

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:

Elderly and Disabled (E&D)

C. Waiver Number:MS.0272

Original Base Waiver Number: MS.0272.90.R1

D. Amendment Number:MS.0272.R05.01

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

10/01/19

Approved Effective Date of Waiver being Amended: 07/01/17

2. Purpose(s) of Amendment

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

The following changes are included in this amendment:

Update Extended Home Health limits to reflect State Plan changes.

Add the option for telephone interviews to supplement home visits as a method for completing participant quality surveys.

Correct Community Transition Service typo in Appendix J.

Remove the In Home Respite worker experience requirement from four or more years' experience as a direct care provider to the aged or disabled to mirror Personal Care.

Change Personal Care Service and In Home Respite worker requirements to replace driver's license with State Issued ID.

Update Personal Care Service, In Home Respite, and Adult Day Care provider requirements to reference Quality Assurance Standards.

Update Training requirements for Personal Care Services and In Home Respite workers.

Update the Transition Plan regarding the open enrollment of Case Management.

Update the language in B6e regarding Level Of Care instrument.

Clarify language regarding community assistance and Personal Care Services.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	I. Public Input
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	B-6-e
Appendix C Participant Services	C-1/C-3 Service Definition for Personal Care Services and Provider
Appendix D Participant Centered Service Planning and Delivery	D-1-b
Appendix E Participant Direction of Services	
Appendix F Participant Rights	

Component of the Approved Waiver	Subsection(s)
Appendix G Participant Safeguards	G QIS PM3 Data Source
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	J-2-d Year 2 Average Cost Per Unit for Community Transition Services

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

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**

Other
Specify:

The following changes are included in this amendment:

Update Extended Home Health limits to reflect State Plan changes.

Add the option for telephone interviews to supplement home visits as a method for completing participant quality surveys.

Correct Community Transition Service typo in Appendix J.

Remove the In Home Respite worker experience requirement from four or more years' experience as a direct care provider to the aged or disabled to mirror Personal Care.

Change Personal Care Service and In Home Respite worker requirements to replace driver's license with State Issued ID.

Update Personal Care Service, In Home Respite, and Adult Day Care provider requirements to reference Quality Assurance Standards.

Update Training requirements for Personal Care Services and In Home Respite workers.

Update the Transition Plan regarding the open enrollment of Case Management.

Update the language in B6e regarding Level Of Care instrument.

Clarify language regarding community assistance and Personal Care Services.

1. Request Information (1 of 3)

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

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

Elderly and Disabled (E&D)

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: MS.0272

Waiver Number:MS.0272.R05.01

Draft ID: MS.005.05.01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/17

Approved Effective Date of Waiver being Amended: 07/01/17

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

[Empty text box for Hospital level of care subcategories]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

The State additionally limits the waiver to individuals who are aged and/or disabled. Individuals must be 21 and over.

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

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

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

[Empty text box for ICF/IID level of care subcategories]

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

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

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

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

Case management agencies serve as the primary point of entry into the E&D Waiver. Under a provider agreement with DOM, the case management agencies are responsible for case management services for all E&D Waiver persons. The main objective of case management is continuity of care. Case management performs the comprehensive assessment by which a waiver person's needs, preferences and goals for services are determined, and arranges for those services through a person-centered approach. Periodic monitoring and reevaluation of the individualized Plan of Services and Supports(PSS)is also performed by the case management agencies.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least

annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except

when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

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

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

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public input was sought through meetings with stakeholders & providers who actively participated with recommendations for waiver changes. Meetings with various stakeholders were held on 1/24/17, 1/27/17, & 2/15/17. A public hearing was held on 5/3/17 where various stakeholders were able to offer additional recommendations. See summary below.

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

Another mechanism through which public input is obtained is from telephone correspondence with applicants/participants, and/or their representatives, regarding inquiries, complaints, or appeals.

The State notifies the Mississippi Band of Choctaw Indians (MBCI) Health Administration via written notice regarding the waiver renewal greater than 60 days prior to submission of the waiver in order to provide an opportunity for their input. Copies of the draft are provided to the Mississippi Band of Choctaw Indians prior to waiver submission to CMS. For the July 1, 2017 waiver renewal the MBCI was notified on February 28, 2017. The State accepts any input from the provider community, advocacy groups, Medicaid beneficiaries & waiver participants at any given time.

Summary of Public Comments & Responses for the E&D Waiver:

Public comments were received with objections to reinstatement of a maximum 100 participant caseload limit for CM service providers.

Response: DOM does not plan to remove the caseload maximum limit at this time. It allows the state to ensure that CMs are able to offer high quality, person-centered care to all individuals enrolled in this waiver. However, DOM will add language to allow for exceptions to the caseload maximum limit if a provider has adequate justification and prior approval from DOM.

Comments were received with concerns regarding the change in the rates for Adult Day Care (ADC) services as well as lifting the requirement that individuals must stay at the facility for at least 4 hours.

Response: DOM removed the 4 hour minimum stay at the facilities to comply with person-centered care requirements set forth in the HCBS Final Rule issued by CMS. After reviewing public comments & concerns, DOM has proposed an alternate rate calculation, wherein ADC service providers would be reimbursed for care at a rate of \$3.88 in 15 minute increments up to maximum daily rate of \$62.08.

Comments were received regarding concerns that PCS providers are not authorized to transport the person into the community, as well as a general lack of transportation services statewide.

Response: DOM does not plan to adopt this recommendation at this time due to resource limitations. DOM will continue to partner with other stakeholders across the state to explore opportunities to increase transportation options and availability.

Comments were received requesting clarity surrounding the Home Delivered Meal service rates listed in the draft waiver renewal application.

Response: The average costs per unit for Home Delivered Meals in the renewal application to be submitted to CMS has been updated to reflect a 2.6% annual increase.

Comment was received suggesting that the waiver renewal include language that required providers to direct participants to a particular entity for assistance with dispute resolution.

Response: DOM does not plan to adopt this recommendation at this time. The dispute resolution process outlined in the proposed renewal requires that CMAs notify individuals enrolled of their rights with regards to disputes, complaints/grievances & hearings. Additionally it allows individuals to address disputes with DOM at any time, & does not conflict with their right to a State Fair Hearing.

Comment was received requesting that DOM encourage more providers to accept Medicaid funds and recruit more new providers to the State.

Response: DOM allows for continuous open enrollment of providers, and will continue to do so.

Comment was received requesting DOM place some minimum stay requirements on ADC services that prevent the participants from taking advantage of the new rules that remove the 4 hour minimum stay.

Response: DOM does not plan to include minimum stay guidelines for ADC services at this time. DOM removed the minimum stay guidelines to comply with person-centered care requirements set forth in the HCB Final Rule issued by CMS.

Comment was received requesting DOM to allow the ADCs to bill for transportation in addition to the new rate or include travel time in the rate as the provider is responsible for the individual during that time.
 Response: Transportation is currently calculated into the rate identified in the renewal application.
 Comment was received requesting clarification on the billing process for the new 15 minute increment billing process for ADCs and for how to track participants' time in the facility for audit purposes.
 Response: Once the waiver renewal is approved, DOM will update the Admin Code and the Provider Billing Manual to reflect any necessary process changes and provide further clarification, as needed.
 Comment was received requesting that DOM strengthen minimum standards for credentialing of PCAs.
 Response: DOM does not intend to increase the minimum requirements for providers of PCS. PCAs must meet minimum requirements, including CPR certification and criminal background checks. They must also complete training requirements, as determined by DOM.

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

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

7. Contact Person(s)

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

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

Fax:

(601) 359-9521

E-mail:

Paulette.Johnson@medicaid.ms.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Mississippi

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

Paulette Johnson

State Medicaid Director or Designee

Submission Date:

Sep 24, 2019

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name:

Johnson

First Name:

Paulette

Title:

Office Director, Long Term Care

Agency:

Mississippi Division of Medicaid

Address:

550 High Street

Address 2:

Walter Sillers Building, Suite 1000

City:

Jackson

State:

Mississippi

Zip:

39201

Phone:

(601) 359-5514

Ext:

TTY

Fax:

(601) 359-9521

E-mail:

Attachments

Paulette.Johnson@medicaid.ms.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

DOM continues to work to implement processes to ensure that there is open enrollment of all willing and qualified providers for case management and home delivered meal services. Due to limited resources, the state has been unable to complete all of the systematic changes necessary to finish the planned implementation at the time of this amendment.

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

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

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

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

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

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

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

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

Overview of Mississippi's 1915(c) HCBS Programs

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

3. 1915(c) Elderly and Disabled (E&D) Waiver:

Adult Day Care services are provided in a non-residential setting which must meet the requirements of the HCB settings and be physically accessible to persons. Adult Day Care services provide a structured, comprehensive program with a variety of health, social and related supportive services during the daytime and early evening hours. It is designed to meet the needs of aged and disabled individuals through an individualized person centered plan of services and supports.

E&D Waiver services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:

- Case management,
- Home-delivered meals,
- Personal care services,
- In-home respite,
- Transition Assistance, and
- Expanded home health visits.

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

- Institutional respite services.

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

1. Two (2) public notices were published on September 17, 2014, and September 24, 2014, in the Clarion Ledger which notified the public of public hearings which were held at the following times:

- Elderly and Disabled (E&D) Waiver – 11 a.m.
- 2. An adapted, accessible version of the STP was available during the public comment period on the Division of Medicaid's website.
- 3. Two (2) Public Hearings held on September 26, 2014, at the Woolfolk Building in Jackson, MS, with teleconference, and October 3, 2014, at the War Memorial Building in Jackson, MS,
- 4. Comments received during the thirty (30) day comment period September 17 – October 17, 2014 were:

- The Arc of Mississippi requested the Personal Outcome Measures as either a substitute for or accompaniment to the NCI for data collection for measuring quality.

Response: The Division of Medicaid has not elected to use the Personal Outcome Measures for data collection for measuring quality for the E&D waiver because the Division of Medicaid is using the NCI performance measure for the IDD population. To use the POM would be a duplication of efforts. The Division of Medicaid currently is expanding the NCI data collection for the Aged and Disabled population which will achieve the same result.

- Beth Porter with Disability Rights Mississippi commented that the MS Statewide Transition Plan was not accessible to the constituents being served and the plan needed to be more accessible.

Response: Ms. Porter was referred to the Division of Medicaid's website and the location of the transition plans as well as instructed her to contact the Division of Medicaid to obtain a copy of the transition plan if unable to download and print. The Mississippi Division of Medicaid strives to reasonably accommodate all target audiences through communications tools,

including the external website at <http://medicaid.ms.gov>. The website was developed with a variety of audiences in mind and includes tools to address issues for non-English speaking, aged, disabled and impaired such as font size buttons, a Google language translator tool, prominent search features, a site map and it is built on a response website frame within a content management system. The Division of Medicaid also routinely performs Web Content Accessibility Guidelines checks to ensure adherence to web standard guidelines, as well as HTML validation to be in line with W3C standards.

• Beth Porter with Disability Rights Mississippi commented “Under Section 3, Quality Management Provider Monitoring it doesn't look like you're doing any changes. It just says annually. You're just going to leave it annually instead of changing any of that? I think that should be changed -- well, that's my comment. I think that should be changed to quarterly. Thank you.”

Response: The Division of Medicaid presently does not have the staffing capacity to perform quarterly monitoring. However, a committee consisting of stakeholders will be formed and will meet by June 30, 2015, to assist in evaluating the feasibility of performing quarterly or biannual monitoring activities.

CMS Review and Revised Statewide Transition Plan

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

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

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

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

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

4. A thirty (30) day comment period from March 11, 2015, through April 10, 2015:

a. Verbal and written comments will be received at the following three (3) public hearings and teleconferences:

- 1) Thursday, March 19, 2015, at 2:30 and 6:30 p.m. at the Hattiesburg Regional Office, 6971 Lincoln Road Extension, Hattiesburg, MS 39402. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
- 2) Tuesday, March 24, 2015 at 2:30 and 6:30 p.m. at the Grenada Regional Office, 1109 Sunwood Drive, Grenada, MS 38901-6601. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
- 3) Thursday, March 26, 2015, at 2:30 and 6:30p.m., at the Jackson Regional Office, 5360 I-55 North, Jackson, MS 39211 To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.

b. Written comments will be received via:

- 1) Mail at the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi, 39201, or
- 2) E-mail to Margaret.Wilson@medicaid.ms.gov.

5. Comments related to the E&D Waiver received during the 30 day comment period from March 11, 2015, through April 10, 2015:

• Pandora Redmond with Professional Staffing Solutions, Greenville, Mississippi, Adult Daycare Center commented: In all due respect, with all the requirements that are asked and all the changes that have been made, we have been in compliance with a lot and we are working on enforcing some of the things that have been implemented. But one of the concerns we have had in the past is the expense of doing a lot of things, especially with the meals having variety. We do cater to the diet each client is supposed to have according to their doctor. My question is; with all the requirements, it's going to incur an expense. This is more of an expense for the daycare centers or whatever facility that is, especially if you have a lower census than most of the ones that have been in business for years. And my question is; will there be an increase in compensation to these centers for the types of services that you're offering? We are in compliance, but like I said, in order to make it even a greater individualized plan of care, we have a limited budget. And most of these clients that we serve do have some type of deficit in their care. I'm a registered nurse and I have two LPNs on staff, as well as two RNs, and that is an expense by itself. To give the care that is needed, like I said, we will have to have more compensation for the services.

Response: The Division of Medicaid will take into consideration the new requirements when the fee schedule is reviewed by the actuary firm.

• Carrol Hudspeth with Runnels Creek commented: Is there a new set of regulatory minimum standards issued for Adult Day Care Services to comply with the transition? If so, how may I get an updated copy?

Response: The Division of Medicaid is in the process of reviewing our policies, procedures and The Mississippi Administrative Code Title 23 Division of Medicaid to ensure compliance with the CMS Final Rule for Home and Community-Based Settings. New policies, procedures and/or administrative code rules will be published on our website as they are updated. Additionally, the new minimum federal regulatory requirements can be found at 42 CFR Section 441.301 (c)(4)(5) and Section 441.710(a)(1)(2).

• Specific Issues related to the Currently Proposed Statewide Transition Plan received from Disability Rights of Mississippi on April 10, 2015.

o We are disappointed in the relatively non-specific nature of the plan. We would like to see a much greater level of detail and more specific tasks.

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

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

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

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

o It is critical that HCBS participants be educated throughout this process, as their settings may be undergoing changes, which they need to understand. They should also know what their experience in the HCBS programs is supposed to be, so they can self-advocate and complain to the appropriate people or entities. The plan does not identify a process for a person to complain about a setting's adherence to the rules, but there should be a clearly identified entity responsible for receiving

complaints about a setting and the process through which they respond to an individual's complaint. We appreciate that there is some indication of education for participants and families in the timeline (p. 18), but these groups are not included in the education mentioned in the narrative (p. 11). We ask that the plan clearly describe educational activities to participants, families, and community members, and that the State plan do so at points throughout implementation.

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

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

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

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

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

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

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

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

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

o CMS officials have confirmed that any comment period for a transition work plan, or for an interim transition plan, does not lessen a state's obligation to solicit and accept public comment on a final substantive transition plan. We expect that the State will clearly announce when updates to the plan are available, and will do so in such a way that the information will reach all stakeholders, including specific efforts to reach participants and their families. Relying on electronic notices or mechanisms used to communicate with provider networks is insufficient, and the State should make a communication plan that will ensure reliable dissemination of information in an accessible way. We would also suggest that, for the next iteration of the transition plan, the State hold information sessions across the state that can be accessed by telephone, so that the plan may be explained to

participants, families, providers and community members. We also suggest that the state take comments at these sessions by making note of the questions and concerns raised at the meetings, rather than requiring that people formally comment at the meetings.

Response: The Division of Medicaid has complied with 42 CFR 441.301(c)(4) regarding public input and notice requirements for the transition plan. The public notice for the four (4) Transition Plans for HCB settings, submitted to CMS on October 21, 2014, consisted of two public notices in the Clarion Ledger, two public hearings, and a thirty (30) day comment period. The public notice for the Revised Statewide Transition Plan, to be submitted to CMS on April 24, 2015, consisted of two public notices which were published in three different newspapers, three public hearings at three separate locations throughout the state of Mississippi, a radio announcement regarding the public hearings and availability of the Revised Statewide Transition Plan, availability of the Revised Statewide Transition Plan at, at www.medicaid.ms.gov, and for those individuals without electronic/internet access, paper copies at the public hearings, at each Medicaid Regional Office, at each Mississippi State Department of Health clinic, and at the Issaquena Department of Human Services office, at each Assisted Living facility, at each Adult Daycare facility, and Case Management agency. The public was notified of the opportunity to request a copy be through standard mail or e-mail. Additionally, the Division of Medicaid notified the following stakeholders of the Revised Statewide Transition Plan, the public notice and public hearings and requested them to assist in notifying their constituents, including, but not limited to:

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

The public was also given the opportunity to give comments on the Revised Statewide Transition plan at the three public hearings, via email and via standard mail.

The Division of Medicaid understands the importance of the public's notice of and input on the Statewide Transition Plan and will continue to comply with all state and federal regulations during the implementation of the Statewide Transition Plan.

6. The Division of Medicaid posted published the following public notice on November 28, 2016 . on the agency's website and in three (3) major newspapers: The Sun Herald, The Clarion-Ledger, and The Commercial Appeal. The public notice and waiver document were available for review in in each county health department office and in the Department of Human Services office in Issaquena County. Stakeholders and advocate organizations were notified to inform interested individuals as well.

Public notice is hereby given to the submission of the revised Mississippi Statewide Transition Plan (STP) for initial approval from the Centers for Medicare and Medicaid Services (CMS).

The Division of Medicaid (DOM) has completed the assessment of its state standards, rules, regulations and other requirements to determine its current level of compliance with the federal Home and Community-Based (HCB) settings final rule. During this assessment, DOM identified gaps between the State Plan, Administrative Code and the Department of Mental Health's (DMH) Operational Standards and federal HCB settings regulations. In addition, revisions to the STP were in response to CMS's request for supplemental information and clarifications. The revision of these documents and the timeframes for completion are included in the revised STP.

Once the initial approval has been received, DOM must complete the following actions in order to obtain final approval of the STP:

- Complete site-specific assessment of all HCB settings,
- Develop a remediation plan for providers that do not comply with the HCB settings federal regulations,
- Validate documentation from providers who have undergone remediation,
- Identify and assess HCB settings that are presumed to have institutional characteristics,
- Identify a plan for participants who live in non-compliant settings to transition to compliant HCB settings, and
- Establish a plan for ongoing monitoring of HCB settings in Mississippi.

Prior to the submission for final approval, DOM will submit its final draft of the STP for public comment.

A copy of the revised STP will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081.

Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days

from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

The only comments received regarding the E&D Waiver during the thirty (30) day comment period from November 28, 2016, through December 28, 2016, were from Micah Distro from Disability Rights Mississippi:

o We believe that all of the waivers offered by MS Medicaid should include both transportation services and employment supports/job discovery services. Transportation is vital to full integration into the greater community. Similarly, employment supports/job discovery services encourage integration and greater independence among waiver participants. The level of integration contemplated by the Final Rule cannot be achieved without services that facilitate the ability to move about the community and the opportunity to engage in competitive employment.

Response: The Division of Medicaid covers medically necessary transportation for persons on all waivers through a NET broker program. Transportation for person's receiving E&D Waiver Adult Day Care (ADC) services is provided by the ADC provider and included in the rate. Transportation services are included in the rates for the following services: Supported Employment, Supervised Living, Day-Services Adult and Prevocational Services. Employment Supports/Job Discovery is not included in the Statewide Transition Plan (STP) as this service is not applicable to the HCB settings final rule.

o There are two issues with Part 208, Chapter 1, Rule 1.1 as it appears on pages 17-18 of the Revised Statewide Transition Plan Summary and Timeline (clean). First, the federal rule referenced in the far right column appears to be in error. 42 CFR 441.301(c)(4)(iv) of the Final Rule does not appear to have anything to do with the due process requirements that Rule 1.1 of the state rules outlines. The referenced federal rule reads, "Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact." Meanwhile, the state Rule 1.1 concerns due process protections and outlines notice requirements for participants in the waiver. We would suggest that notice requirements in the federal rules can be found at 42 CFR 431.210 through 431.214. Secondly, the state Rule 1.1 does not accurately reflect the requirements of the federal regulation that is applicable. Part C of the rule states that "Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the participant must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services." However, 42 CFR 431.211 requires that notice be given to the participant at least 10 days before the date of the action. The federal rules define the term "action" in 42 CFR 431.201 as, "a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by

skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act." The state rules should be amended to be in compliance with the provisions of the Final Rule accordingly. We would also encourage the Division

of Medicaid to require that notices of adverse actions include the contact information of Disability Rights Mississippi, the designated Protection and Advocacy organization for the state of Mississippi, where participants may be able to receive legal services at no cost.

Response: It appears the comment is referring to Rule 1.11: Due Process Protection. This Rule has been deleted from the STP as it is not applicable to the settings requirement; however, the Admin. Code will be revised.

o The Transition Plan Summary and Time line states that the settings requirements have been incorporated into documents and other guidance that are directed at waiver participants. However, it is not clear whether these documents are fully accessible to participants such that they will be able to fully understand and appreciate the requirements, their rights, how to file complaints or grievances if a setting is not in compliance, and how complaints will be handled once they are made. Information directed at waiver participants must be accessible, including being written at an appropriate reading level, in order to be meaningful and effective.

Response: The Division of Medicaid will ensure that all documents regarding HCB settings are fully accessible to persons and their legal representatives such that they are meaningful and effective.

o The validation process for provider self-assessments should be clarified. It is unclear whether providers will be notified as to the exact date and time of the validation review and when the random sample of participant surveys will be conducted. We urge the Division not to give notice of the precise date and time that the validation reviews will take place. This will ensure that the random sample of participant surveys is truly random and makes it difficult for any provider who wishes to act in bad faith to skew the results of the validation review. Furthermore, the language regarding how the random sample of participant surveys will be conducted should be clarified. How will they be chosen? What about participants who may not be physically present at the facility at the time of the validation review because they are working or participating in some other activity out in the community? Why does the plan propose to survey 100% of Assisted Living waiver participants while other settings of a similar, isolating nature (e.g. adult daycare facilities) are not proposed to be surveyed to the same extent?

Response: The Division of Medicaid made the decision to validate AL at one hundred percent (100%) because of the small

number of persons enrolled in the waiver. The number of validations required to create a statistically valid sample is not significantly different than the total number of persons who have elected the waiver. ADC persons were chosen when the reviewer conducted the validation survey at the ADC. The ADC was not notified in advance of the exact time and date of the validation review nor when the random sample of participant's surveys would be conducted. All ADCs were reviewed not just a portion. However, there are still three (3) to be completed. ID/DD Waiver providers were notified the Friday before a site visit. The random sample was pulled from a report generated by the Division of Medicaid which indicates all persons served by each provider. Providers do not know in advance which persons or records will be reviewed. If a person's name is chosen to be reviewed who is absent during the visit, DMH staff will make a concerted effort to remain at the site until the person returns. If it appears the reviewer must leave before the person returns, another person will be chosen to review.

o We believe that the provisions that provide notice to waiver participants who will be transitioning from non-compliant settings into compliant ones is a positive step. We encourage the Division of Medicaid to use the information gathered through the provider self-assessment process (and transition plan process in general) to work with providers to identify areas where provider availability may be reduced due to the full implementation of the Final Rule and make plans to increase capacity in those areas. The state should be working with providers and planning to increase the capacity of non-disability specific settings to ensure that participants have real, meaningful choices as required by the Final Rule.

Response: The Division of Medicaid is currently working with providers to ensure compliance with the final rule.

CMS Review and Revised Statewide Transition Plans

7. The comprehensive assessment was completed on November 20, 2015, and the results are included in the submitted Statewide Transition Plan which is located at www.medicaid.ms.gov.

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

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

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

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

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

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

to provide HCBS who do not meet the HCB setting requirements in the final rule will not be approved as a Medicaid provider or receive DMH certification.

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

- Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- Settings in a building on the grounds of, or immediately adjacent to, a public institution;
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

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

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

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

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

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

- Reason the person has to relocate from a residential or non-residential setting and the process, including timelines for appealing the decision,

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The public notices for the E&D Waiver renewal and the public hearing were posted on the DOM website at:
<https://medicaid.ms.gov/public-notice-for-the-elderly-and-disabled-ed-waiver-renewal/>
<https://medicaid.ms.gov/public-hearing-scheduled-for-the-elderly-and-disabled-waiver-renewal/>

The notice was posted on February 28, 2017 and the end date was March 30, 2017.

A copy of the proposed waiver changes were available in each county health department office and in the Department of Human Services office in Issaquena County, for review. A hard copy was available to be downloaded and printed from www.medicaid.ms.gov or requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081. Written comments could be submitted to the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201. Additionally, a public hearing was held on May 3, 2017 which offered the opportunity for individuals to make comments in person or telephonically.

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Long Term Care, Division of Elderly and Disabled Waiver Program

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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

The DOM Utilization Management/Quality Improvement Organization (UM/QIO) is contracted to make licensed physicians available for secondary review of LOC determinations that cannot be approved by the LOC algorithm or the DOM nurse. The UM/QIO also provide physicians for secondary review of PSS requests that cannot be approved by the DOM Nurse or DOM Administrator, if necessary.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in

accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

PM 1: Number and percent of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. N: Number of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. D: Total number of enrollment reports.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 80%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 80%; height: 20px;" type="text"/>

Performance Measure:

PM 2: Number and percent of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. N: Number of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. D: Total number of quarterly quality improvement strategy meetings.

Data Source (Select one):

Other

If 'Other' is selected, specify:

QIS Tracking Spreadsheet

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

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

Data Aggregation and Analysis:

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

Performance Measure:

PM 3: Number and percent of adult day care providers who met HCB setting requirements as defined by federal regulations. N: Number of adult day care providers who met HCB setting requirements as defined by federal regulations. D: Total number of adult day care

providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Other Specify: <input data-bbox="323 353 748 436" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="820 642 1243 725" type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

For PM 1, DOM will (a) will cease enrollment immediately if current census and unduplicated count exceed estimates of the waiver.
 For PM 2, DOM will (a) hold a quality improvement strategy meeting within 30 days; and (b) collaborate to examine if any changes need to be implemented systemically, as needed.
 For PM 3, DOM will (a) suspend referrals to the adult day center provider immediately; and (b) require the provider to correct deficiencies within 30 days.

ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 1865 775 1948" type="text"/>	Annually
	Continuously and Ongoing
	Other

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver

participants. Complete Items B-2-b and B-2-c.

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	21000
Year 2	21300
Year 3	21600
Year 4	21900
Year 5	22200

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

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

Waiver Year	Maximum Number of Participants Served At Any Point During the Year		

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

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

Appendix B: Participant Access and Eligibility

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

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

Transition of Participants from Nursing Home to Community

Purpose (*describe*):

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	115
Year 3	130
Year 4	145
Year 5	160

Appendix B: Participant Access and Eligibility

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

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

Transition individuals who have been discharged from the Independent Living Waiver

Purpose (describe):

This transition occurs when individuals have been discharged from the Independent Living waiver because they no longer meet the specific level of care criteria for that waiver. If not for the services offered in the Elderly and Disabled waiver, these individuals would be admitted to an institution for long term care support.

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

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

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

Mississippi Division of Medicaid Administrative Code, Title 23: Medicaid Part 208, Chapter 1: Home and Community Based Services(HCBS)Elderly and Disabled Waiver, as well as the CMS approved Elderly and Disabled Waiver application, along with subsequently approved amendments.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- No
- Yes

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

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

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

Select one:

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

Specify percentage:

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

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage

Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

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

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

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

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

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

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage: [input box]

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

The personal needs allowance is equal to the person's total income as determined in the post eligibility process which includes income that is place in a Miller Trust.

Other

Specify:

[input box]

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

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

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

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

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

Through the Balancing Incentive Grant received by the state, DOM has implemented the InterRAI Home Care assessment across waiver populations in its long term services and supports system. DOM worked with the LTSS vendor, FEI, as well as the creators of the InterRAI assessment, AIS, to develop an algorithm based on the assessment currently still in use for nursing facility level of care determinations. Crosswalks and validation testing were done to ensure that the assessment tools resulted in appropriate scoring mechanisms based on defined level of care requirements.

While the same instrument is not currently being utilized for the Elderly & Disabled Waiver and institutional placement in nursing facilities, the algorithms that drive the score for both instruments are similar and the outcomes of both were tested for reliability, validity, and comparability prior to the waiver implementing the new instrument. It is the intent of the state to proceed with the implementation of the comprehensive long term services & supports (LTSS) assessment for institutional care pending the availability of necessary technical resources.

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

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

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

In the LTSS system, a recertification packet is initiated and the case manager is sent an alert 90 days prior to the expiration of the current certification period. DOM provides the case management agencies with a monthly Eligibility Report, which includes person’s names, the end date of the certification period, and the end date for Medicaid financial eligibility. These three processes ensure timely recertification.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

PM 1: Number and percent of waiver applicants who receive a comprehensive LTSS assessment prior to the receipt of waiver services. N: Number of waiver applicants who receive a comprehensive LTSS assessment prior to the receipt of services. D: Total number of applicants who have received services.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

PM 2: Number and percent of initial & recert assessments completed by qualified assessors who were certified to accurately apply the criteria described in the approved waiver. N: Number of initial & recert assessments completed by qualified assessors who were certified to accurately apply the criteria described in the approved waiver. D: Total number of initial & recert assessments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

For PM 1, DOM will (a) obtain correct documentation; and (b) have the Case Management Agency conduct a comprehensive LTSS assessment within fifteen days; (c) dis-enroll the person within seven (7) business days, if they are determined ineligible (Case managers would explore other State plan services as a possibility for care); and (c) recoup provider payment within thirty (30) days.

For PM 2, DOM will (a) require Case Management Agency to conduct a new LOC evaluation by a qualified assessor within seven business days; and (b) conduct provider training on requirements for qualified assessors.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

DOM subscribes to a language line service that provides interpretation services for incoming calls. The subscribed interpretation services provide access in minutes to persons who interpret English into as many as 140 languages. Each DOM Regional office is set up with an automated access code under the DOM identification code. A Limited English Proficient (LEP) Policy has been established. All essential staff has received training on the use of the Language Line Service. All necessary steps have been taken to ensure that staff understand the established LEP policy and are capable of carrying it out. The key to the telephone language interpreter service is to provide meaningful access to benefits and services for LEP persons and to ensure that the language assistance provided results in accurate and effective communication between DOM and applicants/beneficiaries about the type of services and/or benefits available and about the applicants' or beneficiaries' circumstances.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day care (ADC) services are defined as services for aged and disabled individuals and consist of the provision of services at a day care program site. Adult day care is the arrangement of a structured, comprehensive program which provides a variety of health, social and related supportive services in a protective setting during the daytime and early evening hours. This community-based service is designed to meet the needs of aged and disabled individuals through an individualized care plan, including personal care and supervision, provision of meals as long as meals do not constitute a full nutritional regimen, medical care, transportation to and from the site, social, health and recreational activities, and information on, and referral to, vocational services. Adult day care activities must be allowable only to the degree that they are not diversionary in nature, and are included in a person-centered plan of care, are verifiable, and are monitored by the person's assigned case manager. The activities should optimize, but not regiment individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment and personal preferences.

The adult day program must provide, or contract for, safe reliable transportation to enable persons, including persons with disabilities, to attend the center and to participate in center-sponsored outings. Transportation between the person's place of residence and the adult day care center, as well as to and from center-sponsored outings, will be provided as a required component part of adult day care service, and as such the cost of transportation is included in the approved ADC rate.

ADC settings must be integrated in, and support full access to, the greater community.

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

One unit of service equals 15 minutes. The ADC must submit claims in 15 minute increments for the duration of time the services were provided and will be reimbursed by DOM the lessor of the maximum cap as stated in Appendix I for each waiver year or the total amount of the 15 minute increment units billed. The ADC must provide services during normal business hours and must be open for at least eight continuous hours per day. The duration of the service time should begin upon the person's entry in the facility and end upon their departure.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Adult Day Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Qualified Adult Day Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adult Day Care providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid, including, but not limited to, the following requirements:

The ADC must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver persons. Additionally, the ADC must meet the physical and social needs of each waiver persons.

The ADC program will comply with State Medicaid administrative codes/policies regarding the following:

- Activity programs
- Activities of Daily Living
- Medication oversight while in the ADC
- Coordination of care with the case managers
- Providing social services to waiver persons and families
- Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs which includes, at a minimum:
 - (a) A mid-morning snack,
 - (b) A noon meal, and
 - (c) An afternoon snack.
- Providing safe reliable transportation, at no extra cost to the person or their family, to and from the ADC, as well as to and from center-sponsored outings.
- Emergency procedures including medical and non-medical
- Providing ancillary services
- Facility layout, design and construction
- Providing a safe, non-hazardous environment
- Utilization of volunteers
- Quality assurance measures
- Liability insurance to meet the needs of the entity

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

All ADC provided and contracted transportation providers must also adhere to the following standards for the transportation driver and the vehicles:

DRIVER REQUIREMENTS

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

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

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

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

The ADC provider is responsible for ensuring that all vehicles meet or exceed local, State, and federal requirements. They must also maintain manufacturer's safety mechanical operating and maintenance standards.

The ADC provider must:

- Inspect all vehicles prior to the operations start date and at least every six (6) months hereafter.
- Test all communication equipment during regularly scheduled vehicle inspection.
- Maintain records of the ADC scheduled bi-annual vehicle inspections and make available to DOM upon request.
- Comply with State motor vehicle requirements.

Authorized employees of DOM or the ADC provider must immediately remove from service any vehicle or driver found to be out of compliance with these requirements or with any State or federal regulations. The vehicle or driver may be returned to service only after the ADC verifies that the deficiencies have been corrected. Any deficiencies and actions taken to remedy deficiencies must be documented and become a part of the vehicle's and the driver's permanent records.

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

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

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

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

The ADC provider is responsible for ensuring that all vehicles meet or exceed local, State, and federal requirements. They must also maintain manufacturer’s safety mechanical operating and maintenance standards.

The ADC provider must:

- Inspect all vehicles prior to the operations start date and at least every six (6) months hereafter.
- Test all communication equipment during regularly scheduled vehicle inspection.
- Maintain records of the ADC scheduled bi-annual vehicle inspections and make available to DOM upon request.
- Comply with State motor vehicle requirements.

Authorized employees of DOM or the ADC provider must immediately remove from service any vehicle or driver found to be out of compliance with these requirements or with any State or federal regulations. The vehicle or driver may be returned to service only after the ADC verifies that the deficiencies have been corrected. Any deficiencies and actions taken to remedy deficiencies must be documented and become a part of the vehicle’s and the driver’s permanent records.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Definition and Objective: Case Management (CM) is the term used to describe the many approaches needed to meet the service needs of persons who are at risk for institutionalization. Case Management coordinates services to assure the health and social needs, preferences and goals of the persons are met. It is the mechanism by which services are identified and monitored for these persons in an effort to provide continuity of care and avoid costly duplication of services.

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

Case Management Service Requirements:

All providers offering case management services under the Medicaid Waiver Agreement must adhere to the following requirements:

Service Activities:

A. Referral: The initial procedure to determine eligibility and potential need of services. The case manager provider must make contact with the referred person within five working days of receiving the referral.

B. Formulation of the Application Packet: The case managers will complete the following at the person's residence and submit the forms in LTSS for review by DOM: Core Standardized Assessment (SA), Bill of Rights (BOR) form, Informed Choice (IC) form, Emergency Preparedness Plan (EPP) form and the PSS. If application packet is completed in a hospital or facility, the home environment must be assessed prior to approval.

The CM will enroll persons by completing the SA which utilizes an algorithm for level of care (LOC) determination. If the SA does not meet the required LOC, a second review will be completed by the nurse to establish LOC. If the nurse cannot establish a LOC, the LOC is sent to a physician for review. If the physician determines that the person does not meet the required LOC, then the person is provided written notification of the decision, explaining their right to appeal and the procedures for requesting a fair hearing. Services are billable by the providers until the date of the denial, if the application packet is a recertification.

The PSS will be completed through a person-centered process. All forms must be dated with signatures of the CM and the person.

C. Review and Evaluation of the Person's Status: Monthly and quarterly visits are required to determine if the services being rendered need to be modified, replaced or discontinued. Prior approval from DOM will be required for changes on the PSS to initiate new services, increase services or for skilled home health services. Decreases in services are approved by the case manager supervisor and do not require prior approval from DOM. A provider change does not require DOM approval. The PSS must be updated to reflect any changes. All changes to the PSS require documented consent from the person either via new signature/date or via verbal consent with a witness's signature/date. Documentation to justify service request must be noted on the PSS and/or in activity notes. All documentation must be uploaded in LTSS.

When adding hospice service to the PSS, the CM must attend a person centered planning (PCP) meeting prior to services beginning with the hospice staff and the person to coordinate services. The hospice Plan of Care (POC) must have signatures of the person, the CM and all hospice staff providing service to the person. The hospice POC and PCP meeting documentation must be uploaded in LTSS. The PSS, hospice POC and documentation will need to be reviewed by DOM.

If the PSS is approved for less than requested or denied, the person is provided written notification of the decision, explaining their right to appeal and the procedures for requesting a State Fair Hearing through DOM.

Termination of Persons:

A person will be terminated from waiver services for any of the following reasons: (1) The person or his/her legal

representative request termination; (2) The person no longer meets program eligibility requirements; (3) The person refuses to accept services; (4) The person is not available for services after thirty days; (5) The person is in an environment that is hazardous to self or service providers; (6) The person and/or individuals in the person's home become abusive and belligerent including, but not limited to, sexual harassment, racial discrimination, threats, etc.

Each person and/or legal representative will be informed in writing of the reason(s) for termination ten working days prior to actual discharge. In the event of imminent danger to the person, caregiver, or service provider, termination of all waiver services will take place immediately. The person will, in any situation, be informed of their right to a fair hearing. The CM will assist the participant in seeking appropriate alternative care/services, and if necessary, will link the person with the local ombudsman to ease the person's transition into a nursing facility or other long term care facility. If the person is without services for thirty consecutive days, on the thirty first day the person must be discharged.

Case Manager Caseloads:

To ensure quality, each CM team shall maintain an average, active case load of 100 waiver persons. Priority is to be given to referrals desiring transition from nursing homes to a home and community based setting. If a CM team must maintain an average, active case load greater than 100, DOM must be notified, and approval will be considered based upon causation and duration of the increase.

A single CM shall maintain an average, active case load of 50 persons. In the event that one CM leaves a team, the remaining CM will continue to maintain the case load. Persons should not be discharged to meet the 50 person maximum, Instead the CMA should move to immediately hire/train a replacement CM for the team. No new persons should be added to the caseload until the vacating team member is replaced. With adequate justification, DOM will review and approve exceptions.

Case Manager Education Needs: The CM must be certified prior to completing a SA in LTSS. Additionally, CMs must be recertified annually on the completion of the SA. The CM supervisor must offer ongoing training for each CM to improve their CM skills/functions. All new CM staff must receive agency training/in-service education and program orientation. The CM supervisor is to keep detailed records of each employee's training/orientation.

Case Management Supervisor: This is an administrative position involving the planning, direction, and administration of the case management program. Supervision of the CM is a function that is required to ensure that all components of case management are carried out according to the Quality Assurance Standards.

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Team

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Team

Provider Qualifications

License (specify):

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

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

Certificate (specify):

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

Other Standard (specify):

The State restricts case management services to agencies enrolled as current Medicaid providers who are willing and qualified to provide case management services and activities. The agencies must have the infrastructure to provide regular and ongoing supervision, employ a sufficient number of supervisors and quality assurance staff to provide training, support and oversight of all case management activities and health and safety issues, and operate on a statewide basis. A statewide network based system of case management assures the state that, in the event of a major disaster or catastrophe, such services as case management, records management, employee staffing and payroll suffer minimal interruption and benefit from sister network agency support. A statewide network case management provider system also encourages an effective and efficient opportunity for appropriate collaboration of effort with other services with statewide central offices/contacts such as Area Agencies on Aging, Public Housing Authorities, Department of Rehabilitation Services or the Mississippi Access to Care Centers.

Agency supervisory staff must conduct unannounced home visits to ensure quality of monitoring, and provide additional training to staff as needed. The agency must also ensure case management services and activities occur in a conflict free environment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

In-home respite services are provided to persons unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those person's normally providing the care. Respite service is non-medical care and supervision provided to the person in the absence of the person's primary full-time, live-in caregiver/caregivers on a short-term basis. Services are to assist the caregiver/caregivers during a crisis situation and/or as scheduled relief to the primary caregiver/caregivers to prevent, delay or avoid premature institutionalization of the person.

In-home respite services are provided in the home of the person. The person must be homebound due to physical or mental impairments where they are normally unable to leave home unassisted, require 24 hour assistance of the caregiver, and unable to be left alone and unattended for any period of time.

Minimum Program Requirements/Service Activities

All in-home respite service providers must adhere to the following minimum program requirements and service activities:

A) Activities- The respite provider must provide one or more of the following primary activities: companionship, support or general supervision, feeding and personal care needs. The provision of these services does not entail hands- on nursing care. Any assistance with activities of daily living are incidental to the care of the individual and are not provided as discrete services.

B) Safety- The in-home respite provider should be aware of potential hazards in the person's home environment and should do everything possible to ensure a safe environment for the person.

C) Reporting- In-home respite staff shall report abusive behavior or situations to their supervisor immediately. Also, such behavior by a person should be documented in the case record.

D) Harassment- In-home respite staff shall not allow or be subjected to sexual harassment or advances by persons. This kind of behavior should not be tolerated. The staff must firmly state to the person or caregiver in the home that such behavior will be reported to the supervisor. The person and caregiver should be notified that such behavior could jeopardize the service being received in the future.

E) Documentation- The in-home respite provider shall note on the record of contact all factual observation, contacts, or visits with the person and actions or behavior displayed by the person. This documentation is essential in determining if changes should be made on the PSS. It is also essential to show that certain tasks were performed on certain dates and times. The in-home respite supervisor/provider agency must review copies of the in-home respite contact sheets for each visit indicating arrival and departure times, any services performed while in the home, any other pertinent information concerning the person, and signature of the caregiver to verify services were received.

The documentation must be maintained in the provider files.

F) Coordination with case management- The in-home respite supervisor shall maintain regular and ongoing communication with the case management provider regarding case-managed respite persons. The case manager shall develop and direct the PSS for case managed persons that are referred for respite services. The respite provider must report to the case management agency any information pertinent to the person's status.

G) Termination of respite services- Persons receiving respite services shall be terminated based on the following criteria:

- 1) Death;
- 2) Relocation out of state or services area;
- 3) Increase of informal or formal support;
- 4) Improved health status or condition;
- 5) Person and/or caregiver become abusive and belligerent, including sexual harassment;
- 6) Person and/or caregiver refused services;
- 7) Caregiver/person reports that he/she no longer needs the service;
- 8) Caregiver does not return to relieve respite provider as scheduled. Exceptions may be made in extreme cases of emergency;
- 9) Person is placed in a long term care facility;
- 10) Person is not Medicaid eligible;
- 11) The person's home environment is not safe for services to be rendered

Any situation involving the above criteria must be reported to the respite supervisor and waiver case manager, and documented in the person's case record.

The case management agency is the first line of contact with the person and reports situation that may result in termination of respite services as described above to DOM. A decision to terminate is ultimately the responsibility of DOM. After DOM has notified the case management agency that the respite service is being terminated, the case

management agency provides to the person written notification of the decision, explaining their right to appeal, and the procedures for requesting a State Fair Hearing.

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

One unit of service equals 15 minutes of relief to the caregiver. Respite will be approved for no more than sixty(60) hours per month to any person. Any respite greater than sixteen (16) continuous hours must have prior approval by the case management team.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-Home Respite

Provider Category:

Agency

Provider Type:

Qualified In-Home Respite Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

In-Home Respite providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid, including, but not limited to, the following requirements:

IN-HOME RESPITE PROVIDER

In-Home Respite providers/workers must meet the minimum requirements as follows:

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

IN-HOME RESPITE SUPERVISOR

Must have the following qualifications:

- 1) A bachelor's degree in social work, or a related profession, with one year of direct experience working with aged and disabled clients, and two years of supervisory experience, or
- 2) A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.), with one year of direct experience working with aged and disabled clients, and two years of supervisory experience, or
- 3) A high school diploma with four years of direct experience working with the aged and disabled clients, and two years of supervisory experience.

The In-Home Respite Supervisor must have the following responsibilities:

- Supervise no more than twenty full-time respite workers;
- Make home visits with respite workers to observe and evaluate job performance and submit Supervisory reports along with monthly activity sheet;
- Review and approve service plans;
- Receive and process request for service;
- Be accessible to respite workers for emergencies, case reviews, conferences, and problem solving;
- Evaluate the work, skills, and job performance of the respite worker;
- Interpret agency policies and procedures relating to the In-Home Respite program;
- Prepare, submit, or maintain appropriate records and reports; and
- Plan, coordinate, and record ongoing in-service training for the in-home respite staff.

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

Training Requirements

Providers may use any training resources deemed appropriate to meet the following requirements set forth by DOM, including in-service trainings completed by supervisory staff or online training by a vendor of their choice.

A. All direct care workers, unless otherwise excluded in the approved Elderly and Disabled waiver, must successfully complete a 40 hour curriculum training course upon hire and prior to rendering services covering each of the following topics:

- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation
- Participant Rights and Dignity
- Crisis Prevention and Intervention
- Caring for Participants with Alzheimer's/Dementia
- Care of Participants with Mental Illness
- How to Deal with Difficult Participants
- Assisting with Activities of Daily Living
- Assisting with IADLs including Meal Preparation and Housekeeping
- HIPAA Compliance
- Recognition and Care of Individuals with Seizures
- Elopement Risks
- Safe Operation and Care of Individuals with Assistive Devices
- Caring for Individuals with Disabilities
- Safety including Preventing and Reporting of Accidents/Incidents
- Professional Documentation Practices
- Signs and Symptoms of Illness
- Emergency Preparedness
- Universal Precautions & Infection Control
- Person Centered Thinking

In addition to the above, providers must have the following training upon hire and prior to rendering services:

- CPR Certification
- First Aid

B. Additionally, all direct care workers must successfully complete an annual curriculum training course covering at a minimum each of the following topics:

- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation
- Participant Rights and Dignity
- Crisis Prevention and Intervention

- How to Deal with Difficult Participants
- HIPAA Compliance
- Safety including Preventing and Reporting of Accidents/Incidents
- Professional Documentation Practices
- Emergency Preparedness
- Universal Precautions & Infection Control
- Person Centered Thinking

In addition to the above, providers must have the following training annually:

- CPR Certification
- First Aid

C. All training must include a scored examination to ensure retention of training information and materials by trainees.

D. All new hire training must include a hands-on skills assessment to ensure the trainees ability to provide the necessary care safely and appropriately.

E. All providers must maintain a current training plan as a component of their Policies/Procedures documenting their method of choice for the completion of required training. This training plan must be available to DOM upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Service

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Personal Care Services (PCS) are non-medical support services to assist the person in meeting daily living needs and ensure optimal functioning at home and/or in the community. Services must be provided in accordance with a person's PSS. Personal Care Service include: assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Meal preparation may be provided, however, the cost of meals is not covered. Housekeeping chores may be provided if the care is essential to the health and welfare of the individual, rather than the individual's family. Personal Care Service may also involve hands-on assistance or cuing/prompting the person to perform a task; accompanying and assisting the person in accessing community resources and participating in community activities; supervision and monitoring in the person's home, during transportation, and in the community setting. If the person's transportation is being provided by the Medicaid NET provider, the PCS provider may only accompany the person when medically justified. However, they may accompany the participant in the community without justification by any other means of transportation, provided that they are not driving the vehicle in which the participant is being transported.

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

One unit of service equals 15 minutes. Personal Care Service will be approved based upon needs.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Personal Care Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Service

Provider Category:

Agency

Provider Type:

Qualified Personal Care Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personal Care Service providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid, including, but not limited to, the following requirements:

Personal Care Service providers or personal care attendants must meet the minimum requirements as follows:

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

PCS Supervisor

Must have the following qualifications:

1. At least two (2) years supervisory experience in programs dealing with elderly and disabled individuals and meet one (1) of the following requirements:
 - a) A Bachelor's Degree in Social Work, or a related profession, with one year of direct experience working with aged and disabled participants,
 - b) A Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), with one year of direct experience working with aged and disabled participants, and two years of supervisory experience, or
 - c) A high school diploma with four years of direct experience working with the aged and disabled participants, and two years of supervisory experience.

The PCS Supervisor must have the following responsibilities:

1. Supervising no more than twenty (20) full-time PCA Staff;
2. Reviewing and approving service plans;
3. Receiving and processing requests for service;
4. Observing and evaluating the PCA performing assigned tasks in the participants home;
5. Performing supervised and unsupervised visits in the participant's home on a biweekly basis;
6. Being accessible to PCA Staff for emergencies, case reviews, conferences, and problem solving;
7. Interpreting agency policies and procedures relating to the PCS program;
8. Preparing, submitting, or maintaining appropriate records and reports;
9. Planning, coordinating, and recording ongoing in-service training for the PCA Staff.
10. Reporting directly to the Agency's Director;
11. Maintaining the regular, routine, activities of the PCS services program in the absence of the Director.

Training Requirements

Providers may use any training resources deemed appropriate to meet the following requirements set forth by DOM, including in-service trainings completed by supervisory staff or online training by a vendor of their choice. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months

during the last three years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the training requirements.

A. All direct care workers, unless otherwise excluded in the approved Elderly and Disabled waiver, must successfully complete a 40 hour curriculum training course upon hire and prior to rendering services covering each of the following topics:

- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation
- Participant Rights and Dignity
- Crisis Prevention and Intervention
- Caring for Participants with Alzheimer's/Dementia
- Care of Participants with Mental Illness
- How to Deal with Difficult Participants
- Assisting with Activities of Daily Living
- Assisting with IADLs including Meal Preparation and Housekeeping
- HIPAA Compliance
- Recognition and Care of Individuals with Seizures
- Elopement Risks
- Safe Operation and Care of Individuals with Assistive Devices
- Caring for Individuals with Disabilities
- Safety including Preventing and Reporting of Accidents/Incidents
- Professional Documentation Practices
- Signs and Symptoms of Illness
- Emergency Preparedness
- Universal Precautions & Infection Control
- Person Centered Thinking

In addition to the above, providers must have the following training upon hire and prior to rendering services:

- CPR Certification
- First Aid

B. Additionally, all direct care workers must successfully complete an annual curriculum training course covering at a minimum each of the following topics:

- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation
- Participant Rights and Dignity
- Crisis Prevention and Intervention
- How to Deal with Difficult Participants
- HIPAA Compliance
- Safety including Preventing and Reporting of Accidents/Incidents
- Professional Documentation Practices
- Emergency Preparedness
- Universal Precautions & Infection Control
- Person Centered Thinking

In addition to the above, providers must have the following training annually:

- CPR Certification
- First Aid

C. All training must include a scored examination to ensure retention of training information and materials by trainees.

D. All new hire training must include a hands-on skills assessment to ensure the trainees ability to provide the necessary care safely and appropriately.

E. All providers must maintain a current training plan as a component of their Policies/Procedures documenting their method of choice for the completion of required training. This training plan must be available to DOM upon request.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Home Health Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

Extended State Plan visits begin on visit thirty-seven (37) of the fiscal year. The first thirty-six (36) home health visits each fiscal year are state plan visits. Any visit over the thirty-six (36) is only available to the person if approved through the waiver program. Each case is considered on an individual basis, and with appropriate documentation to support the request. Ongoing evaluation of the skilled nurse (SN) notes is required of the case management agency and subsequent approval of skilled (SN) visits are requested to DOM.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Extended Home Health Services

Provider Category:

Agency

Provider Type:

Qualified Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

At time of initial enrollment and at time of recertification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Transition Services are non-recurring set-up expenses and community navigation services provided to a Mississippi Medicaid beneficiary who is transitioning from nursing facility or ICF/IID to a living arrangement in a community residence where the person is directly responsible for his or her own living expenses. All community transition services must be documented in the approved PSS.

Community Transition Services include:

- 1) Activities to assist in identifying barriers and/or mitigates risks to the success of the transition to a more independent living situation. Pre-transition barriers, such as accessible/affordable housing, presence of natural support system, and resources associated with community settings, require specialized assistance and oversight provided by CTS providers. Post-transition, the CTS providers continue to ensure that the transition from institutionalization to community based services is successful by providing necessary services outside of the scope of case management as defined in the E&D Waiver, including intensive 24 hour, 7 day a week crisis management, community integration opportunities, and life skills training for 30 days following the date of de-institutionalization. CTS providers render a service separate from that of a Case Manager. This process provides separate and enhanced formal supports to newly transitioned individuals through a critical limited time period, and allows for a seamless transition into the community. This transition period also allows for a thorough transfer of knowledge from the CTS provider to the individual's Case Manager regarding any information obtained during the pre-transition discovery phase, including potential risks for re-institutionalization and areas where improved quality of life may be achieved in the community going forward.
- 2) Security deposits that are required to obtain a lease on an apartment or home,
- 3) Essential household furnishings required to occupy and use a community domicile, including, but not limited to, furniture, window coverings, food preparation items, bed/bath items, one time pantry stocking, and cleaning supplies.
- 4) Set-up fees or deposits for utility or service access including, but not limited to, telephone, electricity, heating, and water,
- 5) Services necessary for the person's transition into the community, including but not limited to, payment of past due bills which inhibit the person's ability to move from the nursing facility or ICF/IID into the community when no other payment source is available,
- 6) Services necessary for the person's health and safety prior to occupancy of the residence including, but not limited to, pest eradication and/or one-time cleaning,
- 7) Moving expenses,
- 8) Necessary home accessibility adaptations,
- 9) Durable medical equipment and supplies necessary for the person's transition into the community which inhibit the person's ability to move from the nursing facility or ICF/IID into the community when no other payment source is available.

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

Community Transition Services are covered from 180 days prior to the person transitioning from the nursing facility or ICF/IID to 30 days post transition. Services are limited to a total of \$14778.00 per individual. This service may be utilized more than once per lifetime on a beneficiary case by case basis.

Community transition services are furnished only to the extent they are deemed reasonable and necessary. Community transition services do not include monthly rental or mortgage expenses, monthly utility charges, food; except for a one-time pantry stocking, household appliances or items that are intended for diversional or recreational purposes.

All items and services covered must be essential to:

- 1) Ensure that the person is able to transition from the current nursing facility or ICF/IID facility, and
- 2) Remove identified barriers and/or mitigates risks to the success of the transition to a more independent living situation.

To be eligible a person:

- 1) Must be a current nursing facility or ICF/IID resident who has been is in a long term care service segment for a minimum of 90s days with the Division of Medicaid reimbursing for at least one (1) of said days,
- 2) Must not have another source to fund or attain the needed items or supports,
- 3) Must be moving from a living arrangement where needed items were provided,
- 4) Must be moving to a residence where these needed items are not normally furnished,
- 5) The Community Transition Services must be requested and planned prior to discharge from the nursing facility,
- 6) The Community Transition Services can begin as soon as the person meets the criteria of their nursing facility or ICF/IID stay being paid by Medicaid, but they must be completed within 30 days of the discharge, and
- 7) Receipts must be available to DOM for all expenses paid.

Persons whose nursing facility or ICF/IID stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Navigator

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

Community Navigator

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- 1) The provider must be established and in business for a minimum of one (1) year.
- 2) The provider must provide documentation to the Division of Medicaid of successfully transitioning individuals into the community for a minimum of two (2) years, and/or working with individuals in the community for a minimum of eight (8) years. For those without two (2) years of successfully transitioning individuals into the community, experience will be considered on an individual basis.
- 3) The provider must have documentation of attending DOM approved person-centered training or another DOM approved training relating to person-centered planning.
- 4) The provider must attend all quarterly and annual trainings administered by DOM with a minimum of one attendee from the provider.
- 5) There must be a Medicaid provider agreement through which the agency agrees to the Home and Community-Based Waiver requirements.
- 6) There must be an authority and a governing structure for assuring responsibility, and for requiring accountability for performance.
- 7) There must be responsible fiscal management.
- 8) There must be responsible personnel management including:
 - a. Appropriate process used in the recruitment, selection, retention, and termination of CTS professionals such as Community Navigators.
 - b. Written personnel policies and job descriptions.
- 9) There must be a roster of qualified Community Navigators with the area that they will service.
- 10) There must be written criteria for service provision, including procedures for dealing with emergency situations and after-hour crisis.
- 11) Each Community Transition Service provider must have qualified Community Navigators and qualified Supervisors.
 - a. The Community Navigator must meet the following requirements:
 - i. The Community Navigator must meet one of the following criteria: Licensed Social Worker (LSW) with valid state license and a minimum of one (1) year of relevant work experience, Case Manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH), Registered Nurse(RN)with a valid state license and a minimum of one (1) year of relevant work experience, Others with relevant experience and training with a minimum of a bachelor's degree and (1) year of work experience in a social or health services setting, or others with comparable technical and human service training and five (5) years' experience will be considered and approved by the Division of Medicaid.
 - ii. The Community Navigator must also have documented experience and training in person- centered planning. A minimum of 40 hours of training is required, as well as Profile Development training.
 - iii. The Community Navigator must attend an eight (8) hour introductory course to CTS regardless of experience prior to beginning work that is administered by the Division of Medicaid, Office of Community Based Services.
 - iv. Must complete a Person Centered Plan course training designated by DOM within the one (1) year of rendering services, unless otherwise excluded.
 - v. Must demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity. Must also exhibit basic qualities of compassion/maturity, and be able to respond to participants and situations in a responsible manner.
 - vi. Must attend all Quarterly and Annual training administered by DOM, unless written exclusion to Quarterly or Annual training is provided by DOM.
 - vii. Must possess a valid Mississippi Driver's License.
 - viii. Must be able to function independently without constant observation and supervision.
 - ix. Must have interest in, and empathy for, people who are ill, elderly, and/or disabled.
 - x. Must have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people.
 - xi. Must be able to carry out and follow verbal and written instructions.
 - xii. Must have training in current systems used by DOM such as LTSS, or any other system utilized for documentation purposes.
 - b. The Community Navigator Supervisor must have at least two (2) years of supervisory experience in programs dealing with elderly and disabled persons and meet one of the following requirements:
 - i. A Bachelor's Degree in Social Work, Psychology, or related profession with one year of direct experience working with aged and disabled persons transitioning into the community.

- ii. A Licensed Registered Nurse (RN) with (2) years of direct experience working with aged and disabled persons transitioning into the community,
- iii. A High School Diploma or GED with seven (7) years of direct experience working with aged and disabled persons, along with two (2) of the seven (7) years working directly with persons transitioning into the community.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agencies and the Division of Medicaid

Frequency of Verification:

At least annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

A nutritionally balanced meal delivered to the home of an eligible persons who is unable to leave his/her home without assistance, unable to prepare their own meals, and/or has no responsible caregiver in the home.

The purpose of home delivered meals is to:

- 1) Meet the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life;
- 2) Keep the person in his/her home rather than in an institution.

Minimum Program Requirements:

All service providers offering home delivered meals must adhere to the following requirements:

Service Activities:

(A) Safety: Home delivered meals providers are required to ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health regulations governing food service sanitation.

(B) Supplies: The home delivered meals provider shall be responsible for providing at the minimum, the following service supplies with each individual meal:

- 1) Straw: Six inch individually wrapped (jumbo size)
- 2) Napkin: 13 inches by 17 inches
- 3) Flatware: Each individually wrapped package to contain non-brittle medium weight plastic fork or spoon and serrated knife with handles at least 3 1/2 inches long.
- 4) Carry-out tray: FDA approved compartment tray for hot foods.
- 5) Condiments: Individual packets of iodized salt and pepper shall be provided. Other condiments, individually packed, such as ketchup, mustard, mayonnaise, salad dressings, tartar sauce, shall be served when necessary to complete the menu.
- 6) Cups: Styrofoam cups, 4oz. with cover for cold foods to accompany carry-out trays.

(C) Transporting Equipment: Each home delivered meals provider must use transporting equipment designed to protect the meal from potential contamination, and designed to hold the food at a temperature below 45 degrees Fahrenheit, or above 140 degrees Fahrenheit, as appropriate.

(D) Emergency Meals: Home delivered meal providers must have contingency plans to ensure that in the event of an emergency, enrolled persons will have access to a nutritionally balanced meal.

(E) Other requirements:

- 1) The provider must bring to the attention of the appropriate officials for follow-up any conditions or circumstances which place the person or the household in imminent danger.
- 2) Home delivered meals service providers must comply with all state and local health laws and ordinances concerning preparation, handling and service of food.
- 3) Home delivered meals service providers must have available for use, upon request, appropriate food containers and utensils for blind and individuals with limited dexterity or mobility .
- 4) All staff working in the preparation of food must be under the supervision of a person who will ensure the application of hygienic techniques and practices in food handling, preparation and services. This supervisory person shall consult with the service provider dietitian for advice and consultation, as necessary.
- 5) Home delivered meals service providers, where necessary and feasible, may use various methods of delivery. However, all food preparation standards set forth in this section must be met.
- 6) Only one hot meal may be delivered per day and no more than fourteen (14) frozen meals per delivery. In emergency situations, such as under severe weather conditions, it will be permissible to leave nonperishable meals or food items for a person, provided that proper storage and heating facilities are available in the home, and the person is able to prepare the meal with available assistance.
- 7) Establish procedures to be implemented by staff during an emergency (fire, disaster) and train staff in their assigned responsibilities.
- 8) Keep a record of each person served a meal. If person, or designated caregiver, is not home at time of delivery, then meals should not be delivered. Meals, delivered to anyone other than the person or their caregiver, are not billable.
- 9) Documentation of services provided. Documentation of delivered meals must be kept and forwarded along with a copy of billing to the case manager on a monthly basis.

Staffing:

- (a) There must be a person responsible for the day-to-day operation of the service.
- (b) There must be an adequate number of staff to meet the purpose of the program.
- (c) All staff must be trained in the proper technique of preparing and/or serving meals for aged and disabled beneficiaries, sanitation procedures, proper cleaning of equipment/utensils, first aid and emergency procedures.
- (d) In-service training is required of all staff and is the responsibility of the sponsoring agency.

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

One unit of service is one meal delivered. One meal per day, seven days a week will be the maximum meal services allowed. The maximum number of meals that are billable per month is equal to the number of days in the month. Shelf-stable meals are provided to the homebound for designated holidays, weather or other emergencies, elections and various community events.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Vendor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Qualified Vendor

Provider Qualifications

License (specify):

Certificate (specify):

All vendors must be certified through the Mississippi State Department of Health.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Division of Medicaid

Frequency of Verification:

Verification is ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Institutional Respite Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Institutional Respite Services are services provided to persons who are unable to care for themselves, and because of the absence or need for relief of those persons normally providing this care.

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

Up to thirty calendar days per fiscal year. The days do not have to be taken concurrently.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Certified

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Institutional Respite Care

Provider Category:

Agency

Provider Type:

Medicaid Certified

Provider Qualifications

License (specify):

Certificate (specify):

Medicaid certified Hospital, Nursing Facility, Licensed Swing Bed Facility

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Qualified Home Health Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

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

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

At time of initial enrollment and at time of recertification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Speech-language pathology (speech therapy) services are medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma, or congenital anomaly. Services are provided by a qualified home health agency in the home of the person.

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Speech Therapy Services

Provider Category:

Agency

Provider Type:

Qualified Home Health Agency

Provider Qualifications

License (specify):

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

Certificate (*specify*):

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

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

At time of initial enrollment and at time of recertification.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

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

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

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

[Empty box for specifying entities]

Appendix C: Participant Services

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

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

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

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

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

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

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

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

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

The DOM Office of Provider Enrollment performs mandatory screenings on owner's and operators of provider agencies, prior to enrollment and as required by federal regulations. Documentation of provider staff qualifications/screenings are reviewed by DOM's Office of Financial and Performance Review during post-utilization audits. Additionally, this Office checks the Nurse Abuse Registry during audits for direct care workers serving participants of the Elderly and Disabled Waiver.

Appendix C: Participant Services

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

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

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

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

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

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

Other policy.

Specify:

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

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

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

All providers must comply with standards and processes set forth in the Mississippi Administrative Code, Title 23: Medicaid part 208 Chapter 1: HCBS Elderly and Disabled Waiver.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

PM 1: Number & percent of providers by provider type who met, and continue to meet, required credential standards in accordance with waiver qualifications throughout service provision. N: Number of providers by provider type who met, and continue to meet, required credential standards in accordance with waiver qualifications throughout service provision. D: Total number of providers by provider type.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS/Cognos

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

PM 2: Number and percent of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. N: Number of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. D: Total number of enrolled non-licensed/non-certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text" value="Every 24 Months"/>

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

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

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

Performance Measure:

PM 3: Number and percent of reviewed enrolled providers, by provider type, meeting provider training requirements. N: Number of reviewed enrolled providers, by provider type, meeting provider training requirements. D: Total number of enrolled providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">Every 24 months</div>

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

b. Methods for Remediation/Fixing Individual Problems

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

For PM 1, DOM will (a) not issue provider numbers without verification of credentials (licensure/certification); (b) obtain verification of credentials (licensure/certification) prior to issuance of provider number; and (c) notify provider applicant of application denial within sixty (60) days of application to DOM.

For PM 2, DOM will (a) require a Corrective Action Plan from provider within 30 days of the request; (b) suspend referrals; (c) suspend and/or close provider number within 60 days of discovery if the provider continues to not meet the qualification; and (c) offer participants choice of other available providers, if provider number is closed or terminated.

For PM 3, DOM will (a) require a Corrective Action Plan from provider within 30 days of the request; (b) suspend referrals; (c) suspend and/or close provider number within 60 days of discovery if the provider continues to not meet the qualification; and (c) offer participants choice of other available providers, if provider number is closed or terminated.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text" value="Every 24 months"/>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional

limits on the amount of waiver services (*select one*).

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

Applicable - The state imposes additional limits on the amount of waiver services.

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

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

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

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

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet

requirements at the time of submission. Do not duplicate that information here.

***Need updated STP.

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

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

E&D Waiver services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:

- Case management,
- Home-delivered meals,
- Personal care services,
- In-home respite,
- Transition Assistance, and
- Expanded home health visits.

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

- Institutional respite services.

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver

Rule 1.1:General

A. Medicaid covers certain home and community based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D).

B. The E & D Waiver is administered and operated by the Division of Medicaid. Current language is silent on the following verbiage from 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule which will be added as Rule 1.4.C.:

1. Persons enrolled in the E&D waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

2. The Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or on the grounds of or adjacent to institutions or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver

Rule 1.3:Provider Enrollment

C. Provider Qualifications:

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

3. Qualifications for Adult Day Care Services:

a) Adult day care services must be provided by an established, qualified facility/agency.

b) Each adult day care service must meet the following requirements:

- 1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.
- 2) The facility must meet the requirements of the American Disabilities Act of 1990.
- 3) The facility must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.

Current language is in compliance with and supports the Final Rule 42 CFR § 441.301(c)(4)(i)-(iv).

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver

Rule 1.4: Freedom of Choice

A. Medicaid waiver participants have the right to freedom of choice of Medicaid providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Each individual found eligible for the Elderly and Disabled (E&D) waiver must be given free choice of all qualified providers. Persons enrolled in a Medicaid waiver have the right to freedom of choice of providers for Medicaid covered services. Each individual found eligible for the E&D waiver must be given free choice of qualified providers. Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 1.4.C.:

C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver

Rule 1.6:

Covered Services

2. Adult Day Care Services

a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled participants through an individualized care plan that includes the following:

- 1) Personal care and supervision,
- 2) Provision of meals as long as meals do not constitute a full nutritional regimen,
- 3) Provision of limited health care,
- 4) Transportation to and from the site, with cost being included in the rate paid to providers, and
- 5) Social, health, and recreational activities.

b. Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the participant's assigned case manager.

c. To receive Medicaid reimbursement the participant must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the participant to and from the facility.

4. Institutional or In-Home Respite Services

a. Respite Care provides non-medical care and supervision/assistance to participants unable to care for themselves in the absence of the participant's primary full-time, live-in caregiver(s) on a short-term basis.

b. Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the participant.

c. Institutional Respite Services

- 1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities.
- 2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service.
- 3) Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

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

Rule 1.6.A.2.a)2) is revised to comply with 42 CFR § 441.301(c)(4)(iv):

2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs in addition to the following:

- (a) A mid-morning snack,
- (b) A noon meal, and

(c) An afternoon snack.

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

The following verbiage from 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5) will be added as Rule 1.6.A.2.d. and 1.6.A.2.e.:

d. Adult Day Care settings must be physically accessible to the person and must:

- 1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community , to the same degree of access as individuals not receiving Medicaid HCBS.
- 2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
- 3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- 4) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- 5) Facilitate individual choice regarding services and supports, and who provides them.

e. Adult Day Care settings do not include the following :

- 1)A nursing facility,
- 2)An institution for mental diseases,
- 3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
- 4)A hospital, or
- 5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver

Rule 1.12:

Hearing and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.

B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(v) of the Final Rule.

1915(c) HCBS Waiver: MS.0272.R04.01

Elderly and Disabled Waiver Rule Content Determination

Appendix C: Participant Services

C-1/C-3: Service Specification

1915c Elderly and Disabled Waiver A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant. Current language is in conflict with 42 CFR § 441.301(c)(4)(iv) of the Final Rule. The following verbiage will be deleted with the July 2017 waiver renewal: "A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant".

Appendix F: Participant – Rights

F-2: Additional Dispute Resolution

1915c Elderly and Disabled Waiver

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

At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(ii) of the Final Rule

Appendix F: Participant – Rights

F-3: State Grievance/Complaint

1915c Elderly and Disabled Waiver

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

Administrative Code, Title 23: Medicaid Part 100, Chapter 5: The Hearing Process. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

Safeguards

G-1: Response to Critical Events or Incidents

1915c Elderly and Disabled Waiver Upon entry into the waiver, case managers will provide the waiver participant/and/or caregiver education and information concerning the State's protection of the waiver participant against abuse, neglect and exploitation including how participants may notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation.

When participants are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains monthly contact with each participant by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or participant representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

Appendix G:

Participant Safeguards

G-2: Safeguards Concerning Restraints and Restrictive Interventions

1915c Elderly and Disabled Waiver The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and the quality of waiver services provided. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

[Empty box for Case Manager qualifications]

Social Worker

Specify qualifications:

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

Must be credentialed to perform assessments.

Other

Specify the individuals and their qualifications:

The registered nurse in addition to possessing a current and active nursing license to practice in Mississippi, or a privilege to practice on a compact license, must have at least 2 years of nursing experience with aged and/or disabled individuals. If less than two years of experience, the registered nurse must complete ninety (90) days of orientation/training of direct waiver services under the supervision of an established waiver case manager who has two years of waiver experience.

Must be credentialed to perform assessments.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The case management agency develops the person-centered service plan and can only provide other waiver services to the person if there is no other willing provider in the geographic area, as defined by DOM. Oversight of waiver processes and periodic evaluations are completed by DOM Office of Long Term Care and Office of Financial and Performance Review.

Service plan development is a component of the Case Management service. Once completed, each service plan is submitted for review and approval by DOM Office of Long Term Care prior to direct service provision. All PSSs are approved by DOM Office of Long Term Care. The plan of services and supports, otherwise known as the PSS, is the fundamental tool by which the State ensures the health and welfare of waiver persons participating in the E&D Waiver. The process for developing a waiver person's PSS requires the plan to be based on a comprehensive assessment process. A registered nurse and a licensed social worker along with the waiver person, and interested parties as requested by the person, are jointly responsible for determining the waiver person's needs, preferences, and goals through a person centered planning process. The PSS includes a comprehensive emergency preparedness plan specific to meet the person's needs.

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

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

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

The person is informed by the case management agency, at the time of enrollment in the waiver, the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing. The person is given their bill of rights which addresses disputes, complaints/grievances and State Fair Hearings. The person has the right to address any disputes regarding services with DOM at any time.

The informal dispute resolution process may be initiated by the person with the case management agency at the agency local level and is understood as not being a pre-requisite or substitute for a state fair hearing. The types of disputes that can be addressed include issues concerning service providers, waiver services, and anything that directly affects the person's waiver services. Waiver persons may address disputes by first reporting the issue to their case management team, which includes a registered nurse and licensed social worker. The case management team will respond to the person within 24 hours. If a person believes that a resolution has not been reached within 72 hours, the case management team will report the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If the person believes a resolution has not been reached within this time frame, the issue is reported to DOM. DOM will consult with the case management agency to investigate the issue and work towards a resolution within seven days. In the event the dispute involves the case management team, the case management agency and DOM will work with the person to identify and select a new case management team. Once a new case management team is selected, the case management supervisor will evaluate the person's satisfaction with the new case management team within the following month and will notify DOM of the

final resolution. DOM and the case management agency are responsible for operating the dispute process. DOM has the final authority over any dispute.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

A case manager(s), the person, caregivers and/or interested parties work together to develop the PSS, especially in identifying personal goals, health care needs and preferences. These planning meetings are scheduled at the place and time of the participants choosing.

The case manager is responsible for informing the person and others as requested by the person about State Plan services and services furnished through other State and Federal programs. The case manager will coordinate waiver services and non-waiver services to meet the needs of the person.

The case management team is responsible for continued and ongoing monitoring of the person's needs and effectiveness of the PSS. The PSS is reassessed on a regular basis with monthly face-to-face visits. However, a quarterly review of the PSS is required. If a change in the PSS is warranted or desired by the person, the person will confer with the case management team to identify potential changes. The PSS is updated annually or more frequently based on the individual needs, desires and goals of the person and/or responsible party.

Informed Choice is ensured by the case manager informing the person and/or the legal representative of the available Medicaid-covered long term care options including alternatives to nursing facility placement. The person acknowledges their participation in the application process by signature attesting long term care program options were explained to him/her. Fair Hearing Notices are maintained in person's file at the Case Management Agency.

As part of the person centered planning process, service provider signatures are captured on the PSS.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Person involvement and choice, in all aspects of the waiver program and in service planning, is an integral part of identifying and mitigating risks. The case management team must assist the person and provide them with sufficient information and assistance in order to make an informed choice regarding choice of services and supports, always taking into account risks that may be involved for that person. The person and informal caregivers/supports assist in developing strategies and complying with strategies to help mitigate risk and ensure health and safety. This is ensured by ongoing monitoring by the case management agency and DOM. The PSS is monitored by the case management agency and the Medicaid agency. Monthly and quarterly actions are required to review/assess the person's service needs, with a new plan developed every twelve months. The Medicaid agency utilizes an assessment and application process for annual eligibility, admission, and recertification for persons. Beginning at the initial assessment and person-centered planning process, the presence and effect of risk factors must be determined. The assessment is specifically designed to assess and document risks a person may encounter. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. All risk factors identified must be addressed in the PSS. Risk factors considered are documented abuse/neglect/exploitation, socially inappropriate behavior, communication, nutrition concerns, environmental security and safety, falls, orientation, emotional/mental functioning, and lack of informal support. The case management team must also determine whether a medical condition is present that requires specific intervention to prevent a decline in health and safety.

The types of backup arrangements that are used include the person designating alternate care providers in the event that their caregiver is unable to provide care. The person and caregiver identify family members who are able to provide services in the event of an emergency. The case management agency and the person also maintain a list of qualified local community providers from which the person can choose if the caregiver is not available. During a community disaster or emergency the case management agency notifies the local first response team (i.e. the American Red Cross) of persons with special needs who may require special attention. Back up plans are developed by the case management agency in partnership with the person and their family/caregiver upon admission. The case managers evaluate the appropriateness and adequacy of both waiver and non-waiver services at least monthly during monthly face-to-face home visits with the person. As situations warrant, more frequent face-to-face visits may be made. At each visit, the case manager is required to document and monitor the delivery of services, as well as, document the person's health and welfare.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

For initial application packets, DOM utilizes a LOC algorithm to determine if the person meets the LOC criteria. A DOM nurse reviews the application packet and will notify the case manager in a timely manner of the approval/disapproval of services requested. If additional information is needed by DOM prior to making a determination, a clarification request is sent to the Case Management Agency. Waiver services may be provided from the date the person is determined eligible for waiver services. If the LOC criteria is not met, the DOM nurse will review documentation and establish LOC. If the DOM nurse cannot establish LOC, it will be reviewed by a physician.

For recertification application packets, DOM utilize a LOC algorithm to determine if the person meets the LOC criteria. DOM also utilizes within its electronic Long Term Services and Supports system a formula to determine if the amount of services listed on the PSS and the cost for those services are appropriate for the needs identified in the assessment as indicated by the assessment scoring algorithm. Recertification applications that meet specific algorithm criteria will be auto approved in LTSS,, and the case manager is notified of the approval. Recertification application packets that do not meet the established criteria for auto approval will be reviewed by a DOM nurse in the same process as initials.

During the auto approval process, a random number of applications will be selected for Quality Assurance review by DOM staff. Upon review of these applications, if it is found that a particular case management agency is often out of compliance with submission of applications, this agency will be removed from the auto approval process. Each application submitted by that agency will then be reviewed by DOM staff for compliance.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

--

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

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

- b. Monitoring Safeguards.** *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The Case Management Agency is responsible for monitoring service provision and the person's health and welfare on a monthly and quarterly basis. In rural areas where provider agencies also provide direct services, administrative firewalls must exist to ensure the separation between case management and other services provided. For services which include an administrative fee, the fees have been evaluated and determined to be an appropriate administrative fee by an outside actuary. DOM maintains a list of providers and can verify when a case management agency is the only willing and qualified provider in an area.

DOM, as part of its Continuous Quality Improvement process, monitors service provision and referrals to service providers by reports generated from the LTSS system to identify Case Management Agencies that have disproportionately referred to services within their own agency. DOM staff sample cases of people enrolled in the waiver to conduct in-home visits to discuss services they receive, informed choice in the selection of service providers, and whether the services are sufficient to meet the health and welfare of the person in a home and community based setting.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

PM 1: Number and percent of persons reviewed whose PSS addresses all their needs (including health and safety risk factors and personal goals). N: Number of persons whose PSS is reviewed that addresses all their needs (including health and safety risk factors and personal goals). D: Total number of person whose PSS was reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px; text-align: center;">95%</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

PM 2: Number and percent of persons' PSSs reviewed where the individual's signature indicates involvement in the PSS development. N: Number of persons' PSSs reviewed with signature indicating involvement in PSS development. D: Total number of PSS reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
Other Specify: <input data-bbox="408 1285 647 1368" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	Other Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

PM 3: Number and percent of persons reviewed whose quarterly home visits are performed according to the waiver application. N: Number of persons reviewed whose quarterly home visits are performed according to the waiver application. D: Total number of persons reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text" value="Every 24 months"/>

c. Sub-assurance: Service plans are updated/revise at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

PM 4: Number and percent of PSSs reviewed which are updated/revised annually and as warranted. N: Number of PSSs reviewed that are updated annually and as warranted. D: Total Number of PSSs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

PM 5: Number and percent of persons reviewed who received services in accordance with the PSS in the type, scope, amount, duration, and frequency. N: Number of persons reviewed who received services in accordance with the PSS in the type, scope, amount, duration, and frequency. D: Total number of persons reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <input type="text" value="Every 24 months"/>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

PM 6: Number and percent of persons’ reviewed with documented presentation of available service options and freedom of choice of providers. N: Number of persons’ reviewed with documented presentation of available service options and freedom of choice of providers. D: Total number of PSS reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

For PM 1, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) provide one-on-one Case Manager training by phone or letter as needed; and (d) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted that did not document all needs.

For PM 2, DOM (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) conduct Case Manager training quarterly and annually; and (d) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted that did not have the persons signature.

For PM 3, DOM will (a) require Case Management Agency to complete quarterly update; (b) require Case Management Agency to submit a corrective action plan within thirty days; (c) recoup payment for case management services from provider; and (d) provide Case Manager training annually to educate providers on DOM waiver requirements for case management.

For PM 4, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency and include reason for the lapse of the PSS within seven business days; (c) prevent payments from being made to providers if a PSS expires (exceeds 365 days); and (d) conduct provider training on waiver requirements.

For PM 5, DOM will (a) notify Case Management Agency of identified PSS where services were provided outside of the type, scope, amount, duration, and frequency (b) require Case Management Agency to identify the cause of deficiency and intervene within seven business days to assure participants receive services according to the type, scope, amount, duration, and frequency of the (c) require Case Management Agency to submit a revised PSS within fourteen (14) days; (d) require provider to submit an adjust/void within thirty days, if warranted; and (e) provide Case Manager training on waiver requirements.

For PM 6, DOM will (a) require the Case Management Agency to document presentation of service options and freedom of choice within seven business days; and (b) provide Case Manager training annually on waiver requirements; and (c) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted without documentation of presentation of service options and freedom of choice of provider.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text" value="Every 24 months"/>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

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

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

State Fair Hearing procedures are based on the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1.

A case manager sends a Notice of Action (NOA) to the person by certified mail (Signature return requested). Fair Hearing Notices are maintained in person's file at the Case Management Agency.

Contents of Notice of Action include:

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

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

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

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

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

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

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

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

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

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

At no time will the informal dispute resolution process conflict with the person's right to a State Fair Hearing in accordance with State Fair Hearing procedures and processes as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

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

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

State Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes.

Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

Critical incidents are identified as follows:

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

Neglect (N) - can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.

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

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

All reports of A, N and E are taken very seriously by DOM. DOM provides for the reporting and investigation of major and serious incidents of abuse, neglect and exploitation of a waiver persons. All reports of A, N and E are reported immediately verbally and in writing by the appropriate case manager to their supervisor and the Department of Human Services. The potential A, N and E are also to be reported in writing to the DOM/Office of LTC/E&D Waiver Program Division as it occurs. DOM staff review the documentation and report findings to the DOM E&D waiver director. If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. In addition, reports are simultaneously made to DHS who is the investigative agency in Mississippi responsible for investigating allegations of A, N and E. DOM and the case management agency follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

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

The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon entry into the waiver, case managers will provide the person and/or their caregiver education and information concerning the State's protection of the person against abuse, neglect and exploitation including how persons may notify appropriate authorities when the person may have experienced abuse, neglect or exploitation. When person are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains regular contact with each person by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities.

DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

First line entity to receive reports is the E&D Waiver case manager at the case management agency and/or the DOM Office of LTC E&D Waiver Program Division. When DOM receives a critical incident report, DOM staff review the documentation and report findings to the DOM E&D waiver director. The critical incident is reported as indicated and followed by DOM staff until the incident is resolved. The communication continues between the case management agency, DOM, Department of Human Services, and Attorney General's Office, if necessary, until resolution occurs.

The Department of Human Services (DHS), Division of Aging and Adult Services, as the lead agency responsible for investigation, is responsible for the notification of investigation results to parties as designated by state law. Time frames for notification of results vary based on investigation.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The case management agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated § 43-1-1, et seq. (1972, as amended), the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM works with DHS through the provision of a memorandum of understanding to ensure effective incident management of all home and community based waiver person under 42 CFR § 441.302. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents. This is an ongoing process, and as these events occur, immediate action takes place and investigation begins. All of the above entities keep written records of suspected events of abuse, neglect, and exploitation. The LTSS system includes a module that will be implemented and will allow critical incident data to be reported and tracked between DOM, DHS, and the case management agency.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restraints

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

The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver person. The case management team is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restrictive interventions

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

The State does not permit the use of restrictive interventions. DOM and the case management agencies are jointly responsible for ensuring that restrictive interventions are not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

The State does not permit the use of seclusion. DOM and the case management agencies are jointly responsible for ensuring that seclusion is not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

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

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

Complete the following three items:

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

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

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

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

PM 1: Number and percent of critical incidents (alleged A,N,E, and/or unexplained/suspicious death) that were addressed within required timeframe as stated in the approved waiver. N: Number of critical incidents (alleged A,N,E, and/or unexplained/suspicious death) that were addressed within required timeframe as stated in the approved waiver. D: Total number of critical incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Event Tracking Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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

Performance Measure:

PM 2: Number and percent of persons reviewed whose emergency preparedness plan (EPP) and Plan of Services and Supports (PSS) address prevention strategies for identified risks (including critical incidents). N: Number of persons reviewed whose EPP and PSS address prevention strategies for identified risks (including critical incidents). D: Number of persons reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

PM 3: Number and percent of persons who receive information on how to report suspected cases of abuse, neglect, or exploitation. N: Number of persons reviewed who received information on how to report suspected cases of abuse, neglect, or exploitation. D: Total number of person's records reviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

LTC QA Home Visits/Telephone Interviews

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

PM 4: Number and percent of complaints that were addressed/resolved within required timeframes as specified in the waiver application. N: Number of complaints that were addressed/resolved within required timeframes as specified in the waiver application. D: Total number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Tracking Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:

PM 5: Number and percent of annual complaint reviews completed where themes are

identified and training was provided to prevent further similar incidents to the extent possible. N: Number of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. D: Total number of annual complaint meetings.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Tracking Database

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

PM 6: Number and percent of participants for which state policies regarding the prohibition of the use of restrictive interventions (including restraints and seclusion) were followed. N: Number of participants for which state policies regarding the prohibition of the use of restrictive interventions (including restraints and seclusion) were followed. D: Total number of unduplicated participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Tracking Database/LTSS

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

PM 7: Number and percent of persons whose preventative health care standards were assessed. N: Number of persons whose preventative health care standards were assessed. D: Total number of persons assessed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
Other	Annually	Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

For PM 1, DOM will (a) require Case Management Agency to address alleged instances of abuse, neglect, exploitation, and unexplained/suspicious deaths within the required timeframe as specified in the approved waiver; (b) provide additional training to providers on reporting requirements; (c) request immediate follow-up of the reported critical incident for those with no follow-up by MS Department of Human Services; (d) request documentation from DHS within 30 days, for those reported critical incidents with late follow-up.

For PM 2, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) provide one-on-one training with case manager supervisor upon discovery.

For PM 3, DOM will (a) require Case Management Agency to provide participant with information as part of the corrective action plan within thirty (30) days; and (b) provide training annually.

For PM 4, DOM will (a) require unresolved complaints to be sent to DOM within seven business days of report to Case Manager Supervisor; and (b) provide additional training on complaint resolution requirements.

For PM 5, DOM will (a) hold annual complaint review meeting; and (b) will provide training to prevent similar complaints, to the extent possible.

For PM 6, DOM will (a) require the policies surrounding the prohibition of the use of restrictive interventions be followed immediately; (b) require Case Management Agency to report unauthorized use of restrictive interventions via email notification within 24 hours of knowledge of the incident; (c) require Case Management Agency to submit a Monthly Activity Report that will include all critical incidents including unauthorized use of restrictive interventions; (d) will require Case Managers to make unscheduled monthly home visits to monitor for the unauthorized use of restrictive interventions with substantiated cases of critical incidents.

For PM 7, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; and (b) have the Case Management Agency conduct a core standardized assessment which assesses a person's preventative health care standards within fifteen (15) days.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="317 1525 743 1608" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="815 1839 1241 1921" type="text"/>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DOM employs staff to assist in system design. Meetings are held routinely, or as needed, to review analyzed discovery and remediation data, to develop Computer System Request (CSRs), review progress, and test system changes. The CSRs are the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent. The meetings involve participation from DOM’s Office of Information Technology Management, Long Term Care staff and others deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including nurses are held monthly or as needed for the purpose of addressing needs and resolving issues. When DOM identifies a system issue it is reported to the fiscal agent for review and research. System issues that affect services to persons or affect accurate payment to providers are considered a priority. DOM holds monthly meetings with the program staff and the systems staff to address issues that require system changes.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Other Specify: <div style="border: 1px solid black; padding: 2px;">Ongoing and as needed</div>

b. System Design Changes

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

DOM meets on monthly or as needed basis with the Office of Information Technology Management, with daily communication whereby system errors and remedies are discussed and or reported. DOM staff and waiver providers/ direct users of the agency’s electronic system have the ability to notify electronically, telephonically, or in writing concerns of the inability to process application packets or billing processes in a timely manner. The Office of Information Technology Management monitors all errors, omissions, and system downtimes in order for DOM to address either with the fiscal agent for a system change to remedy the problem and/or track the problem to propose a remedy. In addition, DOM and the case management agencies meet periodically to review and analyze the functionality of the LTSS process. Recommendations for improvement are reviewed and applied as appropriate.

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

DOM monitors the Quality Improvement Strategy on a quarterly basis. The Quality Improvement Strategy is reviewed annually. The review consists of 1) analyzing aggregated reports and progress toward meeting 100% of the sub assurances, 2) resolution of individual and systemic issues found during discovery, and 3) notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and the fiscal agent is made to meet waiver reporting requirements. The Quality Assurance nurses will utilize the Quality Improvement Strategy during all levels of QA activities.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DOM maintains responsibility for ensuring that financial audits of E&D Waiver providers are conducted. DOM will also generate all required financial reporting for each E&D Waiver service provided. The audit will verify the maintenance of appropriate financial records and review claims to verify coding and accuracy of the payments made. The audits are also a mean of identifying if services are delivered according to the approved plan of care. Immediate action will be taken when necessary to address any financial irregularities identified in the review, or if services are billed and not delivered according to the person’s plan of services and supports.

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

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

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

Performance Measures

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

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

Performance Measure:

PM 1: Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver. D: Total number of claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS/Cognos

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

PM 2: Number and percent of waiver service claims reviewed that were submitted for services within the persons' PSS. N: Number of waiver service claims reviewed that were submitted for services within the persons' PSS. D: Total number of service claims reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compliance Review

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Every 24 months</div>

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other	Annually	Stratified

<i>Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>		<i>Describe Group:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

DOM contracted with an actuary firm to thoroughly evaluate the service rates.

To set the context for developing service rates, the service descriptions for each waiver service were carefully considered. It was determined whether certain services had essentially the same provider education requirements, expectations and billable productivity levels. If so, these services were grouped together for purposes of rate development.

Rates for meals will be increased by either 2.0% annually or in accordance with, but not to exceed, the rate change in the United States Department of Labor's Consumer Price Index, All Urban Consumers, South Region, Food Away from Home, based upon the preceding calendar year. If the increase in the statewide meals contract rate is greater than the Consumer Price Index for the previous calendar year, DOM will pay the new contracted rate with no less than 20% above for accounting, billing and general management of the meal program. During the 2012 Milliman rate review, this add on was determined to be the comparative administrative fee for known vendor subcontracting terms to provide for the organization and coordination of meal deliveries. Rates for meals will be increased by either 2.6% annually or in accordance with, but not to exceed, the rate change of the average CPI throughout years 1 through 5.

For all services reviewed, we either compared current waiver rates to the same non-waiver Medicaid service rates, or we performed a thorough "ground up" provider rate development.

For the Adult Day Care, Personal Care, Case Management, and In-Home Respite services, we built rates from the ground up using the following rating variables:

- Direct service provider salaries and benefits*
- Direct service-related expense and overhead costs*
- Annual number of hours practitioners are at work*
- Percentage of time an at work practitioner is able to convert to billable units (productivity)*

A benefit load of 35% of salary was added for social workers and nurses, while direct care workers received a load of 25%. A blended load of 30%, was used for Adult Day Care Services which represents a blend of 25% for assistants and activity coordinators and 35% for program coordinator and clinical support. This load accounts for all mandatory Mississippi and Federal benefits, such as unemployment and Social Security, as well as employer costs for optional benefits, such as health and disability insurance.

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, Mississippi Planning and Development District (PDD) and Adult Day Care (ADC) center previous surveys, and DOM and Milliman experience.

The rates for Physical Therapy, Speech Therapy, and Extended Home Health are set to match the State Plan reimbursement rate, which is based on an annual cost report, updated October 1st of each year.

Once we calculated initial service rates, we compared them to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. The ADC must submit claims in 15 minute increments for the duration of time the services were provided and will be reimbursed by DOM the lesser of the maximum daily cap of \$62.08 in Year 1 or the total amount of the 15 minute increment units billed. The duration of the service time should begin upon the person's entry in the facility and end upon their departure.

Projected rates for waiver years following the initial year were based on an expected two point six (2.6) percent increase in accordance with the average projected Consumer Price Index.

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

E&D Waiver providers bill their claim directly to DOM's claims payment system. This system is housed and managed by the State's fiscal agent.

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS houses claims data and information that can be produced upon request. The MMIS has audit functions to deny payment for services when an individual is not Medicaid eligible on the date of service. The MMIS also has an audit function to deny any individual who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS requires an individual to be an approved, eligible Medicaid waiver person, documented in the MMIS, in order for the claim to pay. The lock-in function is housed in the MMIS under the recipient file and is performed/completed by Medicaid staff or the Medicaid Fiscal Agent staff.

DOM conducts post utilization reviews to ensure the services provided were on the person's approved service plan.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the

entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

There are ten (10) Planning and Development Districts (PDD's) in the State of Mississippi. Each PDD is an independent organization governed by a Board of Directors appointed by the local government officials. Each District represents a distinctly different region of the state, but each have common functions such as economic development, loan programs, community development, technical assistance, planning assistance, human resource development, job training, social services, transportation and gerontology. The state Area Agencies on Aging (AAAs) are housed within the PDDs. The PDD's provide case management services, transition assistance, adult day care and home delivered meals.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability**I-3: Payment (7 of 7)****g. Additional Payment Arrangements**

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

[Empty rectangular box]

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

[Empty rectangular box]

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

[Empty rectangular box]

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	33682.71	3549.00	37231.71	66633.49	14080.11	80713.60	43481.89
2	34525.91	3641.27	38167.18	68365.96	14446.19	82812.15	44644.97
3	35440.42	3735.95	39176.37	70143.48	14821.79	84965.27	45788.90
4	36358.10	3833.08	40191.18	71967.21	15207.16	87174.37	46983.19
5	37347.24	3932.74	41279.98	73838.35	15602.55	89440.90	48160.92

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	21000		21000
Year 2	21300		21300
Year 3	21600		21600
Year 4	21900		21900
Year 5	22200		22200

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is 309 days. This number is based upon information captured in the state fiscal year 2014 and 2015 CMS 372 Annual Reports.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The estimates for Factor D were calculated automatically from the numbers entered for number of users, average units per user, and average cost per unit for each component of waiver service. Estimates of the number of persons who will be served on the Elderly and Disabled waiver were based upon the sum of the current unduplicated count and 50% of the current wait list for Year 1. The numbers were then projected forward for each waiver year based on estimated attrition from the previous year and anticipated need for the coming year. During the development of the current waiver, DOM projected the average costs/unit for year one (1) of the waiver and adjusted the costs incrementally over the following four (4) years based on a 2.6% average projected CPI.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are based on the SFY 2015 CMS 372 report. The estimate was applied for year one and every year after was adjusted based on a 2.6% average projected CPI.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G is based upon DOM's analysis of nursing home expenditures for FY2015. The specific nursing home expenditures analyzed were actual paid claims per Medicaid beneficiary in a nursing facility, including elderly and disabled individuals with a similar average length of stay. Every year after was adjusted based on a 2.6% average projected CPI.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these

estimates is as follows:

The estimates for G' are based on DOM's analysis of the expenditures for all Medicaid services other than those included for Factor G for SFY 2015. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility, including elderly and disabled individuals with a similar average length of stay. Every year after was adjusted based on a 2.6% average projected CPI.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Adult Day Care	
Case Management	
In-Home Respite	
Personal Care Service	
Extended Home Health Services	
Community Transition Services	
Home Delivered Meals	
Institutional Respite Care	
Physical Therapy Services	
Speech Therapy Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						6427142.40
Adult Day Care	per 15 minutes	2856	580.00	3.88	6427142.40	
Case Management Total:						37942800.00
Case Management	monthly	21000	10.00	180.68	37942800.00	
In-Home Respite						49609324.80
GRAND TOTAL:						707336858.70
Total Estimated Unduplicated Participants:						21000
Factor D (Divide total by number of participants):						33682.71
Average Length of Stay on the Waiver:						309

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
In-Home Respite	per 15 minutes	3906	2880.00	4.41	49609324.80	
Personal Care Service Total:						592704000.00
Personal Care Service	per 15 minutes	21000	6400.00	4.41	592704000.00	
Extended Home Health Services Total:						311700.00
Skilled Nursing	per visit	50	50.00	115.00	287500.00	
Home Health Aide	per visit	11	50.00	44.00	24200.00	
Community Transition Services Total:						812790.00
Community Transition Services	per occurrence	55	1.00	14778.00	812790.00	
Home Delivered Meals Total:						19498752.00
Home Delivered Meals	per meal	15120	260.00	4.96	19498752.00	
Institutional Respite Care Total:						17293.50
Institutional Respite Care	per day	5	30.00	115.29	17293.50	
Physical Therapy Services Total:						8976.00
Physical Therapy Services	per visit	11	12.00	68.00	8976.00	
Speech Therapy Services Total:						4080.00
Speech Therapy Services	per visit	5	12.00	68.00	4080.00	
GRAND TOTAL:					707336858.70	
Total Estimated Unduplicated Participants:					21000	
Factor D (Divide total by number of participants):					33682.71	
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						6687434.80
Adult Day Care	per 15 minutes	2897	580.00	3.98	6687434.80	
Case Management Total:						39485940.00
Case Management	monthly	21300	10.00	185.38	39485940.00	
In-Home Respite Total:						51575731.20
In-Home Respite	per 15 minutes	3962	2880.00	4.52	51575731.20	
Personal Care Service Total:						616166400.00
Personal Care Service	per 15 minutes	21300	6400.00	4.52	616166400.00	
Extended Home Health Services Total:						325701.50
Skilled Nursing	per visit	51	50.00	117.99	300874.50	
Home Health Aide	per visit	11	50.00	45.14	24827.00	
Community Transition Services Total:						833922.65
Community Transition Services	per occurrence	55	1.00	15162.23	833922.65	
Home Delivered Meals Total:						20295662.40
Home Delivered Meals	each meal	15336	260.00	5.09	20295662.40	
Institutional Respite Care Total:						17743.50
Institutional Respite Care	per day	5	30.00	118.29	17743.50	
Physical Therapy Services Total:						9209.64
Physical Therapy Services	per visit	11	12.00	69.77	9209.64	
Speech Therapy Services Total:						4186.20
Speech Therapy Services	per visit	5	12.00	69.77	4186.20	
GRAND TOTAL:						735401931.89
Total Estimated Unduplicated Participants:						21300
Factor D (Divide total by number of participants):						34525.91
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						6952483.20
Adult Day Care	per 15 minutes	2938	580.00	4.08	6952483.20	
Case Management Total:						41083200.00
Case Management	monthly	21600	10.00	190.20	41083200.00	
In-Home Respite Total:						53693337.60
In-Home Respite	per 15 minutes	4018	2880.00	4.64	53693337.60	
Personal Care Service Total:						641433600.00
Personal Care Service	per 15 minutes	21600	6400.00	4.64	641433600.00	
Extended Home Health Services Total:						340232.00
Skilled Nursing	per visit	52	50.00	121.06	314756.00	
Home Health Aide	per visit	11	50.00	46.32	25476.00	
Community Transition Services Total:						871161.20
Community Transition Services	per occurrence	56	1.00	15556.45	871161.20	
Home Delivered Meals Total:						21107174.40
Home Delivered Meals	each meal	15552	260.00	5.22	21107174.40	
Institutional Respite Care Total:						18204.00
Institutional Respite Care	per day	5	30.00	121.36	18204.00	
Physical Therapy Services Total:						9448.56
Physical Therapy Services	per visit	11	12.00	71.58	9448.56	
Speech Therapy Services Total:						4294.80
Speech Therapy Services					4294.80	
GRAND TOTAL:						765513135.76
Total Estimated Unduplicated Participants:						21600
Factor D (Divide total by number of participants):						35440.42
Average Length of Stay on the Waiver:						309

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per visit	5	12.00	71.58		
GRAND TOTAL:						765513135.76
<i>Total Estimated Unduplicated Participants:</i>						21600
<i>Factor D (Divide total by number of participants):</i>						35440.42
<i>Average Length of Stay on the Waiver:</i>						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						7237135.60
Adult Day Care	per 15 minutes	2978	580.00	4.19	7237135.60	
Case Management Total:						42735660.00
Case Management	monthly	21900	10.00	195.14	42735660.00	
In-Home Respite Total:						55835942.40
In-Home Respite	per 15 minutes	4073	2880.00	4.76	55835942.40	
Personal Care Service Total:						667161600.00
Personal Care Service	per 15 minutes	21900	6400.00	4.76	667161600.00	
Extended Home Health Services Total:						355292.50
Skilled Nursing	per visit	53	50.00	124.21	329156.50	
Home Health Aide	per visit	11	50.00	47.52	26136.00	
Community Transition Services Total:						909771.87
Community Transition Services	per occurrence	57	1.00	15960.91	909771.87	
Home Delivered						21974284.80
GRAND TOTAL:						796242465.65
<i>Total Estimated Unduplicated Participants:</i>						21900
<i>Factor D (Divide total by number of participants):</i>						36358.10
<i>Average Length of Stay on the Waiver:</i>						309

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals Total:						
Home Delivered Meals	each meal	15768	260.00	5.36	21974284.80	
Institutional Respite Care Total:						18678.00
Institutional Respite Care	per day	5	30.00	124.52	18678.00	
Physical Therapy Services Total:						9694.08
Physical Therapy Services	per visit	11	12.00	73.44	9694.08	
Speech Therapy Services Total:						4406.40
Speech Therapy Services	per visit	5	12.00	73.44	4406.40	
GRAND TOTAL:					796242465.65	
<i>Total Estimated Unduplicated Participants:</i>					21900	
<i>Factor D (Divide total by number of participants):</i>					36358.10	
<i>Average Length of Stay on the Waiver:</i>						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						7529386.00
Adult Day Care	per 15 minutes	3019	580.00	4.30	7529386.00	
Case Management Total:						44448840.00
Case Management	monthly	22200	10.00	200.22	44448840.00	
In-Home Respite Total:						58149532.80
In-Home Respite	per 15 minutes	4129	2880.00	4.89	58149532.80	
Personal Care Service Total:						694771200.00
Personal Care Service	per 15 minutes				694771200.00	
GRAND TOTAL:					829108756.70	
<i>Total Estimated Unduplicated Participants:</i>					22200	
<i>Factor D (Divide total by number of participants):</i>					37347.24	
<i>Average Length of Stay on the Waiver:</i>						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		22200	6400.00	4.89		
Extended Home Health Services Total:						364507.50
Skilled Nursing	per visit	53	50.00	127.43	337689.50	
Home Health Aide	per visit	11	50.00	48.76	26818.00	
Community Transition Services Total:						949802.20
Community Transition Services	per occurrence	58	1.00	16375.90	949802.20	
Home Delivered Meals Total:						22857120.00
Home Delivered Meals	each meal	15984	260.00	5.50	22857120.00	
Institutional Respite Care Total:						22996.80
Institutional Respite Care	per day	6	30.00	127.76	22996.80	
Physical Therapy Services Total:						9946.20
Physical Therapy Services	per visit	11	12.00	75.35	9946.20	
Speech Therapy Services Total:						5425.20
Speech Therapy Services	per visit	6	12.00	75.35	5425.20	
GRAND TOTAL:						829108756.70
<i>Total Estimated Unduplicated Participants:</i>						22200
<i>Factor D (Divide total by number of participants):</i>						37347.24
<i>Average Length of Stay on the Waiver:</i>						309