the needs of aged and disabled individuals through an individualized care plan, including personal care and supervision, provision of meals as long as meals do not constitute a full nutritional regimen, medical care, transportation to and from the site, social, health and recreational activities. Adult day care activities must be allowable only to the degree that they are not diversionary in nature and are included in a plan of care related specific, verifiable and monitored by the participant's assigned case manager. Transportation between the individual's place of residence and the adult day care center will be provided as a required component part of an adult day care services. The cost of transportation is included in the ADC rate.

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

A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant. The ADC must be open to provide services during normal business hours and must be open for at least eight continuous hours per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Adult Day Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

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

Certificate *(specify):*

Other Standard *(specify):*
The ADC must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.
The ADC must meet the physical and social needs of each waiver participant. The ADC program will comply with State Medicaid administrative codes/policies regarding the following:
• Activity programs
• Activities of Daily Living
• Medication oversight while in the ADC
• Coordination of care with the E&D case managers
• Providing social services to waiver participants and families
• Providing a minimum of one meal per day to meet the waiver participant's nutritional needs
• Providing safe, reliable transportation at no extra cost to and from the ADC for waiver participants to attend the ADC
• Emergency procedures including medical and nonmedical
• Providing ancillary services
• Facility layout, design and construction
• Providing a safe, nonhazardous environment
• Utilization of volunteers
• Quality assurance measures
• Liability insurance to meet the needs of the entity

Mississippi Administrative Code Title 23: Medicaid Part 208 Chapter 2 Rule 1.3 requires that all Adult Day Care Agencies must keep a record of the volunteer's hours and activities. Volunteers must be individuals or groups who desire to work with adult day service participants. Volunteers must successfully complete an orientation/training program. The responsibilities of volunteers must be mutually determined by the volunteers and staff. Duties must be performed under the supervision of facility staff members. Duties must either supplement staff in established activities or provide additional services for which the volunteer has special talent/training. The facility must not use volunteers in place of required staff and should use volunteers only on a periodic/temporary basis.

The ADC must also adhere to the following standards for the transportation driver and the ADC vehicles:
DRIVER REQUIREMENTS
*All drivers must abide by state and local laws.
• All drivers must be at least 18 years of age and have a current valid driver license to operate the transportation vehicle (s) for the ADC.
• Drivers who receive citations and are convicted of two moving violations or accidents related to transportation will not be permitted to provide transportation.
• Drivers must not have had their driver license suspended or revoked for moving traffic violations in the previous five (5) years.
• The ADC must require that the drivers comply with Mississippi Statute regarding criminal background checks, including fingerprinting. The ADC must conduct criminal background checks on all drivers.Any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed as a direct care provider. Drivers must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

* The ADC must verify that drivers are not listed on the Mississippi Sex Offender Registry.

In addition to any federal, state, county, or local requirements, all vehicles must meet the following

requirements:
• The number of persons in the vehicle, including the driver, must not exceed the vehicle manufacturer's approved seating capacity.
• All vehicles must have adequately functioning heating and air-conditioning systems and must maintain a temperature at all times that is comfortable to the participant.
• All vehicles must have functioning seat belts and restraints as required by federal, state, county, or local statute or ordinance. All such vehicles must have an easily visible interior sign that states: "ALL PASSENGERS MUST USE SEAT BELTS". Seat belts must be stored off the floor when not in use.
• Each ADC provider must have at least two (2) seat belt extensions available.
• For use in emergency situations, each vehicle must be equipped with at least one seat belt cutter that is kept within easy reach of the driver.
• All vehicles must have an accurate, operating speedometer and odometer.
• All vehicles must have two exterior rear view mirrors, one on each side of the vehicle.
• All vehicles must be equipped with an interior mirror for monitoring the passenger compartment.
• The exterior of all vehicles must be clean and free of broken mirrors or windows, excessive grime, major dents or paint damage that detracts from the overall appearance of the vehicles.
• The interior of all vehicles must be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.
• All vehicles must have the ADC provider's business name and telephone number displayed on at least both sides of the exterior of the vehicle. The business name and phone number must
appear in lettering that is a minimum of three (3) inches in height and of a color that contrasts with the surrounding background.
• To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that Medicaid waiver participants are being transported. The name of the ADC provider's business may not imply that Medicaid waiver participants are being transported.
• The vehicle license number and the ADC local phone number must be prominently displayed on the interior of each vehicle. This information and the complaint procedures must be clearly visible and available in written format in each vehicle for distribution to participants upon request.
• Smoking must be prohibited in all vehicles at all times. All vehicles must have an easily visible interior sign that states: "NO SMOKING".
• All vehicles must carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
• All vehicles must be operated within the manufacturers safe operating standards at all times.
• All vehicles must be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash.
• Each vehicle must contain a current map of the applicable geographic area with sufficient detail to locate participant's addresses.
• Each vehicle must be equipped with an appropriate working fire extinguisher that must be stored in a safe, secure location.
• Insurance coverage for all ADC vehicles must be in compliance
with state law, and any county or city ordinance.
• Each vehicle must be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer.
• The ADC provider must require that all their vehicles have a real-time link, phone, or two-way radio. Pagers are not acceptable as a substitute.
• Vehicles must comply with the Americans With Disabilities Act (ADA) Accessibility Specifications for Transportation. The ADC providers must maintain a current copy of the ADA vehicle requirements and inspect their vehicles for compliance during the scheduled bi-annual vehicle inspections. Vehicles used for transporting beneficiaries with disabilities must be in compliance with applicable ADA vehicle requirements in order to be approved for use under this program.
The ADC provider is responsible for ensuring that all vehicles meet or exceed local, State, and federal requirements, and manufacturer's safety mechanical operating, and maintenance
Standards and these standards are maintained at all times. The ADC provider must:
• Inspect all vehicles prior to the operations start date and at least every six (6) months thereafter.
• Test all communication equipment during regularly scheduled vehicle inspection.
• Records of the ADC scheduled bi-annual vehicle inspections must be maintained and made available to DOM upon request.
• The ADC provider must comply with State motor vehicle requirements and maintain a State inspection sticker for all vehicles.
Authorized employees of DOM or the ADC provider must immediately remove from service any vehicle or driver found to be out of compliance with these requirements or with any State or federal regulations. The vehicle or driver

may be returned to service only after the ADC verifies that the deficiencies have been corrected. Any deficiencies and actions taken to remedy deficiencies must be documented and become a part of the vehicle's and the driver's permanent records.

The ADC must provide at a minimum forty (40) hours of classroom training initially upon employment to each employee. The training, to be conducted, must include disability awareness, ethical relationships, the need for respect for the individual's privacy and property, Vulnerable Person's Act/laws, boundaries of a caregiver, managing care of a difficult client, and emergency preparedness. Instructions will cover the basic elements of body functions, infection control procedures, maintaining a clean and safe environment, appropriate and safe techniques in incontinence care, transfers, and equipment use. All ADC staff must demonstrate competency to perform each task pertinent to their job. The ADC is required to provide annual training/in-services for each staff and must include at a minimum training on infection control, Vulnerable Person's Act/laws, and emergency preparedness.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid.

Frequency of Verification:

Verification is performed before initial enrollment as a waiver provider and annually thereafter. The provider must maintain evidence of compliance with all Medicaid policies relevant to the operation of the ADC. Medicaid reserves the right to inspect the ADC at any given time and request for evidence of compliance. Failure to comply with Medicaid policies may result in revocation of a Medicaid provider number.

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):

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):*

Definition and Objective: Case Management (CM) is the term used to describe the many approaches needed to meet the service needs of persons who are at risk for institutionalization. Case Management coordinates services to assure the health and social needs, preferences and goals of the persons are met. It is the mechanism by which services are identified and monitored for these persons in an effort to provide continuity of care and avoid costly duplication of services. Case management services also include the coordination and facilitation of transitioning nursing facility residents to the community to receive Elderly and Disabled Waiver services. Mississippi does not claim additional cost for the facilitation of transition assistance services.

The case managemet agency coordinates waiver services through the PSS. Once the PSS is developed the participant and/or their caregiver is given a list of qualified providers to choose from in their service area. The participant and/or their representative reviews the list of qualified providers to determine which provider would best meet the needs, preferences and goals of the participant. The participant and/or representative is given an opportunity in some instances to meet the provider prior to the selection in order to make a more informed choice. Once all options are taken into consideration the participant and/or caregiver selects the provider they feel best meets their needs.

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

A unit of service equals all case management activities provided in one month. Case management reimbursement is a flat rate which is billed monthly after the service is provided. Case Managers are required to visit the participant on a monthly basis and case management services are centered in the home of the person.

The case management team, consisting of the registered nurse (RN) and the licensed social worker (LSW), must conduct a face to face visit together when an initial assessment is performed. At a minimum thereafter, the case manager must visit the participant on a quarterly basis. The RN must be available at all times for consultation related to a change in status of the person. The case manager will be allowed a maximum of one visit per quarter to the participant while the participant is at an Adult Day Care facility. This does not count as the quarterly RN visit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Team

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Team

Provider Qualifications

License *(specify):*

A registered nurse must maintain an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, with a minimum of two (2) years of nursing experience with aged and/or disabled individuals. It is also beneficial if the nurse has knowledge of geriatrics, clinical assessment techniques, disease processes, rehabilitation principles, psycho-social needs evaluation, and familiarity with public and private funding sources.

A social worker must have a current and active social work license in good standing with a bachelor's degree in social work or other health related field and two years of experience in direct care services for the aged and/or disabled clients. If the RN or the LSW has less than two years experience, they must receive at least 90 days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two years of waiver experience.

Certificate *(specify):*

All case managers must be certified to perform assessments by the method defined by the State.

Other Standard *(specify):*

The State restricts case management services to agencies (i.e., any willing Medicaid enrolled provider agency) to enable the State to provide better supervision and oversight of the case management activities. Agencies have the infrastructure to provide regular and ongoing supervision. In addition, agencies have a sufficient number of supervisors and quality assurance staff to provide training, support and oversight of all case management activities as well as health

and safety issues. Agency supervisory staff conduct unannounced home visits to ensure quality of monitoring, and provide additional training to staff as needed. A statewide agency based system of case management assures the state that, in the event of a major disaster or catastrophe, such services as case management, records management, employee staffing and payroll suffer minimal interruption and benefit from sister network agency support. A statewide case management provider system also encourages an effective and efficient opportunity for appropriate collaboration of effort with other services with statewide central offices/contacts such as Area Agencies on Aging, Public Housing Authorities, Department of Rehabilitation Services or the Mississippi Access to Care Centers.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Division of 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:
Respite

Alternate Service Title (if any):
In-Home Respite

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):*
In-home respite services are provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those person's normally providing the care.
Respite service is non-medical care and supervision provided to the client in the absence of the client's primary full-time, live-in caregiver/caregivers on a short-term basis. Services are to assist the caregiver/caregivers during a crisis situation and/or as scheduled relief to the primary caregiver/caregivers to prevent, delay or avoid premature institutionalization of the client.
In-home respite services are provided in the home of the client. The client must be homebound due to physical or mental impairments where they are normally unable to leave home unassisted, require 24 hour assistance of the caregiver, and unable to be left alone and unattended for any period of time.

Minimum Program Requirements/Service Activities

All providers of in-home respite services under the Home and Community-Based Service Waiver program must adhere to the following minimum program requirements and service activities:
A) The respite provider must provide one or more of the following primary activities: companionship, support or general

supervision, feeding and personal care needs. The provision of these services do not entail hands-on nursing care. Any assistance with activities of daily living are incidental to the care of the individual and are not provided as discrete services.
B) Safety--The in-home respite provider should be aware of potential hazards in the client's home environment and should do everything possible to ensure a safe environment for the client.
C) Reporting-- In-home respite staff shall report abusive behavior or situations to their supervisor immediately. Also, such behavior by a client should be documented in the case record.
D) Harrassment- In-home respite staff shall not allow or be subjected to sexual harrassment or advances by clients. This kind of behavior should not be tolerated. The staff must firmly state to the client or family member in the home that such behavior will be reported to the supervisor. The client and caregiver should be notified that such behavior could jeopardize the service being received in the future.
E) The in-home respite provider shall note on the record of contact all factual observation, contacts, or visits with the client and actions or behavior displayed by the client. This documentation is essential in determining if changes should be made in the PSS. It is also essential to show that certain tasks were performed on certain dates and times. Futhermore, the case record documentation is a valuable source of information in case of legal action. The in-home respite supervisor/provider agency must review copies of the in-home respite contact sheets for each visit indicating arrival and departure times, any services performed while in the home, any other pertinent information concerning the person, and signature of the caregiver to verify services were received. The documentation must be maintained in the provider files.

F) Coordination with Case management--The in-home respite supervisor shall maintain regular and ongoing communication with the case management provider regarding case-managed respite clients. Such communication will keep both the respite provider and case manager abreast of the client's status, and this helps in deciding whether to continue or to terminate services.
1) The case manager shall develop and direct the PSS for case managed clients that are referred for respite services.
2)The respite provider must report to the case management agency any information pertinent to the person's status.

G) Termination of respite services-clients receiving respite services shall be terminated based on the following criteria:
1) Death;
2) Relocation out of state or services area;
3) Increase of informal or formal support;
4) Improved health status or condition;
5) Client and/or caregiver becomes abusive and belligerent, including sexual harassment;
6) Client and/or caregiver refused services;
7) Caregiver/client reports that he/she no longer needs the service;
8) Caregiver does not return to relieve respite provider as scheduled. Exceptions may be made in extreme cases of emergency;
9) Client is placed in a long term care facility;
10) Client is not Medicaid eligible;
11) The client's home environment is not safe for services to be rendered
Any situation involving the above criteria must be reported to the supervisor and waiver case manager, and documented in the client's case record.

The case management agency is the first line of contact with the client and problem cases are reported to the Division of Medicaid. A decision to terminate is ultimately the responsibility of the State. After the State has notified the case management agency that the respite service is being terminated, the case management agency provides to the client written notification of the decision, the right to appeal, and the procedures for requesting an appeal.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit of service equals 15 minutes of relief to the caregiver. Respite will be approved for no more than sixty(60) hours per month to any client. Any respite greater than sixteen (16) continuous hours must have prior approval by the case management team.

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	Qualified In-Home Respite 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:
Qualified In-Home Respite Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The In-Home Respite agency will employ qualified in-home respite providers and qualified in-home respite supervisors.

IN-HOME RESPITE PROVIDER--Must be a high school graduate, have a GED, and four or more years experience as a direct care provider to the aged or disabled. Must demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity. Must exhibit basic qualities of warmth and maturity and be able to respond to clients and situations in a responsible manner.
Additional requirements of the in-home respite provider are as follows:
-Be at least 18 years of age;
-Possess a valid Mississippi driver's license, and have access to reliable transportation;
-Be first aid and CPR certified;
-Be physically able to perform the job tasks required and assurance that communicalbe diseases of major public health concern are not present, as verified by a physician;
-Have interest in, and empathy for, people whao are ill, elderly, or disabled;
-Be emotionally mature and able to respond to clients and situations in a responsible manner;
-Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people;
-Must not have been convicted of a crime substantially related to the dependent population or any violent crime;
-Must be able to recognize the signs of abuse, neglect or exploitation and the procedures to follow as required in the Vulnerable Adult Act; and
-Must have knowledge of how to prevent burns, falls, fires; and emergency numbers to contact emergency personnel if required.

IN-HOME RESPITE SUPERVISOR-Must have the following qualifications:
1) A bachelor's degree in social work, or a related profession, with one year of direct experience working with aged and disabled clients, and two years of supervisory experience, or
2) A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.), with one year of direct experience working with aged and disabled clients, and two years of supervisory experience, or
3) A high school diploma with four years of direct experience working with the aged and disabled clients, and two years of supervisory experience.
The In-Home Respite Supervisor have the following responsibilities:
-Supervise no more than twenty full-time respite workers
-Make home visits with respite workers to observe and evaluate job performance and submit Supervisory reports along with monthly activity sheet.
-Review and approve service plans
-Receive and process request for service
-Be accessible to respite workers for emergencies, case reviews, conferences, and problem solving
-Evaluate the work, skills, and job performance of the respite worker
-Interpret agency policies and procedures relating to the In-Home Respite program
-Prepare, submit, or maintain appropriate records and reports
-Plan, coordinate, and record ongoing in-service training for the in-home respite staff

The In-Home Respite Supervisor is directly responsible to the Agency's Director and is responsible for the regular, routine, activities of the In-Home Respite Program in the absence of the Director.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Medicaid

Frequency of Verification:
Verification is done by the Division of Medicaid before initial enrollment as a waiver provider and through periodic provider reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care Service

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):*
Personal Care Services (PCS)are non-medical support services to assist the beneficiary in meeting daily living needs and ensure optimal functioning at home and/or in the community. Services must be provided in accordance with a participant's PSS. Personal Care Service include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Meal preparation may be provided, however, the cost of meals is not covered. Housekeeping chores may be provided if the care is essential to the health and welfare of the individual, rather than the individual's family. Personal Care Service may also involve hands-on assistance or cuing/prompting the participant to perform a task; accompanying and assisting the participant in accessing community resources and participating in community activities; supervision and monitoring in the participant's home, during transportation, and in the community setting. The Personal Care Service may accompany, when medically justified, participants during transport with transport provided by the Medicaid NET provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit of service equals 15 minutes. Personal Care Service will be approved based upon needs.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Personal Care Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Service

Provider Category:
Agency
Provider Type:
Qualified Personal Care Service Agency
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Qualifications-
Personal Care Service providers or personal care attendants must meet the minimum requirements as follows:
- must be at least 18 years of age
- must be a high school graduate, have a GED or demonstrate the ability to read and write adequately to complete required forms and reports of visits
-must maintain current and active first aid and CPR certification
-must not have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(f) of the Mississippi Codes, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
- must be able to carry out and follow verbal and written instructions
- must have no physical/mental impairments to prevent lifting, transferring, or providing any other assistance to the client
- must be physically able to perform the job tasks required and assurance that communicable diseases of major public health concern are not present, as verified by a physician
-must possess a valid Mississippi's driver's license, and have access to reliable transportation.
-must be able to communicate effectively
-must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant services

The PCA must receive at a minimum forty (40) hours of classroom training initially upon employment. The training, to be conducted, must include disability awareness, ethical relationships, the need for respect for the individual's privacy and property, Vulnerable Person's Act/laws, boundaries of a caregiver, managing care of a difficult client, and emergency preparedness. Instructions will cover the basic elements of body functions, infection control procedures, maintaining a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming to include: sponge, tub or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet.
The PCA must demonstrate competency to perform each task of assistance with activities of daily living to the hiring agency prior to rendering any services under the waiver. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements.
The agency is required to provide annual training/in-services for each PCA pertinent to individual needs of the attendant, but at a minimum must include training on infection control, Vulnerable Person's Act/laws, and emergency preparedness. Evidence of such training must be readily availabe upon request of DOM.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Medicaid

Frequency of Verification:
Review of the Qualified Personal Care Service Agency will be done upon initial enrollment and on a bi-yearly basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Extended Home Health Services

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 health may be a combination of skilled nursing and home health aide services provided in the individual's home. Home Health Care Services provided through the waiver are in addition to the limitations on amount, duration and scope specified in the State Plan. The provider qualifications listed in the State Plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Extended State Plan visits begin on visit 26 of the fiscal year. The first 25 home health visits each fiscal year are state plan visits. Any visit over the 25 is only available to the participant if approved through the waiver program. Each case is considered on an individual basis and with appropriate documentation to support the request. Ongoing evaluation of the skilled nurse(SN) notes are required of the case management agency and subsequent approval of skilled (SN) visits are requested to DOM.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Home Health Services

Provider Category:
Agency
Provider Type:
Qualified Home Health Agency
Provider Qualifications

License *(specify):*

Certificate *(specify):*
All home health agencies must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid (DOM)with a copy of its current State license certification and/or recertification, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need (CON) approval when applicable, and execute a participation agreement with DOM.

Other Standard *(specify):*
The Agency must perform criminal background checks on all direct care employees. The agency must ensure direct care providers have current and active license and or certifications, are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion List.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Medicaid
Frequency of Verification:
At time of initial enrollment and at time of recertification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Delivered Meals

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 nutritionally balanced meal delivered to the home of an eligible participant who is unable to leave his/her home without assistance, unable to prepare their own meals, and/or has no responsible caregiver in the home.
The purpose of home delivered meals is to:
1) Meet the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life;
2) Keep the individual in his/her home rather than in an institution.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit of service is one meal delivered. One meal per day, seven days a week will be the maximum meal services allowed. The maximum number of meals that are billable per month is equal to the number of days in the month. Shelf-stable meals are provided to the homebound for designated holidays, weather or other emergencies, elections and various community events.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Qualified vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
All vendors must be certified through the Mississippi State Department of Health.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Planning and Development District and/or the Division of Medicaid is responsible for verification.
Frequency of Verification:
Verification is ongoing.

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:
Institutional Respite Care

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):*
Institutional Respite Services are services provided to participants who are unable to care for themselves and because of the absence or need for relief of those persons normally providing this care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to thirty calendar days per fiscal year. The days do not have to be taken concurrently.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid certified

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Institutional Respite Care

Provider Category:
Agency
Provider Type:
Medicaid certified
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Medicaid certified Hospital, Nursing Facility, Licensed Swing Bed Facility

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

Upon initial enrollment and recertification set forth in the state or federal guidelines for the above stated facilities.

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:

Physical Therapy Services

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):*

Physical therapy services are medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and the rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease. Services are provided by a qualified home health agency in the home of the participant.

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

One unit of service equals one visit. Physical Therapy Services will be approved based upon needs of the participant.

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	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Qualified Home Health Agency

Provider Qualifications

License *(specify):*

The physical therapist must meet the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi. The physical therapist must have a current and active license issued by the appropriate licensing agency to practice in the State of Mississippi.

Certificate *(specify):*

All home health agencies must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid (DOM)with a copy of its current State license certification and/or recertification, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need (CON) approval when applicable, and execute a participation agreement with DOM.

Other Standard *(specify):*

The Agency must perform criminal background checks on all direct care employees. The agency must ensure direct care providers have current and active license and or certifications, are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion List.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division Of Medicaid

Frequency of Verification:

At time of initial enrollment and at time of recertification.

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:

Speech Therapy Services

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):*
Speech-language pathology (speech therapy) services are medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma or congenital anomaly. Services are provided by a qualified home health agency in the home of the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit of service equals one visit. Speech Therapy Services will be approved based upon needs of the participant.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy Services

Provider Category:
Agency
Provider Type:
Qualified Home Health Agency
Provider Qualifications
License *(specify):*
The speech therapist must meet the state and federal licensing and/or certification requirements to perform speech therapy services in the State of Mississippi. The speech therapist must have a current and active license issued by the appropriate licensing agency to practice in the State of Mississippi.
Certificate *(specify):*
All home health agencies must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid (DOM)with a copy of its current State license certification and/or recertification, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need (CON) approval when applicable, and execute a participation agreement with DOM.
Other Standard *(specify):*
The Agency must perform criminal background checks on all direct care employees. The agency must ensure direct care providers have current and active license and or certifications, are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion List.
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid
Frequency of Verification:
At time of initial enrollment and at time of recertification.

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 Service

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):*

Transition Assistance Services are services provided to a Mississippi Medicaid eligible nursing facility resident in order to assist in transitioning the resident from the nursing facility into the Elderly and Disabled Waiver Program. Transition assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved PSS.

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

Transition assistance services are capped at $800.00 onetime initial expense per lifetime.

Transition Assistance Services include:

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

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

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

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

To be eligible:

1) Individual must be a current nursing facility (NF) resident whose NF services are being paid by Medicaid
2) Not have another source to fund or attain the items or support
3) Be moving from a living arrangement where these items were provided
4) Be moving to a residence where these items are not normally furnished
5) The transition services must be requested on the plan of care prior to discharge from the nursing facility.
6) The transition services can begin as soon as the resident meet the criteria of their nursing facility stay being paid by Medicaid, but the transition services must be completed within 90 days of the discharge.
7) Receipts must be available to DOM for all expenses paid.

Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Case Management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Service

Provider Category:
Individual
Provider Type:
Case Management
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Case Management Teams must meet standards set forth by the Division of Medicaid and the case management agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:
Case management agencies and the Division of Medicaid
Frequency of Verification:
At least annually

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

All providers of E&D Waiver services are required to do a criminal history and or background checks (CBC)of all employees that provide direct services to waiver participants. Prior to provider enrollment approval, the potential providers must submit documentation regarding the manner in which the CBC was performed. Providers and all staff providing direct care to waiver participants must not have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(f) of the Mississippi Codes, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

Any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed to provide direct care to waiver participants.

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

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

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

All providers are responsible for verifying that all employees that provide direct care to waiver participants are not on the Mississippi Nurse Aide Abuse Registry which is housed at the Mississippi State Department of Health within the Division of Licensure and Certification.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

- (●) **Other policy.**

  Specify:

  Personal Care Service may be furnished by the family members provided they are not legally responsible for the individual. Family members must be employed by a Medicaid approved agency that provides Personal Care Services, must meet provider standards and must be deemed competent to performt the required tasks.

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:

DOM has quality assurance standards that define required standards of practice for each provider to follow while providing E&D Waiver services. All potential providers must request a copy of the Quality Assurance (QA) standards for the service they are interested in providing. The potential provider must demonstrate their ability to meet the QA standards and provide documentation of their abilities and qualifications. The potential provider is given an opportunity to correct or address any concerns DOM has regarding their standards of practice and qualifications. Once the potential provider has satisfied DOM requirements, they are given an opportunity to enroll as a waiver provider through the State's fiscal agent provider enrollment division.
All providers must comply with standards and processes set forth in the Mississippi Administrative Code, Title 23: Medicaid part 208 Chapter 1: HCBS Elderly and Disabled Waiver

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:
PM 1):Number & percent of new provider applications by provider type which the provider obtained appropriate licensure/certification in accordance with waiver qualifications prior to service provision. N:Number of new provider apps by provider type which the provider obtained appropriate licensure/cert in accordance with waiver qualifications prior to service provision D:Total of new provider app.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM 2): Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment. N: Number of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment D: Total number of enrolled licensed/certified providers.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
3)PM: Number and percent of non-licensed/non-certified provider applications, by provider type, who met initial waiver provider qualifications. N: Number of non-licensed/non-certified provider applications, by provider type, who met initial waiver provider qualifications. D: Total number of all non-licensed/non-certified provider applications.

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:
Excel Spreadsheet and/or database

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

Data Aggregation and Analysis:

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

Performance Measure:
4)PM: Number and percent of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. N: Number of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. D: Total number of enrolled non-licensed/non-certified providers.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every 24 months	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
5)PM: Number and percent of enrolled providers, by provider type, meeting provider training requirements. N: Number of enrolled providers, by provider type, meeting provider training requirements. D: Total number of enrolled providers.

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

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

	☑ **Other** Specify: Every 24 months	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

PM 1): Provider numbers are not issued by DOM without verification of licensure/certification; 2. DOM must obtain verification of licensure/certification prior to issuance of provider number; 3. Notification to provider applicant of application denial within 60 days of application to DOM

PM 2): 1. DOM will require a Corrective Action Plan from provider within 30 days of the request; 2. Close Provider number within 60 days of discovery if licensure/certification is not reinstated within the 60 days; 3. if a provider number is closed/terminated, beneficiaries will be referred to another provider

PM 3): 1. DOM will not issue a provider number if provider applicant is not qualified; 2. Provider applicant will be notified of denial and reasons for denial within 60 days of application by DOM

PM 4): 1. DOM will require a Corrective Action Plan from provider within 30 days of the request; 2. DOM will suspend referrals; 3. DOM will Suspend and/or close provider number within 60 days of discovery if the provider continue to not meet the qualification; 4. If provider number is closed or terminated, the beneficiaries will be referred to another provider

PM 5): 1. DOM will require a Corrective Action Plan from provider within 30 days of the request; 2. DOM will suspend referrals; 3. DOM will suspend and/or close provider number within 60 days of discovery if provider does not meet the provider training requirements within the 60 days; 5. If provider number is closed or terminated, the beneficiaries will be referred to another provider

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-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.

Refer to Attachment #2 for information regarding the waiver specific transition.

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:

☑ **Social Worker**
Specify qualifications:

A social worker with a current and active license in good standing to practice in the State of Mississippi with a minimum of a Bachelor's degree in social work or health related field and two years of full time experience in direct services to the aged and disabled clients.
or
If less than two years of experience, the licensed social worker must complete ninety (90) days of orientation/training of direct waiver services under the supervision of an established waiver case manager who has two years of waiver experience.

Must be credentialed to perform assessments.

☑ **Other**
Specify the individuals and their qualifications:

The registered nurse in addition to possessing a current and active nursing license to practice in Mississippi, or a privilege to practice on a compact license, must have at least 2 years of nursing experience with aged and/or disabled individuals. If less than two

years of experience, the registered nurse must complete ninety (90) days of orientation/training of direct waiver services under the supervision of an established waiver case manager who has two years of waiver experience.

Must be credentialed to perform assessments.

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:*

Currently, the case management agency develops the person-centered service plan and provides HCBS in rural geographic areas as it is the only statewide entity indicating a willingness to serve in this capacity.

The plan of services and supports, otherwise known as the PSS, is the fundamental tool by which the State assures the health and welfare of waiver participants participating in the E&D Waiver. The State's process for developing a waiver participant's PSS requires the plan to be based on a comprehensive assessment process. A registered nurse and a licensed social worker along with the waiver participant and interested parties as requested by the participant are jointly responsible for determining the waiver participant's needs preferences and goals through a person centered planning process. The PSS includes a comprehensive emergency preparedness plan specific to meet the participant's needs.

The State maintains complete oversight of the PSS development by the provider case management agencies. To assure that service providers are exercising free choice options, developing the PSS in accordance with the waiver participant's needs and respecting the dignity and rights of the waiver participant, PSS's are reviewed by DOM prior to waiver services being initiated.

The case management agency coordinates waiver services through the Plan of Service and Support (PSS). The person is involved in each step of the planning process,including the creation of Emergency Preparedness Plan and PSS. During the planning process, the case management agency fully discloses to the person their rights and choices of service providers. Disclosure is documented on the Bill of Rights and the Informed Choice as evidence by the person's/and or representative's signatures. The person's risk are identified through the assessment process, reviewed with the person and documented on the PSS. During the person centered planning process, the person is allowed to choose persons involved in the development of the PSS. The person has input in choice of services to be provided, including the frequency and duration. Once the PSS is developed the person and/or their representative is given a list of qualified HCBS providers to choose from in their service area. The person and/or their representative reviews the list of qualified providers to determine which provider would best meet their needs, preferences and goals. Once all options are taken into consideration the person and/or representative selects the provider they feel best meets their needs a copy of the fully developed PSS is given to the person. The person and/or representative select the provider they feel best meets their needs.

DOM maintains administrative oversight of the waiver to ensure persons receive freedom of choice of providers and to monitor potential conflicts of interest. This oversight is accomplished through audits and reviews by DOM staff conducting home visits. Also, documentation of a signed freedom of choice form is reviewed during DOM compliance audits.

The person is informed by the case management agency, at the time of enrollment in the waiver, the specific criteria and processes for a dispute, complaint/grievance and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings. The person has the right to address any disputes regarding services with DOM at any time. The informal dispute resolution process may be initiated by the person with the case management agency at the agency local level and is understood as not being a pre-requisite or substitute for a state fair hearing. The types of disputes that can be addressed include issues concerning service providers, waiver services, and anything that directly affects the person's waiver services. Waiver participants may address disputes by first reporting the issue to their case management team, which includes a registered nurse and licensed social worker. The case management team will respond to the participant within 24 hours. If a participant believes that a resolution has not been reached within 72 hours, the case management team will report the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If the person believes a resolution has not been reached within this time frame, the issue is reported to DOM. DOM will consult with the case management agency to investigate the issue and work towards a resolution within seven days. In the event the dispute involves the case management team, the case management agency and DOM will work with the person to identify and select a new case management team. Once a new case management team is selected, the case management supervisor will evaluate the person's satisfaction with the new case management team within the following month and will notify DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute process. DOM has the final authority over any dispute.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The person is encouraged to include interested parties and/or caregivers of his/her choice to participate in the development of the PSS through a person centered planning process.
After the person has made an Informed Choice and meets clinical eligibility, the case managers consult,during a face to face meeting, with the person, caregivers and/or interested parties as requested by the person, to engage them to assist in the development of the PSS. The person, caregivers and/or interested parties are provided meaningful information regarding the range of services and care options available through the waiver. The goal is to empower the person and encourage them to engage in making decisions about the type, amount and frequency of services. Once the PSS has been developed, the application packet is submitted electronically to the DOM/LTC. The person can request a change in services at any time if they feel their needs are not being met. A case manager is required to make monthly home visits with each person to assure the PSS is specific to and meets the needs of the person. A maximum of one visit per quarter will be allowed while the person is at the adult day care facility.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The State uses person centered planning process to assess the person's needs and develop a PSS to meet their needs, strengths, preferences, goals and risk factors. The assessment tool is a collection of objective clinical eligibility criteria that is applied uniformly. Incorporated in the application is a process to assure the waiver participant makes an informed choice between institutional and community-based services. The assessment tool supports nursing facility transition into the community.

A case manager(s), the person, caregivers and/or interested parties work together to develop the PSS, especially in identifying personal goals, health care needs and preferences.

The case manager is responsible for informing the person and others as requested by the person about State Plan services and services furnished through other State and Federal programs. The case manager will coordinate waiver services and non-waiver services to meet the needs of the person.
The case management team is responsible for continued and ongoing monitoring of the person's needs and effectiveness of the PSS. The PSS is reassessed on a regular basis with monthly face-to-face visits. However, a quarterly review of the PSS is required. If a change in the PSS is warranted or desired by the person, the person will confer with the case management team to identify potential changes. The PSS is updated annually or more frequently based on the individual needs, desires and goals of the person and/or responsible party.

Informed Choice is assured by the case manager informing the person and/or the legal representative of the available Medicaid-covered long term care options including alternatives to nursing facility placement. The person acknowledges their participation in the application process by signature attesting long term care program options were explained to him/her.

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.

Person involvement and choice, in all aspects of the waiver program and in service planning, is an integral part of identifying and mitigating risks. The case management team must assist the participant and provide them with sufficient information and assistance in order to make an informed choice regarding choice of services and supports, always taking into account risks that may be involved for that participant. The waiver participant and informal caregivers/supports assist in developing strategies and complying with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the case management agency and DOM. The

PSS is monitored by the case management agency and the Medicaid agency. Monthly and quarterly actions are required to review/assess participant service needs, with a new plan developed every twelve months. The Medicaid agency utilizes an assessment and application process for annual eligibility, admission, and recertification for waiver participation. Beginning at the initial assessment and person-centered planning process, the presence and effect of risk factors must be determined. The assessment is specifically designed to assess and document risks a person may encounter. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. All risk factors identified must be addressed in the PSS. Risk factors considered are documented abuse/neglect/exploitation, socially inappropriate behavior, communication, nutrition concerns, environmental security and safety, falls, orientation, emotional/mental functioning, and lack of informal support. The case management team must also determine whether a medical condition is present that requires specific intervention to prevent a decline in health and safety.
The types of backup arrangements that are used include the waiver participant designating alternate care providers in the event that their caregiver is unable to provide care. The person and caregiver identify family members who are able to provide services in the event of an emergency. The case management agency and the person also maintains a list of qualified local community providers from which the person can choose if the caregiver is not available. During a community disaster or emergency the case management agency notifies the local first response team (i.e. the American Red Cross) of persons with special needs who may require special attention. Back up plans are developed by the case management agency in partnership with the person and their family/caregiver upon admission. The case managers evaluate the appropriateness and adequacy of both waiver and non-waiver services at least monthly during monthly face-to-face home visits with the person. As situations warrant, more frequent face-to-face visits may be made. At each visit, the case manager is required to document and monitor the delivery of services, as well as, document the person's health and welfare.

Development of the PSS includes an emergency preparedness plan for each person.

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.

During the person-centered planning process, the person and/or their caregiver is given a list of qualified providers to choose from in their service area to be included in their PSS. The person and/or their representative reviews the list of qualified providers to determine which provider would best meet the needs, preferences and goals of the person. The person and/or representative is given an opportunity in some instances to meet the provider prior to the selection in order to make a more informed choice. Once all options are taken into consideration the person and/or caregiver selects the provider they feel best meets their needs.

When a person selects a provider agency that is owned and/or operated by a family member, the services may be delivered if the family member who owns and/or operates the agency is not normally considered a caregiver nor legally responsible for the person. A person's spouse, the executor of a person''s estate and/or individual with durable/medical power of attorney for the person are considered legally responsible for the person.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

After the Case Management Agency has completed the application packet, which includes the assessment, a PSS, Emergency Preparedness Plan, Informed Choice, Bill of Rights, and LOC Determination, the packet is submitted electronically to DOM.

For initial application packets, DOM utilizes a LOC algorithm to determine if the person meets the LOC criteria. A DOM nurse reviews the application packet and will notify the case manager in a timely manner of the approval/disapproval of services requested. If additional information is needed by DOM prior to making a determination, a clarification request is sent to the Case Management Agency. Waiver services may be provided from the date the person is determined eligible for waiver services.

For recertification application packets, DOM utilizes a LOC algorithm to determine if the person meets the LOC criteria. DOM also utilizes within it's electronic Long Term Services and Supports system a formula to determine if the amount of services listed on the PSS and the cost for those services are appropriate for the needs identified in the assessment as indicated by the assessment scoring algorithm.

Recertification application packets that do not meet the established criteria for approval will be reviewed by a DOM nurse in the same process as initials.

Any changes to PSS during the certification year will follow the same criteria as recertification for comparing most recent assessment to the cost of services. Any outliers or substantial increase in services will be reviewed by the DOM nurse.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PSS is the fundamental tool by which the State assures the health and welfare of waiver participants in the Elderly and Disabled Waiver. The State's process for developing a person's PSS requires the plan to be based on a person centered planning process which identifies the needs, preferences and goals for the participant. A case management team which includes a licensed social worker and registered nurse along with the person and others as requested by the person are jointly responsible for the development of the PSS.

Face-to-face in home visits with each person enrolled in the waiver by the case manager are required to determine the appropriateness and effectiveness of the waiver services and to ensure that the services furnished are consistent with the person's needs, goals and preferences. The monthly home visits with the person provide the case manager the ability to evaluate whether services are provided in accordance with the PSS.

If service provision in accordance with the PSS is found to be inconsistent during the monitoring process, the Case Management Agency contacts the service provider to engage in a problem solving process to determine how to get the person the services needed in a consistent manner in accordance with the PSS.

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 Case Management Agency is responsible for monitoring service provision and the person's health and welfare on a monthly and quarterly basis. In rural areas where provider agencies also provide direct services, administrative firewalls have been put in place to ensure the separation between case management and other services provided. For services which include an administrative fee, the fees have been evaluated and determined to be an appropriate administrative fee by an outside actuary.

DOM, as part of it's Continuous Quality Improvement process, monitors service provision and referrals to service providers by reports generated from the eLTSS system to identify Case Management Agencies that have disproportionately referred to services within their own agency. DOM staff sample cases of people enrolled in the waiver to conduct in-home visits to discuss services they

receive, informed choice in the selection of service providers, and whether the services are sufficient to meet the health and welfare of the person in a home and community based setting.

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:
PM 1 PSS address all person's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. N:Number of PSS reviewed that address person's needs including health and safety risk factors. D: Total number of PSS' reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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:
PM 3): The number and percent of service plan quarterly updates that are performed according to the waiver application. N: Number of service plan quarterly updates that are performed according to the waiver application. D: Number of service plan quarterly updates reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 4): Number and percent of participant's plans of care where the individual's signature indicates involvement in the POC development. N: Number of participant's plans of care with signature indicating involvement in POC development. D: Number of participants' POCs .

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure 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:
PM 5): PSS are updated/revised annually and as warranted. N: Number of PSS reviewed that are updated annually and as warranted D: Total Number of PSS reviewed.

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

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

		95% based on total number of people enrolled annually.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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:
PM 7): Services are delivered in accordance with the PSS in type, scope, amount, duration and frequency. N: Number of PSS reviewed in which people received services in accordance with the PSS in the type, scope, amount, duration and frequency. D: Total Number of PSS reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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:
PM 9): People are afforded choice between waiver services (and institution)and among waiver providers. N: Number of persons files reviewed that documented' freedom of choice of provider. D: Total Number of persons files reviewed. Additional N/D: N: Number of surveyed people who indicate he/she was given a choice of waiver providers. D: Total number of surveyed participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and off-site record reviews, home visits and consumer surveys.

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure 1 : 1. Upon discovery, DOM contacts the Case Management Agency (CMA) requiring them to review the PSS to ensure person's assessed needs (including health and safety risk factors) and personal goals are addressed. The PSS must be reviewed and updated if appropriate within 7 days; 2. DOM provides One-on-one CM training by phone or letter as needed.
Performance Measure 3): 1. DOM will educate providers on DOM waiver requirements for case management. 2. DOM may recoup payment for one month of case management from provider;
Performance Measure 4): 1. Upon discovery of non-compliance, DOM will notify the case manager to obtain and submit the completed document within 7 days of notification; 2.Individual cases will be evaluated by DOM and proof of beneficiary participation in the care plan will be obtained prior to approving the cases; 3. DOM conducts CM Training quarterly and annually.
Performance 5): 1. Upon discovery, the provider is notified to submit updated/revised PSS; 2. Payment is not made to providers if a PSS expires (exceeds 365 days); 3. DOM conducts provider training on waiver requirements .
Performance Measure 7): 1. Upon discovery, DOM contacts Case Management Agency to determine the reason the services were not delivered. The CMA should secure the provision of services, enlist another provider of the persons choosing or change the PSS to meet the participants' needs. The updated PSS must be submitted to DOM within 14 days; 2. DOM conducts provider training on waiver requirements.
Performance Measure 9): 1. Upon discovery, DOM would investigate the cause of the system failure within LTSS that allowed a PSS to be submitted without documentation of freedom of choice of provider. 2. One-on-one provider training as needed; 3) If discovered via home visit or survey, the person is asked to document their current choice of providers.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Fair Hearing procedures are based on the Mississippi Division of Medicaid's Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process
A case manager sends a Notice of Action (NOA) to the waiver participant by certified mail (Signature return requested).

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

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

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

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

A hearing will not be scheduled until a written request is received by either the case management agency or state office. If the written request is not received within the 30 day time period, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as identified in the Administrative Code.

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

The participant has the right to appeal a local hearing decision by requesting a State hearing;
However, the State hearing request must be made within 15 days of the mailing date of the local hearing decision.

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.
The participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record. The right to have legal representation at the hearing and to bring witnesses.

2. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

3. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.
Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the participant or service providers. Upon receipt of the request for a state hearing, the DOM's Bureau of Administrative Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

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

The informal dispute resolution process is initiated with the case management agencies at the local level and is understood as not being a pre-requisite or substitute for a fair hearing.
The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants address disputes by first reporting to their case management team, which is composed of a registered nurse and a licensed social worker. The case management team responds to the participant within 24 hours. If a resolution is not reached within 72 hours the case management team reports the issue to the case management supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the client's satisfaction with the new case management team within the following month and notifies DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the case management agency at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.

At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

DOM and the case management agency are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

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

The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints /grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Waiver participants must first address any complaints/grievance by reporting it to their case management team which is composed of a registered nurse and a licensed social worker. The case management team begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case management team reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the participant's satisfaction with the new case management team within the following month and notifies DOM of the final resolution. Upon admission to the waiver, the participant receives a written copy of their bill of rights which addresses disputes, complaints/grievances and hearings.

Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

Critical incidents are identified as follows:
Abuse (A) -- willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.
Neglect (N)--can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.
Exploitation (E)--Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.
The Department of Human Services (DHS), Division of Aging and Adult Services, is the agency responsible for investigating allegations of A, N and E. There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver participants.
DOM provides DHS with a list of waiver participants on a monthly basis by which DHS can bump this information against active ongoing investigations to alert DOM of any critical incidents that DOM may not have already been made aware of. The system will make a comparison based of the waiver participant's social security number as a unique identifier.
All reports of A, N and E are taken very seriously by DOM. DOM provides for the reporting and investigating of major and serious incidents of abuse, neglect and exploitation of a waiver participant.
All reports of A, N and E are reported immediately verbaly and in writing by the appropriate case manager to their supervisor and the Department of Human Services. The potential A, N and E are also to be reported in writing to the DOM/LTC/E&D Waiver Program Division as it occurs. DOM assigns each potential A, N or E case to a social worker in LTC to follow up on and report their findings to Administration in LTC.
If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. In addition, reports are simultaneously made to DHS who is the investigative agency in Mississippi responsible for investigating allegations of A, N and E. DOM, the case management agency, and DOM/LTC social workers follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

Mississippi Vulnerable Persons Act, Section 43-47-9 (1). "Upon receipt of a report pursuant to Section 43-47-7 that a vulnerable person is in need of protective services, the department (The Mississippi Department of Human Services)shall initiate an investigation and/or

evaluation within forty-eight (48) hours if immediate attention is needed, or within seventy-two (72) hours if the vulnerable person is not in immediate danger, to determine whether the vulnerable person is in need of protective services and what services are needed."

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 entry into the waiver, case managers will provide the waiver participant/and/or caregiver education and information concerning the State's protection of the waiver participant against abuse, neglect and exploitation including how participants may notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation.
When participants are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains monthly contact with each participant by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or participant representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities.
DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.

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.

First line entity to receive reports is the E&D Waiver case manager at the case management agency and/or the DOM/LTC Bureau/E&D Waiver Program Division.
When DOM receives a critical incident report, it is assigned to a DOM social worker within 48 hours of receipt. The DOM social worker begins follow up on the case within 24 hours, contacting the appropriate case manager and/or provider and the worker at the Department of Human Services(DHS),if one has been assigned. If the case has not been reported to DHS the DOM social worker reports it immediately. The DOM social worker will follow within thirty days for a status report from DHS.
A visit to the client's home is conducted by the social worker/nurse at DOM as the situation warrants.
The communication continues between the case management agency, DOM, Department of Human Services, and Attorney General's Office, is necessary, until resolution occurs.

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.

The case management agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated §n 43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM work with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302. As stated in the memorandum of understanding, DHS agrees to provide information on critical incidences involving alleged A, N and E of waiver participants on a monthly basis. Critical incident data will be shared through the use of information technology that will report types of incidents, providers, participant characteristics, results of investigations and the timeliness of investigations. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents This is an ongoing process, and as these events occur, immediate action takes place and investigation begins.
All of the above entities keep written records of suspected events of abuse, neglect, and exploitation.

Appendix G: Participant Safeguards

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

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

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

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

The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and the quality of waiver services provided.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not permit the use of restrictive interventions.
DOM and the case management agencies are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and to ensure quality of services provided.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not permit the use of seclusion.
DOM and the case management agencies are jointly responsible for ensuring that seclusion is not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and to ensure quality of services provided.

All providers are required to receive training in methods to detect abuse, neglect and exploitation which includes unauthorized use of

seclusion. The person and their environment is monitored to detect unauthorized use of seclusions during provider scheduled visits, unannounced home visits by the provider's supervisor, monthly home visits by the case management agency and randomly selected annual visits by DOM staff. Incidents of seclusion are immediately reported verbally and in writing by the case manager to their supervisor and the Department of Human Services (DHS). The report is also sent to DOM. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

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

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

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

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof 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:
PM 1): Number and percent of waiver participants who have an emergency preparedness plan (EPP)developed with the case management agency. N: Number of waiver participants who have an EPP. D: Number of participants reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 2): Number and percent of waiver participants who receive information from the case management agency on how to report suspected cases of abuse, neglect or exploitation. N: Number of waiver participants who receive information on how to report suspected cases of abuse, neglect or exploitation; D: Total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Compliance review, home visit

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 3): Number and percent of complaints that were addressed by the case managemtn agency within required time frames as specified in the waiver application. N: Number of complaints that

were addressed within required time frames as specified in the waiver application. D: Total number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
E&D Waiver Complaint Database

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 4): Number and percent of reported critical incidents that adhere to the time frames for follow-up as specified in the approved waiver application. N: Number of reported critical incidents that adhere to the time frames for follow-up as specified in the approved waiver application. D: Total number of reported critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure 1): 1. DOM will require case managers to develop EPP with the waiver participant within 7 days of discovery and submit the EPP document to DOM upon completion; 2. DOM will do one-on-one training with case manager supervisor upon discovery.
Performance Measure 2): 1. DOM will require a Corrective Action Plan from provider within 30 days of the request; 2. DOM will require provider to provide participant with information within 30 days of discovery.
Performance Measure 3): 1. Unresolved complaints are reported to DOM administrative staff for resolution within 7 days of the report to the case manager supervisor;
Performance Measure 4): 1. For those reported critical incidents with no follow-up by MS Department of Human Services, DOM will request immediate follow-up of the reported critical incident; 2. For those reported critical incidents with late follow-up DOM will request documentation from DHS within 30 days.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DOM employs staff to assist in system design. Meetings are held routinely, or as needed, to review analyzed discovery and remediation data, to develop Computer System Request (CSRs), review progress, and test system changes. The CSRs are the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent. The meetings involve participation from DOM's Bureau of Systems Management, Long Term Care staff and others deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including QA nurses are held monthly or as needed for the purpose of addressing needs and resolving issues.
When the state identifies a system issue it is reported to the fiscal agent for review and research. System issues that affect services to beneficiaries or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff and the systems staff to address issues that require system changes. Additionally the State as a whole has bi-weekly Medicaid Advisory Board (MAB) meetings to identify, correct, and implement system changes to improve the State's ability adhere to state and federal regulations, policies and procedures.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: Ongoing and as needed

b. System Design Changes

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

DOM meets on monthly or as needed basis with the Bureau of Systems Management, with daily communication whereby system errors and remedies are discussed and or reported. DOM staff and waiver providers/ direct users of the agency's electronic system have the ability to notify electronically, telephonically, or in writing concerns of the inability to process preadmission screening applications or billing processes in a timely manner. The Bureau of Systems Management monitors all errors, omissions, and system downtimes in order for DOM to address either with the fiscal agent for a system change to remedy the problem and/or track the problem to propose a remedy. In addition, DOM and the case management agencies meet on a quarterly basis to review and analyze the functionality of the Preadmissions screening process. Recommendations for improvement are reviewed and applied as appropriate.

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

DOM monitors the Quality Improvement Strategy on a quarterly basis. The Quality Improvement Strategy is reviewed annually. The review consists of 1) analyzing aggregated reports and progress toward meeting 100% of the sub assurances, 2) resolution of individual and systemic issues found during discovery, and 3) notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and the fiscal agent is made to meet waiver reporting requirements. The Quality Assurance nurses will utilize the Quality Improvement Strategy during all levels of QA activities.

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).

Claims for Federal financial participation in the costs of waiver services are based on state payment for waiver services that have been rendered to waiver participants, authorized in the plan of care, and properly billed by qualified waiver providers in accordance with the approved waiver.

DOM maintains responsibility for assuring financial audits of E&D Waiver providers are conducted. DOM will also generate all required financial reporting for each E&D 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. The audits are also a mean of identifying if services are deliverd according to the approved plan of care. Immediate action will be taken when necessary to address any financial irregularities identified in the review or if services are billed and not delivered according to the participant's plan of care.

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

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:
PM 1): Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver. D: Total number of claims paid.

Data Source (Select one):
Other

If 'Other' is selected, specify:
MMIS/Cognos Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 2) Number and percent of waiver service claims reviewed that were submitted for services within the participants'service plan. Numerator: Number and percent of waiver service claims reviewed that were submitted for services within the participants'service plan. Denominator: Total number of service claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Compliance Reviews, MMIS, Cognos Reports

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
PM 1 & 2): 1.DOM will recoup money paid erroneously to providers within 30 days of notification; 2. Submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; 3. Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

To set the context for developing service rates, we carefully considered the service descriptions and provider handbook information for each waiver service. We determined whether certain services had essentially the same provider education requirements, expectations and billable productivity levels. If so, we grouped these services together for purposes of rate development.
Rates for meals will be increased by either 2% annually or in accorandance with, but not to exceed, the rate change in the United States Department of Labor's Consumer Price Index, All Urban Consumers, South Region, Food Away from Home, based upon the preceding calendar year. If the new statewide meals contract rate established for October 1, 2003, and forward is greater than the Consumer Price Index for the previous calendar year, DOM will pay the new contracted rate with no less than 20% above for accounting, billing and general management of the meal program.

For all services reviewed, we either compared current waiver rates to the same non-waiver Medicaid service rates, or we performed a thorough "ground up" provider rate development.

For the Adult Day Care, Personal Care and Case Management services, we built initial rates from the ground up using the following rating variables:

> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hours practitioners are at work
> Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, Mississippi Planning and Development District (PDD) and Adult Day Care (ADC) center surveys, and DOM and Milliman experience.

Once we calculated initial service rates, we compared them to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. Projected rates for waiver years following the initial year were based on an expected two (2) percent increase in accordance with the Bureau of Labor Statistics and the Consumer Price Index.

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:

E&D Waiver providers bill their claim directly to the State's claims payment system. This system is housed and managed by the State's fiscal agent.

Appendix I: Financial Accountability

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

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

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver

payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS houses claims data and information that can be produced upon request. The MMIS has audit functions to deny payment for services when an individual is not Medicaid eligible on the date of service. The MMIS also has an audit function to deny any individual who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS requires an individual to be an approved, eligible Medicaid waiver participant, documented in the MMIS, in order for the claim to pay. The lock-in function is housed in the MMIS under the recipient file and is performed/completed by Medicaid staff or the Medicaid Fiscal Agent staff. The State conducts post utilization reviews to ensure the services provided were on the participant's approved service plan.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

There are ten (10) Planning and Development Districts (PDD's) in the State of Mississippi. Each PDD is an independent organization governed by a Board of Directors appointed by the local government officials. Each District represents a distinctly different region of the state, but each have common functions such as economic development, loan programs, community development, technical assistance, planning assistance, human resource development, job training, social services, transportation and gerontology. The state Area Agencies on Aging (AAAs) are housed within the PDDs. The PDD's provide case management services, transition assistance, adult day care and home delivered meals.

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*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

  Check each that applies:

  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	31584.00	3524.00	35108.00	54800.00	3524.00	58324.00	23216.00
2	33340.81	3595.00	36935.81	56992.00	3595.00	60587.00	23651.19
3	35490.81	3667.00	39157.81	59272.00	3667.00	62939.00	23781.19
4	39163.53	3740.00	42903.53	61643.00	3740.00	65383.00	22479.47
5	40987.41	3815.00	44802.41	64108.00	3815.00	67923.00	23120.59

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	19000	19000
Year 2	19500	19500
Year 3	20000	20000
Year 4	20500	20500
Year 5	21000	21000

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 is 295 days or 10 months. This number is based upon information captured in the state fiscal year 2010 CMS 372 Annual Report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for factor D were calculated automatically from the numbers entered for number of users, average units per user, and average cost per unit for each component of waiver service. Our estimates of the number of persons who will be served on the Elderly and Disabled waiver were based upon a careful appraisal of the State's resources available at the time of renewal. During the development of the current waiver, DOM had projected waiver growth for year five(5) based on trends and expectations. During the development of the current waiver, DOM projected the average costs/unit for year one (1) of the waiver and adjusted the rates incrementally over the following four (4) years to reflect anticipated inflation to adjust for the costs of services.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for D'are based on the average D' for a two (2) year reporting period. This period spans from FY 2010 through 2011. The average was applied for year one and for every year after a 2% inflation rate was applied.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G is based upon DOM's analysis of nursing home expenditures per beneficiary for FY 2010 and the first year is based upon the analysis. The specific nursing home expenditures analyzed are actual paid claims per Medicaid beneficiary. Every year after is projected using a 2% inflation rate.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for G'are based on the average D' for a two (2) year reporting period. This period spans from FY 2010 through 2011. The average was applied for year one and for every year after a 2% inflation rate was applied.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Care	
Case Management	
In-Home Respite	
Personal Care Service	
Extended Home Health Services	
Home Delivered Meals	
Institutional Respite Care	
Physical Therapy Services	
Speech Therapy Services	
Transition Assistance Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**10769005.00**
Adult Day Care	per day	1300	145.00	57.13	**10769005.00**	
Case Management Total:						**33250000.00**
Case Management	monthly	19000	10.00	175.00	**33250000.00**	
In-Home Respite Total:						**23616000.00**
In-Home Respite	per 15 minutes	2050	2880.00	4.00	**23616000.00**	
Personal Care Service Total:						**486400000.00**
Personal Care Service	per 15 minutes	19000	6400.00	4.00	**486400000.00**	
Extended Home Health Services Total:						**35012500.00**
Skilled Nursing	per visit	350	50.00	115.00	**2012500.00**	
Home Health Aide	per visit	5000	150.00	44.00	**33000000.00**	
Home Delivered Meals Total:						**10764000.00**
Home Delivered Meals	per meal	9000	260.00	4.60	**10764000.00**	
Institutional Respite Care Total:						**34587.00**
Institutional Respite Care	per day	10	30.00	115.29	**34587.00**	
Physical Therapy Services Total:						**81600.00**
Physical Therapy Services	per visit	100	12.00	68.00	**81600.00**	
Speech Therapy Services Total:						**81600.00**
Speech Therapy Services	per visit	100	12.00	68.00	**81600.00**	
Transition Assistance Service Total:						**92000.00**
Transition Assistance Service	once lifetime	115	1.00	800.00	**92000.00**	
				GRAND TOTAL:		**600101292.00**
				Total Estimated Unduplicated Participants:		**19000**
				Factor D (Divide total by number of participants):		**31584.00**
				Average Length of Stay on the Waiver:		10

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**13518640.00**
Adult Day Care	per day	1600	145.00	58.27	**13518640.00**	
Case Management Total:						**35080500.00**
Case Management	monthly	19500	10.00	179.90	**35080500.00**	
In-Home Respite Total:						**31314816.00**
In-Home Respite	per 15 minutes	2665	2880.00	4.08	**31314816.00**	
Personal Care Service Total:						**509184000.00**
Personal Care Service	per 15 minutes	19500	6400.00	4.08	**509184000.00**	
Extended Home Health Services Total:						**46426575.00**
Skilled Nursing	per visit	455	50.00	117.30	**2668575.00**	
Home Health Aide	per visit	6500	150.00	44.88	**43758000.00**	
Home Delivered Meals Total:						**14266980.00**
Home Delivered Meals	each meal	11700	260.00	4.69	**14266980.00**	
Institutional Respite Care Total:						**45864.00**
Institutional Respite Care	per day	13	30.00	117.60	**45864.00**	
Physical Therapy Services Total:						**108201.60**
Physical Therapy Services	per visit	130	12.00	69.36	**108201.60**	
Speech Therapy Services Total:						**108201.60**
Speech Therapy Services	per visit	130	12.00	69.36	**108201.60**	
Transition Assistance Service Total:						**92000.00**
Transition Assistance Service	once lifetime	115	1.00	800.00	**92000.00**	
				GRAND TOTAL:		**650145778.20**
				Total Estimated Unduplicated Participants:		**19500**
				Factor D (Divide total by number of participants):		**33340.81**
				Average Length of Stay on the Waiver:		10

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**17924088.00**
Adult Day Care	per day	2080	145.00	59.43	**17924088.00**	
Case Management Total:						**36986000.00**
Case Management	monthly	20000	10.00	184.93	**36986000.00**	
In-Home Respite Total:						**41513472.00**
In-Home Respite	per 15 minutes	3465	2880.00	4.16	**41513472.00**	
Personal Care Service Total:						**532480000.00**
Personal Care Service	per 15 minutes	20000	6400.00	4.16	**532480000.00**	
Extended Home Health Services Total:						**61555825.00**
Skilled Nursing	per visit	590	50.00	119.65	**3529675.00**	
Home Health Aide	per visit	8450	150.00	45.78	**58026150.00**	
Home Delivered Meals Total:						**18902988.00**
Home Delivered Meals	each meal	15210	260.00	4.78	**18902988.00**	
Institutional Respite Care Total:						**61179.60**
Institutional Respite Care	per day	17	30.00	119.96	**61179.60**	
Physical Therapy Services Total:						**144330.00**
Physical Therapy Services	per visit	170	12.00	70.75	**144330.00**	
Speech Therapy Services Total:						**144330.00**
Speech Therapy Services	per visit	170	12.00	70.75	**144330.00**	
Transition Assistance Service Total:						**104000.00**
Transition Assistance Service	once lifetime	130	1.00	800.00	**104000.00**	
				GRAND TOTAL:		**709816212.60**
				Total Estimated Unduplicated Participants:		**20000**
				Factor D (Divide total by number of participants):		**35490.81**
				Average Length of Stay on the Waiver:		10

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**23728815.00**
Adult Day Care	per day	2700	145.00	60.61	**23728815.00**	
Case Management Total:						**38964350.00**
Case Management	monthly	20500	10.00	190.07	**38964350.00**	
In-Home Respite Total:						**55011456.00**
In-Home Respite	per 15 minutes	4505	2880.00	4.24	**55011456.00**	
Personal Care Service Total:						**556288000.00**
Personal Care Service	per 15 minutes	20500	6400.00	4.24	**556288000.00**	
Extended Home Health Services Total:						**108022675.00**
Skilled Nursing	per visit	770	50.00	122.05	**4698925.00**	
Home Health Aide	per visit	14750	150.00	46.70	**103323750.00**	
Home Delivered Meals Total:						**20259200.00**
Home Delivered Meals	each meal	16000	260.00	4.87	**20259200.00**	
Institutional Respite Care Total:						**80757.60**
Institutional Respite Care	per day	22	30.00	122.36	**80757.60**	
Physical Therapy Services Total:						**190528.80**
Physical Therapy Services	per visit	220	12.00	72.17	**190528.80**	
Speech Therapy Services Total:						**190528.80**
Speech Therapy Services	per visit	220	12.00	72.17	**190528.80**	
Transition Assistance Service Total:						**116000.00**
Transition Assistance Service	once lifetime	145	1.00	800.00	**116000.00**	
				GRAND TOTAL:		**802852311.20**
				Total Estimated Unduplicated Participants:		**20500**
				Factor D (Divide total by number of participants):		**39163.53**
				Average Length of Stay on the Waiver:		10

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**31463289.00**
Adult Day Care	per day	3510	145.00	61.82	**31463289.00**	
Case Management Total:						**41031900.00**
Case Management	monthly	21000	10.00	195.39	**41031900.00**	
In-Home Respite Total:						**72845568.00**
In-Home Respite	per 15 minutes	5855	2880.00	4.32	**72845568.00**	
Personal Care Service Total:						**580608000.00**
Personal Care Service	per 15 minutes	21000	6400.00	4.32	**580608000.00**	
Extended Home Health Services Total:						**113415000.00**
Skilled Nursing	per visit	1000	50.00	124.50	**6225000.00**	
Home Health Aide	per visit	15000	150.00	47.64	**107190000.00**	
Home Delivered Meals Total:						**20633600.00**
Home Delivered Meals	each meal	16000	260.00	4.96	**20633600.00**	
Institutional Respite Care Total:						**104840.40**
Institutional Respite Care	per day	28	30.00	124.81	**104840.40**	
Physical Therapy Services Total:						**252663.84**
Physical Therapy Services	per visit	286	12.00	73.62	**252663.84**	
Speech Therapy Services Total:						**252663.84**
Speech Therapy Services	per visit	286	12.00	73.62	**252663.84**	
Transition Assistance Service Total:						**128000.00**
Transition Assistance Service	once lifetime	160	1.00	800.00	**128000.00**	

GRAND TOTAL:	**860735525.08**
Total Estimated Unduplicated Participants:	**21000**
Factor D (Divide total by number of participants):	**40987.41**
Average Length of Stay on the Waiver:	10