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

Administration and Operation

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

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

Day Habilitation Services, Prevocational Services, Meaningful Opportunities Supports, Supported Employment Services, and Supported Living

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
●	**Applicable**

Check the applicable authority or authorities:

☑ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:*
(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 specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§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 §1115 of the Act.** *Specify the program*:

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

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

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

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

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

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

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

DMH, in addition to DOM performs 2, 3, 4, 5, 6, 8, 9, 10

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

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

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

DMH's Diagnostic and Evaluation (D&E) Teams perform the evaluations, reevaluations and assessments for 1915(i) for eligibility. Enrolled case management agencies provide Targeted Case Management (TCM) Services to coordinate and facilitate Person-Centered Planning to develop Plans of Services and Supports (PSS) for individuals receiving HCBS.

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

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

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

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/01/2018	6/30/2019	950
Year 2	7/01/2019	6/30/2020	1,150
Year 3	7/01/2020	6/30/2021	1,350
Year 4	7/01/2021	6/30/2022	1,550
Year 5	7/01/2022	6/30/2023	1,750

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

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

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

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

Evaluation/Reevaluation of Eligibility

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

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

	DMH

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

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

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

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

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

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

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

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

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

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

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

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

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Based on evaluation/reevaluation, individuals who participate in State plan HCBS must have a need for assistance demonstrated by a need for habilitation services,	For an individual to qualify for the Elderly and Disabled, Independent Living, Traumatic Brain/Spinal Cord and Assisted Living waivers, the individual must be	For an individual to be eligible for services in an ICF/IID, the individual must have an intellectual disability, a developmental disability, or Autism Spectrum Disorder.	Mississippi does not have any hospital waivers.

as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.) to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands. The individual must also have a likelihood of retaining new skills acquired through habilitation over time. Individual must have a condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require planning and coordination of services to assist the individual in achieving maximum potential that continues or can be expected to continue, indefinitely. In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis: • Is unemployed or employed in a sheltered setting, or has markedly limited skills and a poor or non-existent work history. • Shows severe inability to establish or	assessed and score 50 or less on a standardized preadmission screening tool designed and tested to determine whether the individual meets nursing home level of care. Additionally, the physician must certify level of care. For participation in the Traumatic Brain or the Independent Living waivers, the individual must have either a specific condition or diagnose which requires specialized services to meet the unique needs of the waiver participant. The Traumatic Brain Injury waiver requires the individual to have a diagnosed traumatic brain/spinal cord injury to qualify for services. The Independent Living waiver requires the individual to have either a neurological or orthopedic condition with impairment resulting in the need for nursing home level of care. The Assisted Living waiver requires an individual to have a diagnosed traumatic brain injury with complicating behavioral issues resulting in the need for specialized care to qualify for the traumatic brain injury	An intellectual disability as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. A developmental disability includes multiple types of disabilities (cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability) that are brought about by either a physical impairment, mental impairment, or both before the age of 22 that is likely to continue for an indefinite period of time and results in limitations of functioning in 3 or more areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Autism Spectrum Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.	

maintain a beneficial, meaningful personal social support system. • Requires help in basic Instrumental Activities of Daily Living (IADL) such as money management, housekeeping, meal planning and preparation, shopping for food, clothing and other essential items, communicating by phone or other media, and traveling around and participating in the community. • Exhibits inappropriate social behavior that results in the need for intervention. • Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.	residential services offered through this waiver.		

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The state is targeting Individuals with Intellectual Disabilities, Developmental Disabilities, or Autism Spectrum Disorder. In addition to the needs identified above, the individual must also have a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	○	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The Centers for Medicare and Medicaid Services (CMS) granted the State initial approval of its Statewide Transition Plan (STP) on May 25, 2017, to bring settings into compliance with the federal home and community based services (HCBS) regulations found at 42 C.F.R. §§441.30l(c)(4)(5) and Section 441.710(a)(l)(2). The STP can be found at https://medicaid.ms.gov/wp-content/uploads/2017/05/MS-STP-Summary-and-Timeline-approved-5.25.17.pdf.

Mississippi assures that the settings transition plan included with this 1915(i) renewal will be subject to the provisions or requirements included in the State's approved Statewide Transition Plan.

Mississippi's 1915(i) Community Support Program uses a person directed, person focused planning process in determining the type and level of supports to incorporate each participant/beneficiary's unique desires and wishes in the services they receive. The goal is to provide supports for persons/beneficiaries to receive services in settings that meet the requirements of the final rule. Persons/beneficiaries are able to choose non-disability specific settings to receive services.

1915(i) Community Support Program:
ID/DD 1915(i) services provided in non-residential settings which must meet the requirements of the HCBS settings include:

- Day Habilitation services are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities, which support and enhance the individual's independence in the community. This service is provided in a Department of Mental Health certified, non-residential setting,
- Prevocational services provide learning and work experiences so that the individual can develop the strengths and skills needed to gain paid employment in integrated community settings. This service is provided in a Department of Mental Health certified, non-residential setting,
- Meaningful Opportunities Supports is intended to foster community integration and employment for the individuals served. This will be accomplished through the provision of opportunities for developing and maintaining competency in personal, social, and community activities. This service is provided in a Department of Mental Health certified, non-residential setting,
- Supported Employment is ongoing support for people who, because of their support needs, require intensive, ongoing services to obtain or maintain a job in competitive, integrated employment or self-employment. Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

ID/DD 1915(i) services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:

- Supported Living services are provided to individuals who reside in their own residence (either owned or leased) for the purposes of increasing and enhancing independent living. in the community.

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

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

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

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

Targeted Case Managers (TCM) are responsible for the development of a person-centered plan (PSS) for each person receiving 1915(i) Services. Targeted Case Management is provided by an individual with at least a Bachelor's degree in an intellectual/developmental disabilities or related field and at least one year experience in working with people with intellectual or developmental disabilities. Targeted Case Management can also be provided by a Registered Nurse with at least one year experience in working with people with intellectual or developmental disabilities. Additionally, Targeted Case Managers must complete training in Person-Centered Planning and demonstrate competencies associated with that process.

The State will implement a process to ensure open enrollment for all willing and qualified providers for case management services. Case Management Agencies must have a statewide network of case managers. Additionally, the following requirements must be met:

TCM Education Needs: The TCM must be certified in order to provide case management. Additionally, TCMs must be recertified annually. DMH, as the operating agency, will be responsible for certification standards, as approved by the State.

TCM Supervisors: This is an administrative position involving the planning, direction, and administration of the case management program. Supervision of the TCM is a function that is required to ensure that all components of case management are carried out according to the Quality Assurance Standards. DMH, as the operating agency, will be responsible for certification standards for TCM supervisors, as approved by the State.

The State will transition from the current case management system to the one outlined above by October 31, 2019.

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

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

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance

requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

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

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

Each PSS is initially reviewed by DMH to verify the HCBS services are:

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

DMH then forwards the Plan of Services and Supports to the State for review and approval.

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

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Day Habilitation Services
Service Definition (Scope)*:*	
Day Habilitation Services are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports to enhance an individual's acquisition of skills, appropriate behaviors and personal choice. Day Habilitation activities must aim to improve skills needed for the individuals to function as independently as possible. Day Habilitation will be provided based on a person-centered approach with supports tailored to the individual desires and life plan of the individual participant. Day Habilitation Services take place in a non-residential setting that is separate from the residence of the individuals receiving the service. The State covers Day Habilitation Services for individuals enrolled in the Community Support Program up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State. A minimum staffing ratio of 1 staff member to every 8 individuals receiving the service will be in place. Individuals will be able to choose their provider of Day Habilitation Services from those certified by the MS Department of Mental Health to provide the service. The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person. With the addition of Meaningful Opportunities Supports, Day Habilitation will be phased out. There will be no new enrollments in Day Habilitation after 11/01/2018. Individuals receiving this service will be transitioned to other appropriate services, including Meaningful Opportunities Supports, from 11/01/2018 to 12/01/2018. This transition will be accomplished through Person-Centered Planning meetings with Targeted Case Managers.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Day Habilitation Providers	Division of Medicaid	Annually

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Prevocational Services

Service Definition (Scope)*:*

Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Individuals receiving Prevocational Services must have employment related goals in their PSS; the general habilitation activities must be designed to support such employment goals.

Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals

without disabilities, is considered to be the optimal outcome of Prevocational Services. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

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

Ability to communicate effectively with supervisors, coworkers and customers

Generally accepted community workplace conduct and dress

Ability to follow directions; ability to attend to tasks

Workplace problem solving skills and strategies

General workplace safety and mobility training

Attention span

Motor skills

Interpersonal relations

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

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

The State covers Prevocational Services for individuals enrolled in CSP up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State.

Individuals may be compensated in accordance with applicable Federal Laws.

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

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

Department of Labor.

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

With the addition of Meaningful Opportunities Supports, Prevocational Services will be phased out. There will be no new enrollments in Prevocational Services after 11/01/2018. Individuals receiving this service will be transitioned to other appropriate services, including Meaningful Opportunities Supports, from 11/01/2018 to 12/01/2018. This transition will be accomplished through Person-Centered Planning meetings with Targeted Case Managers.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

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

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

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

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

Provider Type	Entity Responsible for Verification	Frequency of Verification

(Specify):	*(Specify):*	*(Specify):*
Prevocational Services Providers	Division of Medicaid	Annually

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	**Meaningful Opportunities Supports**

Service Definition (Scope)*:*

A new service, Meaningful Opportunities Supports, is being added to the array of services. Meaningful Opportunities Supports is intended to foster community integration and employment for the individuals served. This will be accomplished through the provision of opportunities for developing and maintaining competency in personal, social, and community activities.

Meaningful Opportunities Supports will provide a flexible array of meaningful opportunities based on individual preferences and needs identified in the PSS. This new service can include:

- **Career exploration**
- **Community integration experiences**
- **Socialization experiences**
- **Development and maintenance of independent living skills**
- **Pursuit of leisure interests and hobbies**

Pursuit of employment will be a central component of Meaningful Opportunities Supports for individuals wishing to find employment. Activities in this area will include skill building, networking, and activities fostering the steps needed to locate and gain employment.

Central to the success of Meaningful Opportunities Supports is the philosophy of maximizing time in the community.

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

Meaningful Opportunities Supports are for people ages 18 and older who no longer participate in services provided by IDEA. The services are for people who: are on a pathway to employment; are employed part-time and need a structured and supervised program of services during the time that they are not working; have declined employment opportunities; or are of retirement age.

Meaningful Opportunities Supports provide a supervised program of services and supports, both individually and in groups of no more than three (3) while in the community. Groups of three (3) or fewer people participating in community activities are to be composed of people with like interests.

People receiving Meaningful Opportunities Supports may also receive Supported Employment services as long as Meaningful Opportunities Supports services do not duplicate activities being provided by other services. Any combination of these services cannot be provided at the same time of day.

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

The State covers Meaningful Opportunities Supports for individuals enrolled in CSP up to the maximum amount of 138 hours per month. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State

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

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

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

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

Provider Type *(Specify)*:	**License *(Specify):***	**Certification *(Specify):***	**Other Standard *(Specify):***
Meaningful Opportunities	DMH Certification	Certified every three years by	Enrolled as a provider by the MS Division of Medicaid and the MS

Supports Providers		DMH after initial certification. DMH conducts an annual compliance review.	Dept. of Mental Health.

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

Provider Type *(Specify)*:	**Entity Responsible for Verification *(Specify):***	**Frequency of Verification *(Specify):***
Meaningful Opportunities Supports Providers	Division of Medicaid	Annually

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

☐	**Participant-directed**	☑	**Provider managed**

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

Service Title:	**Supported Employment**

Service Definition (Scope)*:*

Supported Employment is the ongoing support to individuals who, because of their support needs, will require intensive, ongoing services to obtain and maintain a job in competitive, integrated employment, or self-employment. Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Providers must reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. The plan for reduction in services is based on the individual's identified need for support as established in the PSS and must be documented in the individual's record.

Supported Employment Services are provided in a work site where individuals without disabilities are employed; therefore payment is made only for adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not

include payment for the supervisory activities rendered as a normal part of the business setting. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting.

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

Providers must provide all activities that constitute Supported Employment:

1. Job Seeking – Activities that assist an individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours per certification year. Additional hours may be approved by the DMH Bureau of Intellectual and Developmental Disabilities on an individual basis with appropriate documentation. Job seeking includes:

a. Completion of IDD Employment Profile

b. Person-Centered Career Planning, conducted by Supported Employment provider staff, which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches

c. Job Development

(1) Determining the type of environment in which the person is at his/her best

(2) Determining in what environments has the person experienced success

(3) Determining what work and social skills does the person bring to the environment

(4) Assessing what environments are their skills viewed as an asset

(5) Determining what types of work environments should be avoided

d. Employer research

e. Employer needs assessment

(1) Tour the employment site to capture the requirements of the job

(2) Observe current employees

(3) Assess the culture and the potential for natural supports

(4) Determine unmet needs

f. Negotiation with prospective employers

(1) Job developer acts as a representative for the job seeker

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

a. Meeting and getting to know co-workers and supervisors

b. Learning company policies, dress codes, orientation procedures, and company culture

c. Job and task analysis

(1) Core work tasks

(2) Episodic work tasks

(3) Job related tasks

(4) Physical needs

(5) Sensory and communication needs

(6) Academic needs

(7) Technology needs

d. Systematic instruction

(1) Identification and instructional analysis of the goal

(2) Analysis of entry behavior and learner characteristics

(3) Performance Objectives

(4) Instructional strategy

e. Identification of natural supports

(1) Personal associations and relationships typically developed in the community that enhance the quality and security of life

(2) Focus on natural cues

(3) Establish circles of support

f. Ongoing support and monitoring

If an individual moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during the job search

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

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

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

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

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

The State covers Supported Employment Services for individuals enrolled in CSP up to the maximum amount of 100 hours per month. In instances in which a person requires additional amounts of services, as identified through Person Centered Planning, those services must be authorized by DMH or the State.

Supported Employment does not include volunteer work.

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

payments passed through to users of Supported Employment Services.

Staff are required to be present and supporting the individual during Supported Employment activities.

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

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

Individuals receiving Supported Employment may receive Meaningful Opportunities Supports, but not at the same time of day, and Supported Employment services cannot duplicate activities taking place in Meaningful Opportunities Support Services.

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

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

The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

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

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

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

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

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

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

☐	**Participant-directed**	☑	**Provider managed**

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

Service Title:	Supported Living

Service Definition (Scope)*:*

A new service, Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency.

Supported Living Services are provided in residences in the community with four (4) or fewer individuals.

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

- **Grooming**
- **Eating**
- **Bathing**
- **Dressing**
- **Other personal needs.**

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

A. Planning and preparing meals, including assistance in adhering to any diet prescribed by an M.D., Nurse Practitioner or Licensed Dietician/Nutritionist,

B. Cleaning

C. Transportation

D. Assistance with mobility both at home and in the community

E. Supervision of the individual's safety and security

F. Banking

G. Shopping

H. Budgeting

I. Facilitation of the individual's participation in community activities

J. Use of natural supports and typical community services available to everyone

K. Social activities

L. Participation in leisure activities

M. Development of socially valued behaviors

N. Assistance with scheduling and attending appointments

Providers must facilitate meaningful days and independent living choices about activities/services/staff for the individual(s) receiving Supported Living services. Procedures must be in place for individual(s) to access needed medical and other services, as well as typical community services, available to all people.

If chosen by the person, Supported Living staff must assist the person in participation in community activities. Supported Living services for community participation activities may be shared by up to four (4) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

Each individual must have an Activity Support Plan that is developed by the provider with the person present. Information from the PSS and Initial Discovery (which takes place during the first thirty (30) days of services) is to be included in the Activity Support Plan and must address the outcomes on his/her approved PSS.

The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing

the Activity Support Plan with the person.

The State covers Support Living Services for individuals enrolled in CSP up to the maximum amount of four (4) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

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

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

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

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

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

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

Service Delivery Method. ***(Check each that applies)*****:**		
☐ **Participant-directed**		**Provider managed**

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

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

Participant-Direction of Services

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

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

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

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

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

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

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

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

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

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

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

●	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

● The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PSSs in which the services and supports align with assessed needs N: Number of PSSs reviewed in which the services and supports align with assessed needs D: Number of PSSs reviewed
Discovery Activity *(Source of Data &*	Data Source – DMH/DOM review of individual service plan prior to implementation Sample – 100%

sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH/DOM
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The proportion of participants reporting that Case Managers (CM) help them get what they need N: Number of individuals who report CM helps them get what they need D: Number of returned surveys
Discovery Activity *(Source of Data & sample size)*	Data Source – DOM Survey
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and*	DOM

aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of services and supports that were provided in the type, scope, amount, duration and frequency as defined in the PSS. N: Number of PSSs reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the individual service plan. D: Number of PSSs in review sample
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings Sample Size – 95% +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	4. DMH/DOM
Frequency *(of Analysis and Aggregation)*	4. Quarterly

Requirement	***Service plans b) are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PSSs updated at least once per certification period N: Number of PSSs updated annually D: Number of PSSs requiring annual update
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings and IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans c) document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of 1915 (i) Choice of Service forms completed N: Number of 1915(i) Choice of Service forms completed D: Number of individuals in the program
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings and IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities	DOM

(Agency or entity that conducts discovery activities)	
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Eligibility Requirements: a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new enrollees who had a Level of Care (LOC) evaluation indicating need for ICF/IID level of care prior to receipt of services N: Number of new enrollees who received LOC prior to the receipt of services D: Number of new enrollees
Discovery Activity *(Source of Data & sample size)*	Data Source – Long Term Services and Supports (LTSS) Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation	DMH/DOM

Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of initial LOC evaluations conducted where the LOC criteria outlined in the 1915(i) was accurately applied N: Number of initial LOC evaluations reviewed where the LOC criteria outlined in the 1915(i) was accurately applied D: Number of initial LOC evaluations conducted
Discovery Activity *(Source of Data & sample size)*	Data Source - IDD Community Support Program PSS Review Checklists Sample Size - 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	DMH/DOM

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***Eligibility Requirements: c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements N: Number of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements D: Total number of individuals recertified
	Discovery Activity *(Source of Data & sample size)*	Data Source: Monitoring Checklist, LTSS Sample Size: 100% Review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that initially meet DMH certification requirements prior to service delivery N: Number of provider agencies meeting initial certification requirements prior to service delivery. D: Number of provider agencies seeking initial DMH certification.
Discovery Activity *(Source of Data & sample size)*	Data Source - DMH Provider Management System Sample – 100% of initial applicants for DMH certification
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	One time upon initial certification
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of 1915 (i) provider agencies that meet DMH requirements for certification N: Number of 1915 (i) provider agencies who meet certification requirements D: Number of 1915 (i) provider agencies
Discovery Activity	Data Source – DMH Written Reports of Findings

	(Source of Data & sample size)	Sample Size – 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	At least twice during the three year certification period.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***Providers meet required qualifications.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that initially meet Medicaid provider requirements prior to service delivery N: Number of provider agencies meeting initial Medicaid provider requirements D: Number of provider agencies seeking initial Medicaid Provider Status
	Discovery Activity *(Source of Data & sample size)*	Initial provider applications submitted to DOM fiscal agent Sample size -100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
	Frequency	One time upon enrollment
Remediation		
	Remediation Responsibilities	DOM

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who meet Medicaid provider requirements N: Number of 1915 (i) provider agencies who meet Medicaid provider requirements D: Number of 1915 (i) provider agencies
Discovery Activity *(Source of Data & sample size)*	DOM Fiscal Agent Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of certified CSP provider settings assessed for compliance with HCBS Final Rule settings requirements N: Number of CSP settings meeting HCBS Final Rule setting requirements D: Total number of settings reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of monthly quality improvement meetings held in accordance with the requirements of the 1915(i) N: Number of monthly quality improvement meetings held in accordance with the requirements in the 1915(i) D: Total number of monthly quality improvement meetings scheduled
Discovery Activity *(Source of Data &*	Data Source - DOM/DMH monthly quality improvement meeting agendas and meeting minutes

sample size)	Sample size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM/DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM/DMH
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number of and percent of claims for each payment made for services included in the beneficiary's PSS N: Number of claims paid that were included in the individuals PSS D: Number of total claims paid.
Discovery Activity *(Source of Data & sample size)*	Data Source - MMIS system. Data are claims paid for 1915(i) services. Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Continuous and Ongoing
Remediation	
Remediation	DOM

Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of CSP individuals whose records document information of Rights and Options, which include the right to be free from abuse, in addition to procedures for reporting grievances (inclusive of serious incidents) N: Number of individuals whose records indicate acknowledgement of Rights and Options and grievance procedures (inclusive of serious incidents) D: Number of individuals in the program
Discovery Activity *(Source of Data & sample size)*	Data Source – Individual Record Review – DMH Written Reports of Findings Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and*	Annually

	Aggregation)	

Requirement		***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents reported to DMH within timelines N: Number of serious incidents received within timelines D: Number of serious incidents reported
	Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample – 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	Continuous and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
	Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement		***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents received and inquiry was required N: Number of serious incidents that received an inquiry as required D: Number of serious incidents subject to inquiry
	Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size– 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incident that included follow up action that was completed as a result of inquiry N: Number of serious incidents that include completed follow up action D: Number of serious incident requiring follow up action
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMH/DOM

remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of individuals who feel safe in their home, neighborhood, workplace and day program/other daily activities N: Number of individuals who report feeling safe in their home, neighborhood, workplace, and day program/other activities D: Number of completed surveys
Discovery Activity *(Source of Data & sample size)*	Data Source – Sample Size –100% of surveys completed
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents with investigation initiated within the required timeframe N: Number of serious incident investigations initiated within the required timeframe D: Number of serious incidents reported
	Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size – 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	Continuous and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
	Frequency *(of Analysis and Aggregation)*	Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Data is gathered via on-site visits and administrative reviews conducted by DMH. DMH analyzes data against stated performance measures and prioritizes the needs for system improvement based on data gathered. Through Plans of Compliance, remediation is required of all providers when requirements are not met. All Plans of Compliance are reviewed by the DMH Division of Certification and the Bureau of Intellectual/Developmental Disabilities for completeness and appropriateness. Recommendations for approval/disapproval are made to DMH Review Committee which is comprised of DMH's Executive Leadership Team.

DOM's eligibility and claims data is gathered through Medicaid Management Information System (MMIS), also referred to as Envision. MMIS is the mechanized claims processing and information system for DOM. Payments are monitored through monthly reports by DOM's Office of Mental Health. System improvements to the MMIS are made through a Change Service Request (CSR).

DOM operates two (2) audit units to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud, waste and abuse reported or identified through the SURS program. The Office of Financial and Performance Review conducts routine monitoring of cost reports and contracts with other agencies. In addition, these CSP services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the CSP program to identify areas of misuse.

Trends and patterns are analyzed and aggregated on both the provider and system level to identify areas of needed improvement and possible changes in DOM's Administrative Code, DMH Operational Standards, data collection and reporting methods, or records management practices.

2. Roles and Responsibilities

DMH's Division of Certification is responsible for the agency's quality assurance activities such as the development of provider certification standards and monitoring adherence to those standards. The Division of Certification will primarily be responsible for ensuring quality assurance reviews are conducted, data collection and analysis. Trends and patterns will be identified by the Division of Certification and the DMH BIDD.

DOM and DMH hold monthly quality improvement management meetings to assess required system changes, focus on trends and patterns identified, and develop strategies and/or interventions for improved outcomes.

3. Frequency

Data is aggregated and analyzed at least annually.

4. Method for Evaluating Effectiveness of System Changes

To determine if number of instances of remediation in identified areas decreases based on changes made to implement systems improvement. Remediation activities are monitored by DMH's Division of Certification.

DMH and DOM will utilize a number of sources to analyze effectiveness of system changes, including but not limited to on-site visits and administrative reviews, performance indicators, claims data, critical incident data, and Medicaid Fair Hearing data.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
	Day Habilitation Services - Low Support (Level 1 & 2) $3.78 per 15 min. unit Day Habilitation Services - Medium Support (Level 3) $4.10 per 15 min. unit Day Habilitation Services - High Support (Level 4 & 5) $4.66 per 15 min. unit Prevocational Services Low Support (Level 1 & 2) $12.48 per hour Prevocational Services Medium Support (Level 3) $13.28 per hour Prevocational Services High Support (Level 4 & 5) $14.64 per hour Supported Employment –Job Development, $8.80 per 15 minute Supported Employment – Job Maintenance (1 person) $8.35 per 15 minute Supported Employment – Job Maintenance (2 person) $5.22 per 15 minute Supported Employment – Job Maintenance (3 person) $4.17 per 15 minute Meaningful Opportunities Supports - Low Support (Level 1 & 2) $3.78 per 15 minute Meaningful Opportunities Supports - Medium Support (Level 3) $4.10 per 15 minute Meaningful Opportunities Supports - High Support (Level 4 & 5) $4.66 per 15 minute Supported Living (1 person) $6.34 per 15 minute Supported Living (2 person) $3.97 per 15 minute Supported Living (3 person) $3.17 per 15 minute
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	

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

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

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

Administration and Operation

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

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

Day Habilitation Services, Prevocational Services, ~~and~~ Meaningful Opportunities Supports, Supported Employment Services, and Supported Living

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
●	**Applicable**

Check the applicable authority or authorities:

☑	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§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 §1115 of the Act.** *Specify the program*:

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

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

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

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

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

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

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

DMH, in addition to DOM performs 2, 3, 4, 5, 6, 8, 9, 10

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

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

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

DMH's Diagnostic and Evaluation (D&E) Teams perform the evaluations, reevaluations and assessments for 1915(i) for ~~medical~~ eligibility. ~~DMH~~ Enrolled case management agencies provide~~s~~ Targeted Case Management (TCM) Services to coordinate and facilitate Person-Centered Planning to develop ~~individualized plans of care~~Plans of Services and Supports (PSS) for individuals receiving HCBS.

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

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

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

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

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/01/2018	6/30/2019	~~2,000~~ 950
Year 2	7/01/2019	6/30/2020	~~2,000~~ 1,150
Year 3	7/01/2020	6/30/2021	~~2,000~~ 1,350
Year 4	7/01/2021	6/30/2022	~~2,000~~ 1,550
Year 5	7/01/2022	6/30/2023	~~2,000~~ 1,750

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

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

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

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

Evaluation/Reevaluation of Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

participate in State plan HCBS must have a need for assistance demonstrated by a need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.) to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands. The individual must also have a likelihood of retaining new skills acquired through habilitation over time. Individual must have a condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require planning and coordination of services to assist the individual in achieving maximum potential that continues or can be expected to continue, indefinitely. In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis: • Is unemployed or employed in a sheltered setting, or has markedly limited skills and a poor or non-	Independent Living, Traumatic Brain/Spinal Cord and Assisted Living waivers, the individual must be assessed and score 50 or less on a standardized preadmission screening tool designed and tested to determine whether the individual meets nursing home level of care. Additionally, the physician must certify level of care. For participation in the Traumatic Brain or the Independent Living waivers, the individual must have either a specific condition or diagnose which requires specialized services to meet the unique needs of the waiver participant. The Traumatic Brain Injury waiver requires the individual to have a diagnosed traumatic brain/spinal cord injury to qualify for services. The Independent Living waiver requires the individual to have either a neurological or orthopedic condition with impairment resulting in the need for nursing home level of care. The Assisted Living waiver requires an individual to have a diagnosed traumatic brain injury with complicating behavioral issues resulting in the	the individual must have an intellectual disability, ~~or~~ a developmental disability, or Autism Spectrum Disorder. ~~with associated deficits in adaptive functioning and have a need for active treatment.~~ An intellectual disability as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM~~S~~) published by the American Psychiatric Association. ~~In order to receive a diagnosis of mental retardation (an intellectual disability),~~ an individual must have an IQ score of approximately 70 or below and confirmation a determination of deficits in adaptive behavior. Both must exist and originate prior to the age of 18. A developmental disability includes multiple types of disabilities (cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability) that are brought about by either a physical impairment, mental impairment, or both before the age of 22 that is likely to continue for an indefinite period of time and results in limitations ~~in~~ of functioning in 3 or more areas: self-care, receptive and expressive language,	

existent work history. • Shows severe inability to establish or maintain a beneficial, meaningful personal social support system. • Requires help in basic Instrumental Activities of Daily Living (IADL) such as money management, housekeeping, meal planning and preparation, shopping for food, clothing and other essential items, communicating by phone or other media, and traveling around and participating in the community. • Exhibits inappropriate social behavior that results in the need for intervention. • Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.	need for specialized care to qualify for the traumatic brain injury residential services offered through this waiver.	learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Autism Spectrum Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM~~S~~) published by the American Psychiatric Association.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The state is targeting Individuals with Intellectual Disabilities, ~~and/or~~ Developmental Disabilities, or Autism Spectrum ~~-~~Disorder~~(IID~~ID/DD~~)~~. ~~Commencing November 1, 2013, I~~in addition to the needs identified above, the individual must also have a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	○	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive*

HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The Centers for Medicare and Medicaid Services (CMS) granted the State initial approval of its Statewide Transition Plan (STP) on May 25, 2017, to bring settings into compliance with the federal home and community based services (HCBS) regulations found at 42 C.F.R. §§441.30l(c)(4)(5) and Section 441.710(a)(l)(2). The STP can be found at https://medicaid.ms.gov/wp-content/uploads/2017/05/MS-STP-Summary-and-Timeline-approved-5.25.17.pdf.

Mississippi assures that the settings transition plan included with this 1915(i) renewal will be subject to the provisions or requirements included in the State's approved Statewide Transition Plan.

Mississippi's 1915(i) Community Support Program uses a person directed, person focused planning process in determining the type and level of supports to incorporate each participant/beneficiary's unique desires and wishes in the services they receive. The goal is to provide supports for persons/beneficiaries to receive services in settings that meet the requirements of the final rule. Persons/beneficiaries are able to choose non-disability specific settings to receive services.

1915(i) Community Support Program:
ID/DD 1915(i) services provided in non-residential settings which must meet the requirements of the HCBS settings include:

- Day Habilitation services are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities, which support and enhance the individual's independence in the community. This service is provided in a Department of Mental Health certified, non-residential setting,
- Prevocational services provide learning and work experiences so that the individual can develop the strengths and skills needed to gain paid employment in integrated community settings. This service is provided in a Department of Mental Health certified, non-residential setting,
- Meaningful Opportunities Supports is intended to foster community integration and employment for the individuals served. This will be accomplished through the provision of opportunities for developing and maintaining competency in personal, social, and community activities. This service is provided in a Department of Mental Health certified, non-residential setting,
- Supported Employment is ongoing support for people who, because of their support needs, require intensive, ongoing services to obtain or maintain a job in competitive, integrated employment or self-employment. Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

ID/DD 1915(i) services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:

- Supported Living services are provided to individuals who reside in their own residence (either owned or leased) for the purposes of increasing and enhancing independent living. in the community.
-

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

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

Each D&E Team consists of at least the following: psychologist~~,~~ and social worker. Additional team members, such as physical therapists, dieticians, etc. may be utilized depending upon the needs of the individual being evaluated. All members of the D&E Teams are licensed and/or certified through the appropriate State licensing/certification body for their respective discipline.

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

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

Targeted Case Managers (TCM) are responsible for the development of a person-centered plan (PSS) for each person receiving 1915(i) Services. Targeted Case Management is provided by an individual with at least a Bachelor's degree in an intellectual/developmental disabilities or related field and at least one year experience in working with people with intellectual or developmental disabilities. Targeted Case Management can also be provided by a Registered Nurse with at least one year experience in working with people with intellectual or developmental disabilities. Additionally, Targeted Case Managers must complete training in Person-Centered Planning and demonstrate competencies associated with that process.

The State will implement a process to ensure open enrollment for all willing and qualified providers for case management services. Case Management Agencies must have a statewide network of case managers. Additionally, the following requirements must be met:

TCM Education Needs: The TCM must be certified in order to provide case management. Additionally, TCMs must be recertified annually. DMH, as the operating agency, will be responsible for certification standards, as approved by the State.

TCM Supervisors: This is an administrative position involving the planning, direction, and administration of the case management program. Supervision of the TCM is a function that is required to ensure that all components of case management are carried out according to the Quality Assurance Standards. DMH, as the operating agency, will be responsible for certification standards for TCM supervisors, as approved by the State.

The State will transition from the current case management system to the one outlined above by October 31, 2019.

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

The active involvement of individuals and their families and/or legal guardians are essential to the development and implementation of a ~~plan of care~~PSS that is person-

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

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

Targeted Case Managers will assist ~~the~~ individuals in selecting qualified providers of the 1915(i) services. A qualified provider must be a Medicaid provider and be certified by DMH to provide the services. During the development of the ~~plan of care~~ PSS, ~~c~~Targeted Case ~~m~~Managers will educate the individual about the qualified providers certified to provide the services in the area the individual lives as identified on the plan of care. Individuals have a right to choose a provider and may change service providers at any time. Should additional qualified providers be identified, the Targeted Case Managers will inform the individuals of the new qualified providers ~~of service~~. DMH, Division of Certification, is the entity responsible for notifying the Targeted Case Managers regarding providers who have received DMH certification to provide services.

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

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

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

DMH then forwards the Plan of ~~Care~~ Services and Supports to ~~DOM~~ the State for review and approval.

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

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

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

Services

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

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

Day Habilitation Services are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports to enhance an individual's acquisition of skills, appropriate behaviors and personal choice. Day Habilitation activities must aim to improve skills needed for the individuals to function as independently as possible. Day Habilitation will be provided based on a person-centered approach with supports tailored to the individual desires and life plan of the individual participant. Day Habilitation Services take place in a non-residential setting that is separate from the residence of the individuals receiving the service~~. Services cannot exceed five (5) hours a day and must be delivered at least four (4) hours one (1) day per week and are based on the individual's plan of care~~. The State covers Day Habilitation Services for individuals enrolled in the Community Support Program up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State. A minimum staffing ratio of 1 staff member to every 8 individuals receiving the service will be in place. Individuals will be able to choose their provider of Day Habilitation Services from those certified by the MS Department of Mental Health to provide the service.

The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

With the addition of Meaningful Opportunities Supports, Day Habilitation will be phased out. There will be no new enrollments in Day Habilitation after 11/01/2018. Individuals

receiving this service will be transitioned to other appropriate services, including Meaningful Opportunities Supports, from 11/01/2018 to 12/01/2018. This transition will be accomplished through Person-Centered Planning meetings with Targeted Case Managers.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Day Habilitation Providers	Division of Medicaid	Annually

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the*

state plans to cover):	
Service Title:	Prevocational Services
Service Definition (Scope)*:*	

Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Individuals receiving Prevocational Services must have employment related goals in their ~~Plans of Care~~PSS; the general habilitation activities must be designed to support such employment goals.

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

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

Ability to communicate effectively with supervisors, coworkers and customers

Generally accepted community workplace conduct and dress

Ability to follow directions; ability to attend to tasks

Workplace problem solving skills and strategies

General workplace safety and mobility training

Attention span

Motor skills

Interpersonal relations

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

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

The State covers Prevocational Services for individuals enrolled in CSP up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State. ~~Services provided cannot exceed six (6) hours per day.~~

Individuals may be compensated in accordance with applicable Federal Laws.

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

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

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

With the addition of Meaningful Opportunities Supports, Prevocational Services will be phased out. There will be no new enrollments in Prevocational Services after 11/01/2018. Individuals receiving this service will be transitioned to other appropriate services, including Meaningful Opportunities Supports, from 11/01/2018 to 12/01/2018. This transition will be accomplished through Person-Centered Planning meetings with Targeted Case Managers.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐	Medically needy *(specify limits):*

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Prevocational Services Providers	Division of Medicaid	Annually

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	**Meaningful Opportunities Supports**

Service Definition (Scope)*:*

A new service, Meaningful Opportunities Supports, is being added to the array of services. Meaningful Opportunities Supports is intended to foster community integration and employment for the individuals served. This will be accomplished through the provision of opportunities for developing and maintaining competency in personal, social, and community activities.

Meaningful Opportunities Supports will provide a flexible array of meaningful opportunities

based on individual preferences and needs identified in the PSS. This new service can include:

- **Career exploration**
- **Community integration experiences**
- **Socialization experiences**
- **Development and maintenance of independent living skills**
- **Pursuit of leisure interests and hobbies**

Pursuit of employment will be a central component of Meaningful Opportunities Supports for individuals wishing to find employment. Activities in this area will include skill building, networking, and activities fostering the steps needed to locate and gain employment.

Central to the success of Meaningful Opportunities Supports is the philosophy of maximizing time in the community.

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

Meaningful Opportunities Supports are for people ages 18 and older who no longer participate in services provided by IDEA. The services are for people who: are on a pathway to employment; are employed part-time and need a structured and supervised program of services during the time that they are not working; have declined employment opportunities; or are of retirement age.

Meaningful Opportunities Supports provide a supervised program of services and supports, both individually and in groups of no more than three (3) while in the community. Groups of three (3) or fewer people participating in community activities are to be composed of people with like interests.

People receiving Meaningful Opportunities Supports may also receive Supported Employment services as long as Meaningful Opportunities Supports services do not duplicate activities being provided by other services. Any combination of these services cannot be provided at the same time of day.

The provider is required to allow at least one staff person, invited by the person and who works with him/her on a regular basis, to attend the person's PSS meeting. Supervisory staff who do not have regular contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

The State covers Meaningful Opportunities Supports for individuals enrolled in CSP up to the maximum amount of 138 hours per month. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State

The service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq). Records for people receiving ID/DD Meaningful Opportunities Supports will document that the Mississippi Department of

Rehabilitation Services (MDRS) was unable to serve the person.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. ***(Choose each that applies):***
☐ **Categorically needy *(specify limits):***
☐ **Medically needy *(specify limits):***

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

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

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

Provider Type *(Specify)*:	**Entity Responsible for Verification** ***(Specify):***	**Frequency of Verification *(Specify):***
Meaningful Opportunities Supports Providers	Division of Medicaid	Annually

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

☐	**Participant-directed**	☑	**Provider managed**

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

Service Title:	**Supported Employment**

Service Definition (Scope)*:*

Supported Employment is the ongoing support to individuals who, because of their support needs, will ~~need~~ require intensive, ongoing ~~support~~ services to obtain and maintain a~~n individual~~ a job in competitive, integrated employment ~~or customized employment~~, or self-employment. Employment must be in an integrated work setting in the general workforce ~~for whom~~ where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Providers must reduce the number of hours of staff involvement as the ~~over the first few weeks of employment as the supported~~ employee becomes more productive and less dependent on paid supports. The plan for reduction in services is based on the individual's identified need for support as established in the ~~Plan of Services and Supports~~PSS and must be documented in the individual's record.

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

Each individual must have an Activity Plan that is developed based on his/her ~~Plan of Services and Supports~~ PSS.

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

1. Job Seeking – Activities that assist an individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours per certification year. Additional hours may be approved by the DMH Bureau of Intellectual and Developmental Disabilities on an individual basis with appropriate documentation. Job seeking includes:

a. Completion of IDD Employment Profile

b. Person-Centered Career Planning, conducted by Supported Employment provider staff, which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches

c. Job Development

(1) Determining the type of environment in which the person is at his/her best

(2) Determining in what environments has the person experienced success

(3) Determining what work and social skills does the person bring to the environment

(4) Assessing what environments are their skills viewed as an asset

(5) Determining what types of work environments should be avoided

d. Employer research

e. Employer needs assessment

(1) Tour the employment site to capture the requirements of the job

(2) Observe current employees

(3) Assess the culture and the potential for natural supports

(4) Determine unmet needs

f. Negotiation with prospective employers

(1) Job developer acts as a representative for the job seeker

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

a. Meeting and getting to know co-workers and supervisors

b. Learning company policies, dress codes, orientation procedures, and company culture

c. Job and task analysis

(1) Core work tasks

(2) Episodic work tasks

(3) Job related tasks

(4) Physical needs

(5) Sensory and communication needs

(6) Academic needs

(7) Technology needs

d. Systematic instruction

(1) Identification and instructional analysis of the goal

(2) Analysis of entry behavior and learner characteristics

(3) Performance Objectives

(4) Instructional strategy

e. Identification of natural supports

(1) Personal associations and relationships typically developed in the community that enhance the quality and security of life

(2) Focus on natural cues

(3) Establish circles of support

f. Ongoing support and monitoring

If an individual moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during the job search

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

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

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

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

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

The State covers Supported Employment Services for individuals enrolled in CSP up to the maximum amount of 100 hours per month. In instances in which a person requires additional amounts of services, as identified through Person Centered Planning, those services must be authorized by DMH or the State. ~~Service hours cannot exceed forty (40) hours per month.~~

Supported Employment does not include volunteer work.

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

Staff are required to be present and supporting the individual during Supported Employment activities.

~~Individuals receiving Supported Employment cannot be left alone at any time.~~

Assistance with toileting and hygiene may be a component part of Supported Employment, but

may not comprise the entirety of the service.

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

Individuals receiving Supported Employment may receive Meaningful Opportunities Supports, but not at the same time of day, and Supported Employment services cannot duplicate activities taking place in Meaningful Opportunities Support Services.

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

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

The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

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

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

Provider Type *(Specify)*:	**License *(Specify):***	**Certification *(Specify):***	**Other Standard *(Specify):***
Supported	DMH	Certified every	Enrolled as a provider by the MS

Employment Providers	Certification	three years by DMH after initial certification. DMH conducts an annual compliance review.	Division of Medicaid and the MS Dept. of Mental Health.

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

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

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

☐	**Participant-directed**	☑	**Provider managed**

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

Service Definition (Scope)*:*

A new service, Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency.

Supported Living Services are provided in residences in the community with four (4) or fewer individuals.

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

- **Grooming**
- **Eating**
- **Bathing**
- **Dressing**
- **Other personal needs.**

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

A. Planning and preparing meals, including assistance in adhering to any diet prescribed by an M.D., Nurse Practitioner or Licensed Dietician/Nutritionist,

B. Cleaning

C. Transportation

D. Assistance with mobility both at home and in the community

E. Supervision of the individual's safety and security

F. Banking

G. Shopping

H. Budgeting

I. Facilitation of the individual's participation in community activities

J. Use of natural supports and typical community services available to everyone

K. Social activities

L. Participation in leisure activities

M. Development of socially valued behaviors

N. Assistance with scheduling and attending appointments

Providers must facilitate meaningful days and independent living choices about activities/services/staff for the individual(s) receiving Supported Living services. Procedures must be in place for individual(s) to access needed medical and other services, as well as typical community services, available to all people.

If chosen by the person, Supported Living staff must assist the person in participation in community activities. Supported Living services for community participation activities may be shared by up to four (4) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

Each individual must have an Activity Support Plan that is developed by the provider with the person present. Information from the PSS and Initial Discovery (which takes place during the first thirty (30) days of services) is to be included in the Activity Support Plan and must address the outcomes on his/her approved PSS.

The provider is required to allow at least one staff person, invited by the person, who works with him/her on a daily basis and who knows him/her best to attend the person's PSS meeting. Supervisory staff who do not have at least daily contact with a person do not meet the staff attendance requirement, but may attend, if invited by the person, in order to assist in writing the Activity Support Plan with the person.

The State covers Support Living Services for individuals enrolled in CSP up to the maximum amount of four (4) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. ***(Choose each that applies):***

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

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

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

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

Provider Type *(Specify)*:	**Entity Responsible for Verification *(Specify):***	**Frequency of Verification *(Specify):***

Supported Living Providers	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:			
☐	**Participant-directed**	☑	**Provider managed**

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

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

Participant-Direction of Services

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

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

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

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

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

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

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

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

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

●	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.

○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

●	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

●	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement		~~***Service plans address assessed needs of 1915 (i) participants, are updated annually, and document choice of service services and providers.***~~ ***Service plans a) address assessed needs of 1915(i) participants***
Discovery		
	Discovery Evidence *(Performance Measure)*	~~1.~~ Number and percent of ~~individual service plans~~ PSSs in which the services and supports align with assessed needs ~~Numerator (~~N~~):~~ # Number of ~~individual service plans~~ PSSs reviewed in which the services and supports align with assessed needs ~~Denominator (~~D~~)~~: # Number of ~~individual service plans~~ PSSs reviewed
	Discovery	~~1.~~ Data Source – DMH/DOM review of individual service plan prior to

	Activity *(Source of Data & sample size)*	implementation Sample – 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~1.~~ DMH/DOM
	Frequency	~~1.~~ Discovery is continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~1.~~ DMH/DOM
	Frequency *(of Analysis and Aggregation)*	~~1.~~ Quarterly

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The proportion of participants reporting that Case Managers (CM) help them get what they need N: Number of individuals who report CM helps them get what they need D: Number of returned surveys
Discovery Activity *(Source of Data & sample size)*	Data Source – DOM Survey
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of services and supports that were provided in the type, scope, amount, duration and frequency as defined in the PSS. N: Number of PSSs reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the individual service plan. D: Number of PSSs in review sample
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings Sample Size – 95% +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	4. DMH/DOM

Frequency *(of Analysis and Aggregation)*	4. Quarterly

Requirement	***~~Service plans address assessed needs of 1915 (i) participants, are updated annually, and document choice of service services and providers.~~*** ***Service plans b) are ~~updated~~updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PSSs updated at least once per certification period N: Number of PSSs updated annually D: Number of PSSs requiring annual update
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings and IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***~~Service plans address assessed needs of 1915 (i) participants, are updated annually, and document choice of service services and providers.~~*** ***Service plans c) document choice of services and providers.***
Discovery	

Discovery Evidence *(Performance Measure)*	~~2.~~ Number and percent of 1915 (i) ~~participants who were afforded a choice of providers.~~ Choice of Service forms completed N: ~~#~~ Number of 1915(i) Choice of Service forms completed ~~sampled participants who were afforded choice of provider.~~ D: ~~#~~ N~~n~~umber of ~~participants sampled.~~ individuals in the program
Discovery Activity *(Source of Data & sample size)*	~~2.~~ Data Source – DMH Written Report of Findings and IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~2.~~ ~~DMH~~DOM
Frequency	~~2.~~ Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~2.~~ ~~DMH~~DOM
Frequency *(of Analysis and Aggregation)*	~~2.~~ Quarterly

Requirement	***Eligibility Requirements: a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new enrollees who had a Level of Care (LOC) evaluation indicating need for ICF/IID level of care prior to receipt of services N: Number of new enrollees who received LOC prior to the receipt of services D: Number of new enrollees
Discovery	Data Source – Long Term Services and Supports (LTSS)

Activity *(Source of Data & sample size)*	Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of initial LOC evaluations conducted where the LOC criteria outlined in the 1915(i) was accurately applied N: Number of initial LOC evaluations reviewed where the LOC criteria outlined in the 1915(i) was accurately applied D: Number of initial LOC evaluations conducted
Discovery Activity *(Source of Data & sample size)*	Data Source - IDD Community Support Program PSS Review Checklists Sample Size - 100% Review
Monitoring Responsibilities *(Agency or entity that*	DMH

conducts discovery activities)	
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements N: Number of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements D: Total number of individuals recertified
Discovery Activity *(Source of Data & sample size)*	Data Source: Monitoring Checklist, LTSS Sample Size: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~1.~~ Number and percent of provider agencies that initially meet DMH certification requirements prior to service delivery~~.~~ N: ~~#~~ Number of provider agencies meeting initial certification requirements prior to service delivery. D: ~~#~~ Number of provider agencies seeking initial DMH certification.
Discovery Activity *(Source of Data & sample size)*	Data Source - DMH Provider Management System Sample – 100% of initial applicants for DMH certification
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	One time upon initial certification
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	DMH

timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~2.~~ Number and percent of 1915 (i) provider agencies that ~~continue to~~ meet DMH requirements for certification~~.~~ N: # Number of 1915 (i) provider agencies who ~~continue to~~ meet certification requirements D: # Number of 1915 (i) provider agencies
Discovery Activity *(Source of Data & sample size)*	~~2.~~ Data Source – DMH Written Reports of Findings Sample Size ~~–~~ 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~2.~~ DMH
Frequency	~~1.~~ At least twice during the three year certification period.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~2.~~ DMH
Frequency *(of Analysis and Aggregation)*	~~2. Continuous and Ongoing~~ Annually

Requirement	***Providers meet required qualifications.***
Discovery	

	Discovery Evidence *(Performance Measure)*	~~3.~~ Number and percent of provider agencies that initially meet Medicaid provider requirements prior to service delivery~~.~~ N: ~~#~~ Number of provider agencies meeting initial Medicaid provider requirements~~.~~ D: ~~# number~~ Number of provider agencies seeking initial Medicaid Provider Status
	Discovery Activity *(Source of Data & sample size)*	~~3.~~ Initial provider applications submitted to DOM fiscal agent~~.~~ Sample size -100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~3.~~ DOM
	Frequency	~~3.~~ One time upon enrollment~~.~~
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~3.~~ DOM
	Frequency *(of Analysis and Aggregation)*	~~3. Continuous and Ongoing~~ Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~4.~~ Number and percent of provider agencies t~~hat~~ who ~~continue to~~ meet Medicaid provider requirements~~.~~ N: # Number of 1915 (i) provider agencies who ~~continue to~~ meet Medicaid provider requirements~~.~~ D: # Number of 1915 (i) provider agencies
Discovery Activity *(Source of Data & sample size)*	~~4.~~ DOM Fiscal Agent Sample size -100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~4.~~ DOM
Frequency	~~4.~~ Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~4.~~ DOM
Frequency *(of Analysis and Aggregation)*	~~4. Continuous and Ongoing~~Annually

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of certified CSP provider settings assessed for compliance with HCBS Final Rule settings requirements ~~service settings that meet item 9 requirements~~ N: Number of CSP settings meeting HCBS Final Rule setting requirements D: ~~# of t~~ Total number of settings reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	~~Continuous and Ongoing~~ Annually
Remediation	
Remediation Responsibilities	DMH/DOM

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	~~Continuous and Ongoing~~ Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~Number and percent of individuals who are certified/recertified to receive 1915 (i) services who meet Medicaid eligibility requirements. N: # of individuals who are certified/recertified to receive 1915 (i) services who meet Medicaid eligibility requirements D: # of individuals certified/recertified by DMH to receive 1915 (i) services~~ Number and percent of monthly quality improvement meetings held in accordance with the requirements of the 1915(i) N: Number of monthly quality improvement meetings held in accordance with the requirements in the 1915(i) D: Total number of monthly quality improvement meetings scheduled
Discovery Activity *(Source of Data & sample size)*	~~Data Source – Individual Record Review~~ ~~Sample Size – 100% at initial certification/ annual recertification~~ Data Source - DOM/DMH monthly quality improvement meeting agendas and meeting minutes Sample size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM/DMH
Frequency	~~Continuous and Ongoing~~ Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	DOM/DMH

activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number of and percent of claims for each payment ~~was~~ made for services included in the beneficiary's ~~plan of care~~PSS~~.~~ N: ~~#~~ Number of claims paid that were included in the individuals ~~plan of care~~PSS~~.~~ D: # Number of total claims paid.
Discovery Activity *(Source of Data & sample size)*	Data Source ~~-~~ ~~is~~ MMIS system. Data are claims paid for 1915(i) services. Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***

Discovery	
Discovery Evidence *(Performance Measure)*	~~1.~~ Number and percent of CSP individuals whose records document information of Rights and Options, which include the right to be free from abuse, in addition to procedures for reporting grievances (inclusive of serious incidents)~~.~~ N: ~~#~~ Number of individuals whose records ~~that~~ indicate acknowledgement of Rights and Options and grievance procedures (inclusive of serious incidents) D: # Number of ~~records reviewed~~ individuals in the program~~.~~
Discovery Activity *(Source of Data & sample size)*	~~1.~~ Data Source – Individual Record Review – DMH Written Reports of Findings Sample Size – ~~less than 100% review – confidence interval = 95 +/- 5% margin of error~~100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~1.~~ DMH
Frequency	~~1. Continuous and Ongoing~~ Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~1.~~ DMH/DOM
Frequency *(of Analysis and Aggregation)*	~~1. Quarterly~~ Annually

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~2.~~ Number and percent of serious incidents reported to DMH within timelines~~.~~ N: ~~#~~ Number of serious incidents received within timelines~~.~~ D: ~~#~~ Number of serious incidents reported~~.~~
Discovery Activity *(Source of Data &*	~~2.~~ Data Source – DMH Serious Incident Management System – Sample – 100%

sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~2.~~ DMH
Frequency	~~2.~~ Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~2.~~ DMH/DOM
Frequency *(of Analysis and Aggregation)*	~~2.~~ Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~3.~~ Number and percent of serious incidents received and inquiry was required~~.~~ N: ~~#~~ Number of serious incidents that received an inquiry as required~~.~~ D: ~~#~~ Number of serious incidents subject to inquiry~~.~~
Discovery Activity *(Source of Data & sample size)*	~~3.~~ Data Source – DMH Serious Incident Management System – Sample Size~~–~~ 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~3.~~ DMH
Frequency	~~3.~~ Continuous and Ongoing
Remediation	
Remediation Responsibilities	~~3.~~ DMH/DOM

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	~~3.~~ Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~4.~~ Number and percent of serious incident that included follow up action that was completed as a result of inquiry~~.~~ N: ~~#~~ Number of serious incidents that include completed follow up action~~.~~ D: ~~#~~ Number of serious incident requiring follow up action
Discovery Activity *(Source of Data & sample size)*	~~4.~~ Data Source – DMH Serious Incident Management System – Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~4.~~ DMH
Frequency	~~4.~~ Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~4.~~ DMH/DOM
Frequency *(of Analysis and Aggregation)*	~~4.~~ Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	~~5. The proportion of individuals who report that~~ Number and percent of individuals who ~~they~~ feel safe in their home, neighborhood, workplace and day program/other daily activities~~.~~ N: ~~#~~ Number of individuals who report feeling safe in their home, neighborhood, workplace, and day program/other activities~~.~~ D: ~~#~~ Number of ~~individuals in survey sample~~ completed surveys~~.~~
Discovery Activity *(Source of Data & sample size)*	~~5.~~ Data Source ~~– National Core Indicators – Consumer Survey –~~ Sample Size ~~– less than~~ 100% of surveys completed
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~5.~~ DMH
Frequency	~~5.~~ Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~5.~~ DMH/DOM
Frequency *(of Analysis and Aggregation)*	~~5.~~ Annually

Requirement	
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents with investigation initiated within the required timeframe N: Number of serious incident investigations initiated within the required timeframe D: Number of serious incidents reported

	Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size – 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	Continuous and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
	Frequency *(of Analysis and Aggregation)*	Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Data is gathered via on-site visits and administrative reviews conducted by DMH. DMH analyzes data against stated performance measures and prioritizes the needs for system improvement based on data gathered. Through Plans of Compliance, r~~R~~emediation is required of all providers when requirements are not met. All Plans of Compliance are reviewed by the DMH ~~Bureaus of Quality Management, Operations and Standards (BQMOS)~~ Division of Certification and the Bureau of Intellectual/Developmental Disabilities for completeness and appropriateness. Recommendations for approval/disapproval are made to DMH Review Committee which is comprised of DMH's Executive Leadership Team.

DOM's eligibility and claims data is gathered through Medicaid Management Information System (MMIS), also referred to as Envision. MMIS is the mechanized claims processing and information system for DOM. Payments are monitored through monthly reports by DOM's Office of Mental Health. System improvements to the MMIS are made through a Change Service Request (CSR).

DOM operates two (2) audit units to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud, waste and abuse reported or identified through the SURS program. The Office of Financial and Performance Review conducts routine monitoring of cost reports and contracts with other agencies. In addition, these CSP services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the CSP program to identify areas of misuse.

Trends and patterns are analyzed and aggregated on both the provider and system level to identify areas of needed improvement and possible changes in DOM's Administrative Code, DMH Operational Standards, data collection and reporting methods, or records management practices.

2. Roles and Responsibilities

DMH's ~~BQMOS~~ Division of Certification is responsible for the agency's quality assurance activities such as the development of provider certification standards and monitoring adherence to those standards. ~~BQMOS~~ The Division of Certification will primarily be responsible for ensuring quality assurance reviews are conducted, data collection and analysis. Trends and patterns will be identified by ~~BQMOS, the agency's Quality Management Council~~ the Division of Certification and the DMH BIDD.

DOM and DMH hold monthly quality improvement management meetings to assess required system changes, focus on trends and patterns identified, and develop strategies and/or interventions for improved outcomes.

3. Frequency

Data is aggregated and analyzed at least annually.

4. Method for Evaluating Effectiveness of System Changes

To determine if number of instances of remediation in identified areas decreases based on changes made to implement systems improvement. Remediation activities are monitored by ~~the BQMOS.~~ DMH's Division of Certification.

DMH and DOM will utilize a number of sources to analyze effectiveness of system changes, including but not limited to on-site visits and administrative reviews, performance indicators, claims data, critical incident data, and Medicaid Fair Hearing data.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
	~~Day Habilitation Services $10.80 per hour~~ Day Habilitation Services - Low Support (Level 1 & 2) $3.78 per 15 min. unit Day Habilitation Services - Medium Support (Level 3) $4.10 per 15 min. unit Day Habilitation Services - High Support (Level 4 & 5) $4.66 per 15 min. unit ~~Prevocational Services $12.53 per hour~~ Prevocational Services Low Support (Level 1 & 2) $12.48 per hour Prevocational Services Medium Support (Level 3) $13.28 per hour Prevocational Services High Support (Level 4 & 5) $14.64 per hour ~~Supported Employment Services $25.00 per hour~~ Supported Employment –Job Development, $8.80 per 15 minute Supported Employment – Job Maintenance (1 person) $8.35 per 15 minute Supported Employment – Job Maintenance (2 person) $5.22 per 15 minute Supported Employment – Job Maintenance (3 person) $4.17 per 15 minute Meaningful Opportunities Supports - Low Support (Level 1 & 2) $3.78 per 15 minute Meaningful Opportunities Supports - Medium Support (Level 3) $4.10 per 15 minute Meaningful Opportunities Supports - High Support (Level 4 & 5) $4.66 per 15 minute Supported Living (1 person) $6.34 per 15 minute Supported Living (2 person) $3.97 per 15 minute Supported Living (3 person) $3.17 per 15 minute
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	

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

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*