PUBLIC NOTICE
February 28, 2023

Pursuant to 42 C.F.R. Section 441.304, public notice is hereby given to the submission of a Medicaid 1915(c) Assisted Living (AL) Waiver renewal. The Division of Medicaid, in the Office of the Governor, will submit this proposed waiver to the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2023, contingent upon approval from CMS.

1. The proposed changes to the AL Waiver are to:

    a. Updates to Factor C to project unduplicated enrollment limits.
    b. Addition of language to allow reserved capacity for priority admission to the waiver for high acuity members.
    c. Updates to auditing methodology to reflect new risk-based methodology.
    d. Updates to service rates and rate methodologies.
    e. Updates to quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
    f. Updates to language to streamline provider qualifications.
    g. Update Case Management services to allow for monthly contacts to be completed telephonically where appropriate.
    h. Update Case Management provider qualifications to allow for additional flexibilities in staff credentials.

2. The expected increase in annual aggregate expenditures is $1,776,873.14 in federal dollars and $341,730.82 in state dollars.

3. A copy of the proposed waiver 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 requested at 601-359-2081 or by emailing at DOMPolicy@medicaid.ms.gov.

4. 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 DOMPolicy@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.

5. A public hearing on this waiver will not be held.

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

This renewal application includes the following major changes:

• Updates to Factor C to project unduplicated enrollment limits.
• Addition of language to allow reserved capacity for priority admission to the waiver for high acuity members.
• Updates to auditing methodology to reflect new risk-based methodology.
• Updates to service rates and rate methodologies.
• Updates to quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
• Updates to language to streamline provider qualifications.
• Updates to Case Management services specifications and provider qualifications to allow for additional flexibilities in staff credentials and service provision.

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

1. Request Information (1 of 3)

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

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

Assisted Living Waiver

C. Type of Request: renewal

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.0355
Draft ID: MS.008.05.00

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

Regular Waiver

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

02/27/2023

07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

The State additionally limits the waiver to individuals who are 21 and over.

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [☒] **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 Assisted Living (AL) waiver provides individuals seeking Long Term Services and Supports with meaningful choices to support residency in a Home and Community Based setting. The waiver strives to identify the needs of the person and provide services in the most cost-efficient manner possible with the highest quality of care. This is accomplished through the utilization of a comprehensive Long Term Services and Supports (LTSS) assessment process that includes a single point of entry for individuals seeking services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term services and supports across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.

This waiver is administered and operated by the Division of Medicaid (otherwise known as the State or DOM). The following are services provided under the AL Waiver: case management, assisted living, and adult residential care for acquired traumatic brain injury participants.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ◉ **Not Applicable**

○ **No**

○ **Yes**

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

◉ **No**

○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified

provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

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

Mississippi actively sought public input during the development of this waiver renewal by seeking comments, conducting group meetings, and meeting with providers and stakeholders. A Public Input meeting was held on December 14, 2022. Attendees included providers, waiver participants, advocates and representatives of the operating agency. Sixty days prior to submission of the waiver renewal application to CMS, the Mississippi Band of Choctaw Indians was notified via certified mail of the renewal process including proposed changes and considerations. Thirty days prior to submission of the waiver renewal application to CMS, the full draft was posted for public notice at https://medicaid.ms.gov/news-and-notices/public-notices/.

DOM obtains ongoing public input through the waiver quality interviews conducted by the State staff. During these interviews, direct feedback is received from the participant and/or their representatives. Specific feedback is obtained regarding the participants satisfaction with their services, their satisfaction with their case manager, and any additional services that they believe could be of benefit to them. This feedback is utilized to improve and/or further develop waiver services. Public input is also obtained through calls from providers, applicants/participants and their designated representatives, regarding inquiries, complaints, or appeals.

Summary of Public Comments and Responses:
Public comments were received regarding the need for additional AL waiver funding/capacity and additional transparency for providers into waiting list status.
DOM Response: DOM will determine if there is a way to increase transparency at a very high-level summary of data. Please keep in mind that the wait list is managed from a statewide perspective. If a person is discharged from a facility, the next person on the statewide waitlist will be assessed.
Public comments were received regarding options/limitations related to rate increases for AL services.
State's Response: DOM is conducting a workforce study including a comprehensive provider survey that will gather data regarding provider costs, employee recruitment and retention policies, and other best practices to be utilized in rate updates across the waiver during this renewal.
Public comments were received regarding special services needs of individuals with behavioral health conditions which may not be addressed in the bundled rate.
State's Response: Participants have access to many behavioral health services through their State Plan benefits. If additional services are needed at the facility, providers can propose additional services to DOM that will be considered for incorporation in a future amendment/renewal.
Public comments were received regarding the possibility of implementing cost-based reimbursement similar to nursing facility providers and bed hold days in the AL facility when a participant is admitted to the hospital.
State's Response: At this time, DOM does not plan to convert to cost based reimbursement for assisted living waiver services.
Public comments were received with regards to pharmacy coverage for members admitted to the AL facility while still on the waiver waiting list.
State's Response: Pharmacy is not covered benefit under the assisted living waiver. Depending on their category of eligibility, applicant's may be eligible for pharmacy benefits under the Medicaid State Plan.
Public comments were received with regards to whether waiver eligibility could be retroactive to the date that the person was admitted to the facility.
State's Response: The person must be assessed to determine that they meet nursing facility level of care. Eligibility cannot be prior to the level of care effective date.
Public comments were received regarding options regarding the removal of administrative burdens including the requirement for a physician to sign the LOC certification form or the requirement to print and submit billing for verification each month.to allow Nurse Practitioner to sign the certification form?
State's Response: Administrative Code updates associated with this renewal will address these flexibility requests.

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

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

Proficient persons.

7. Contact Person(s)

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

Last Name: Johnson

First Name: Paulette

Title: Nurse Office Director, Long Term Care

Agency: Mississippi Division of Medicaid

Address: Walter Sillers Building, Suite 1000

Address 2: 550 High Street

City: Jackson

State: **Mississippi**

Zip: 39201

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

Fax: (601) 359-9521

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

No transition plan is required.

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.

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Office of Long Term Services and Supports

   (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 Level of Care determinations and service requests that cannot be approved by the automated algorithm or the DOM nurses. The UM/QIO physicians provide clinical recommendations to DOM who is responsible for final determinations.

○ **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 is responsible for contract monitoring of the services performed by the contracted 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 submitted by the contractor and reviewed by DOM 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:
PM1: Number and percent of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. Numerator: Number of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. Denominator: Total number of enrollment reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM2: Number and percent of monthly waiver expenditures reports received that, on average, are at or below the projected expenditure levels for the month. N: Number of monthly waiver expenditure reports received that. on average, are at or below the projected expenditure levels for the month. D: Number of required monthly waiver expenditure reports received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

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

Data Aggregation and Analysis:

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

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:

Performance Measure:
PM3: Number and percent of participants' who received services in an HCB setting as defined by federal regulations. N: Number of participants' who received services in an HCB setting as defined by federal regulations. D: Total number of participants who received services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA Telephone Interviews

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

Data Aggregation and Analysis:

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

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.

When individual and/or system-wide remediation activities are warranted based on discovery and analysis, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systemically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	21	64	
	☒	**Disabled (Other)**	21	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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:

For the ten (10) slots specifically set aside for acquired traumatic brain injury participants, participants must be in a crisis/high stress situation at risk for institutionalization. These participants require 24 hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury. Acquired Traumatic Brain Injury is defined as a traumatically acquired non-degenerative structural brain damage. This term does not apply to brain injuries that are congenital or to brain injuries induced by birth trauma.

Others with brain injuries, who do not require 24-hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury, could also be served in the waiver along with others with disabilities.

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:

There is no maximum age limit for this waiver. The waiver application will not allow the selection of "No maximum age limit" for the Disabled (Physical) or Disabled (Other) target groups.

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)

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:

Prior to admission to this waiver, the case manager(s) completes a thorough comprehensive Long Term Support Services (LTSS) assessment. Along with the core standardized assessment, the case manager(s) submits a person-centered plan of services and supports (PSS) outlining the specific service needs of the individual and providing an estimated projection of the total cost for services to DOM. An oversight review is conducted by a registered nurse at DOM to ensure the person's needs are able to be met by the specified services/frequencies. If a person's needs cannot be met within the capacity of the waiver, it is explained to the applicant and a Notice of Action for a Fair Hearing is sent to them. Suggestions are given for other long term services and supports alternatives.

On average, the cost for a person's waiver services must not be above the average estimated cost for nursing home level of care approved by CMS for the current waiver year. DOM ensures the waiver remains cost neutral.

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:

Upon a change in the participant's condition, the case manager(s) assesses the person to determine if their health and welfare can continue to be assured through the provision of waiver services in the community. If so, a change request PSS is submitted for review. Each additional service request is thoroughly reviewed by a DOM nurse. If the service is deemed appropriate and does not threaten overall cost neutrality, the DOM nurse will approve the request and will notify the case manager(s) of the approval. If the additional services requested are determined to exceed the average estimated cost, then the request may be denied and the applicant/person will be notified of their right to a State Fair Hearing (Appendix F). The denial must not compromise the overall quality of care for the individual. If it is determined that the denial compromises the quality of care, an approval may be granted by management of DOM thereby overturning the denial. If an increase in services is denied, the person will be informed and notified of their right to request a Fair Hearing.

☒ **Other safeguard(s)**

Specify:

DOM works to ensure the person's needs are met. This process includes examining third-party resources, possible transition to another waiver, or institutional services. Medicaid waiver funds are to be utilized as a payer of last resort.

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	1100
Year 2	1200
Year 3	1200
Year 4	1200
Year 5	1200

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
Priority Admission of Applicants with Emergent Need to Prevent Institutionalization
Transition of Persons from Other Mississippi 1915(c) HCBS Waivers

Purposes
Priority Admission to Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries
Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting

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):*

Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

Purpose *(describe):*

The state reserves capacity within the waiver for the priority admission of applicants meeting the eligibility criteria outlined in Appendix B-1 in combination with one or more of the following criteria that may result in imminent institutionalization:
- Have experienced the death, long-term incapacitation, or loss of their primary live-in caregiver directly affecting the person’s ability to remain in their home within the prior 90 days.
- Referred by the MS Department of Human Services Office of Adult/Child Protective Services following a substantiated incident of abuse, exploitation, abandonment, and/or neglect resulting in an ongoing risk to their health and safety without immediate services and supports through the waiver.
- Diagnosed by a physician with a terminal illness and in jeopardy of entering a non-Hospice institution because their care needs cannot be met with current supportive services.
- Diagnosed by a physician with progressive debilitating disease that has resulted in the need for at least moderate physical assistance with 3 or more activities of daily living (ADLs). Examples may include, but not be limited to, Amyotrophic Lateral Sclerosis (ALS), primary progressive multiple sclerosis (PPMS), Alzheimer's, or Parkinson's.

If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals requesting priority admission.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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 Persons from Other Mississippi 1915(c) HCBS Waivers

Purpose *(describe):*

The state reserves capacity within the waiver for individuals transferring from an alternate MS 1915(c) waiver or aging out of the Disabled Child Living at Home (DCLH) waiver. Individuals must have been enrolled in the original waiver for at least 30 days and be requesting immediate transfer because that waiver can no longer meet their needs. If the original waiver meets their needs and the switch is preference based, the individual does not meet the criteria for reserved capacity.

If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals requesting transfer to an alternate waiver.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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):*

Priority Admission to Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries

Purpose *(describe):*

The state reserves capacity within the waiver for the priority admission of applicants with an acquired traumatic brain injury who are in a crisis/high stress environment with behavioral issues requiring services that if not for the supervision and care provided by this waiver, would require institutional care.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below would be allocated to meet the needs of individuals requesting priority admission.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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 Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting

Purpose *(describe):*

The state reserves capacity within the waiver for individuals transitioning from institutional long term care settings to a home and community-based services (HCBS) setting. Individuals must have resided in the institutional setting for a minimum of thirty (30) days with at least one (1) of those days being covered in full by Mississippi Medicaid.

If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals wishing to transition out of institutional facilities into a Home and Community setting.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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:

Entrance into the Waiver will be on a first come-first served basis for those who meet the criteria outlined in Appendix B. The exception to this first come-first served policy is those individuals who meet the reserved capacity criteria for priority admission. Entry into the Waiver will be offered to individuals based on their date of referral for the Waiver. Individuals who are referred in excess of the waiver capacity within any given year will be placed on a waiting list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ( ) **No**
- (●) **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

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

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

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

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

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

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

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

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

in 42 §CFR 435.726:

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

    Specify percentage:
  - ○ **Other standard included under the state Plan**

    Specify:

- ○ **The following dollar amount**

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

  Specify:

  The 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:

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

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

  Specify:

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

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

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

  Specify:

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

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

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

  Specify:
- **Other**

  Specify:

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

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

Select one:

- **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant,*

not applicable must be selected.

- ○ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- ○ **The following dollar amount:**

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

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

Specify formula:

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

- ○ **Other**

Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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:

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 comprehensive preadmission screening process is conducted by a DOM case manager. Case managers must be a Mississippi licensed social workers (LSW). 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.

Qualified assessors perform the core standardized assessment at the time of evaluation, and enter the person's pertinent data into the eLTSS system. In eLTSS, an automated scoring algorithm is applied to the core standardized assessment data generating a numerical score, the level of care (LOC) score. Case managers do not determine an applicant’s LOC.

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 (LOC) is determined through the application of a comprehensive long term services and supports (LTSS) assessment instrument by qualified assessors. The assessment encompasses activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. The LTSS assessment data is then 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. Persons scoring below the threshold may qualify for a secondary review and a tertiary review by a physician before waiver services are denied. If a person is denied waiver services based on failure to meet the level of care, he/she will be notified of the reason for denial along with information, and assistance if needed, to request and arrange for a State Fair Hearing.

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.

DOM utilizes a comprehensive long term services and supports (LTSS) assessment tool supported by algorithms developed in conjunction with our eLTSS vendor and AIS (InterRAI Home Care) across its LTSS system to determine nursing facility level of care (LOC). For the HCBS populations, the full assessment is utilized to determine LOC and inform care planning. For institutional populations, a subset of those questions is utilized as the pre-admission screening tool for institutional admissions. Crosswalks and validation testing were done to ensure that the algorithms resulted in appropriate scoring mechanisms based on defined level of care requirements.

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:

Initially and at recertification, the core standardized assessment tool is completed by the case manager to ensure the needs of the person are fully captured. This process is a collection of clinical eligibility criteria that is used across all HCBS services. A scoring algorithm is used to establish an eligibility threshold per DOM policy.

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 eLTSS system, a recertification packet is initiated, and the case manager is sent an alert 90 days prior to the expiration of the current certification period. This prompt encourages case manager(s) to begin recertification activities in advance to ensure recertifications and prevent lapses in eligibility. Also, DOM provides the case manager with a monthly Eligibility Report, which includes person's name, the end date of the certification period, and the end date for Medicaid financial eligibility. The report ensures that case managers are aware of any person that is about to lose eligibility or waiver services. The report is reviewed by the case manager(s) and any discrepancies are reported to DOM for resolution.

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 person's original record is maintained at the DOM Central Office. The core standardized assessment along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. DOM is required to maintain the entire document, either electronically or in paper, for the period of time specified under the current federal guidelines.

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, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. N: Number of waiver applicants, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. D: Total number of waiver applicants.

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

Data Aggregation and Analysis:

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

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

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 *(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 = Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

In any instance in which it is discovered that a participant was not evaluated/reevaluated by a qualified assessor in accordance with the procedures outlined in Appendix B of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systemically. DOM will ensure a qualified assessor conducts a comprehensive LTSS assessment within fifteen (15) days of the discovery. If it is identified at that time that the participant does not meet the criteria, the participant will be disenrolled from the waiver and receive notice of their appeal rights in accordance with Appendix F of this waiver. The case manager will be required to explore other community or public funded services that may be available to the individual and assist with any referrals to those resources. Provider cClaims for the period of ineligibility identified will be reviewed and recouped appropriately.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The LTSS assessment process requires the person or their legal representative to sign and attest to their choice of setting and waiver on an Informed Choice form. Long term services and supports options are explained by the case manager(s) prior to enrollment, and the person indicates their choice of waiver services or institutional services by evidence of their selection and signature.

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 person's original record is maintained at the DOM Central Office. The Informed Choice along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. DOM is required to maintain the entire document, either electronically or in paper, for the period of time specified under the current federal guidelines.

Appendix B: Participant Access and Eligibility

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

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

The State subscribes to a language line service that provides interpretation services for incoming calls from the person with limited English proficiency (LEP). The subscribed interpretation service provides access in minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code.

An LEP Policy has been established. All essential staff have 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 the Division of Medicaid and individuals about the types of services and/or benefits available, and about the person's 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		
Other Service	Adult Residential for Care for Acquired Traumatic Brain Injury Participants		
Other Service	Assisted Living		

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:

Adult Residential for Care for Acquired Traumatic Brain Injury Participants

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These are bundled services provided in a residential environment to individuals with an acquired traumatic brain injury in the need of long term care services to avoid institutionalization. Services may include personal assistance or supervision for a period of twenty-four (24) hours continuously per day in a residential and community setting. This environment provides for a range of choices through personal preference, self- determination and dignity with full consideration of identified risks. Services provide for an environment of peer support that is conducive to enhancing the functional abilities of the individual with a brain injury. The physical environment must be conducive to enhancing the functional abilities of the waiver participant.

Waiver participants in the Assisted Living waiver who are receiving services in the TBI-residential care facilities are eligible for Medicaid coverage of physical therapy, occupational services, speech therapy and behavioral services provided as part of the bundle of services included in a comprehensive rate. They will not be eligible for Medicaid coverage for physical therapy, occupational services and behavioral services outside of the waiver. Necessary therapeutic services must be available as needed. These services include, but are not limited to, social work, behavioral services, speech therapy, physical therapy, occupational therapy, vocational services, cognitive activities, medication oversight or administration, transportation escort service, essential shopping, housekeeping service, laundry service, dining service and therapeutic recreational services. All therapeutic providers must be licensed by the appropriate state and national boards. When provided to the participant, the above services are included in the comprehensive rate paid to the provider and the Medicaid agency will not be billed separately. The provider agrees not to bill the waiver participant or their responsible party beyond what Medicaid has agreed to pay.

Nursing or skilled services are incidental, rather than an integral, to the provision of these services. A nurse must be available minimally eight (8) hours per day, and must practice in accordance with the applicable nurse practice law and in accordance with acceptable standards of practice.

Escort service is defined as providing assistance accompanying, or physically assisting, a waiver participant who is unable to travel or wait alone for medical appointments.

An Acquired Traumatic Brain Injury means an insult to the brain, not of a degenerative or congenital nature, that may produce a diminished or altered state of consciousness, which results in an impairment of cognition abilities or physical functioning. It can also result in the disturbance of behaviors or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functioning disability, or psychosocial maladjustment.

Providers must provide:
1) A private living quarter with bath consisting of a toilet and sink,
2) Normal daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial paper, tissue, laundry soap and dental hygiene products at no additional cost to the participant.

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

Therapy services must not be duplicative of available state plan therapy benefits.

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	MS Medicaid Enrolled AL Waiver TBI Residential Assisted Living Facility Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential for Care for Acquired Traumatic Brain Injury Participants

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled AL Waiver TBI Residential Assisted Living Facility Providers

Provider Qualifications

License *(specify):*

Providers must maintain a current and active Mississippi license to function as a Personal Care Home – Assisted Living Facility (PCH-AL).

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements are detailed in Part 208 of the code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider is responsible for verifying the qualifications are met for all facility staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

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:

Assisted Living

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assisted Living services include personal care services, chore services, attendant care, medication oversight and administration (to the extent permitted under State Law), therapeutic, social and recreational programming, in an environment that is home like and provides the participant full access to the typical facilities in a home while providing for privacy and easy access to resources and unscheduled activities in the community. The setting allows for participants to have visitors at times of preference and convenience to them. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Nursing and skilled therapy services (except periodic nursing evaluations, if specified above) are incidental, rather than integral, to the provision of assisted living services. Payment will not be made for 24-hour skilled nursing care or supervision. The Division of Medicaid will neither reimburse the waiver participant, nor the care facility, for the cost of room and board.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. At no time should more than two (2) participants occupy a single unit. The participant has a right to privacy. Living units must have lockable doors with appropriate staff having keys. (This requirement does not apply where it conflicts with fire code). Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) which may also serve as living or dining rooms.

The waiver participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.

Attendant Call Systems are functionally operating emergency response systems required to be available for each participant. The attendant call system must enable the participant to summon emergency help from an assisted living attendant via a wearable electronic device (e.g., a medallion or a bracelet) or call buttons located in each living area (i.e. restroom, living room, and bedroom). Additionally, the facility must have a security protocol in place which alerts an attendant if a participant wanders from the facility.

Providers must provide:
1) Normal daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial paper, tissue, laundry soap and dental hygiene products at no additional cost to the participant.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled AL Waiver Assisted Living Facility Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled AL Waiver Assisted Living Facility Providers

Provider Qualifications

License *(specify):*

Providers must maintain a current and active Mississippi license to function as a Personal Care Home – Assisted Living Facility (PCH-AL).

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements are detailed in Part 208 of the code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider is responsible for verifying the qualifications are met for all facility staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

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:

Licensed social workers (LSWs) employed by the Division of Medicaid are responsible for case management functions.

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):

A national criminal background check with fingerprints must be conducted on all individuals providing case management, assisted living, or adult residential care for acquired traumatic brain injury participants in accordance with Title 23 of the Mississippi Administrative Code. Waiver specific provider compliance requirements are detailed in Part 208 of the code. Compliance with mandatory background check requirements is ensured through post payment audit activities as outlined in Appendix I of this 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):

Screenings of the Mississippi Nurse Aide Registry and the Office of Inspector General’s Exclusion Database must be conducted on all individuals providing ccase management, assisted living, or adult residential care for acquired traumatic brain injury participants in accordance with Title 23 of the Mississippi Administrative Code. Waiver specific provider compliance requirements are detailed in Part 208 of the code. Compliance with mandatory screening requirements is ensured through post payment audit activities as outlined in Appendix I of this waiver.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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:

When a participant selects a provider facility 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 family is not normally considered a caregiver nor are they legally responsible for the participant. A person's spouse, a guardian/conservator, the executor of a person's estate and/or an individual with durable/medical power of attorney for the person are considered legally responsible for the person.

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:

All willing and qualified providers of Medicaid services may apply to the state to become a Medicaid provider. Medicaid providers agree to abide by Medicaid policy, procedure, rules and guidance.

Provider enrollment information along with the credentialing requirements for each provider type and timeframes are available via the DOM website.

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:
PM1: # and % of providers by provider type who met, and continue to meet, required credential standards in accordance with waiver qualifications throughout service provision. N: # 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 reviewed by provider type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial and Performance Audit

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

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.

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 2: Number and percent of enrolled provider staff, trained in accordance with state requirements and the approved waiver. N: Number of of enrolled providers staff, trained in accordance with state requirements and the approved waiver. D: Total number of enrolled providers staff reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial and Performance Audit

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Statistically Valid Sample Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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: Every 24 months

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.

DOM requires verification of credentials/qualifications for all providers prior to enrollment in accordance with Part 200 of the Medicaid Administrative Code. If an approved provider has failed to maintain required credentials and/or is deemed non-compliant with qualifications, DOM will hold a quality improvement strategy meeting within thirty (30) days to examine if any changes need to be implemented systemically. DOM will further investigate and notify providers of findings of non-compliance along with any remediation requirements, which may include the submission of a written corrective action plan (CAP) for DOM review and approval.

If it is identified that a staff member at a provider facility does not meet the qualifications or training requirements outlined in Part 208 of the Medicaid Administrative Code, the provider will be notified of the finding and required to submit a CAP.

In instances in which a CAP is required, the provider will have thirty (30) days to submit the written corrective action plan detailing the actions that will be taken to ensure immediate and ongoing compliance with requirements. Once DOM approves the submitted corrective action plan, the provider will have a defined timeframe to implement the plan fully. DOM will follow up to determine the effectiveness of remediation actions. If a provider does not submit an approved CAP or fails to implement the approved CAP, DOM may suspend and/or terminate the Medicaid provider number. Upon any discovery that a provider or their staff no longer meets qualifications, affected participants will be offered the opportunity to choose an alternate qualified 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**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Assisted Living Waiver services are provided in a non-residential setting which must meet the requirements of the HCB settings. Part 208, Chapter 3 of the Medicaid Administrative Code requires enrolled AL waiver providers to ensure settings are fully integrated with opportunities for full access to the greater community and meet the requirements of the Home and Community-Based (HCB) settings. It further defines that the Division of Medicaid does not cover AL waiver services to persons in 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). All AL provider requirements are in compliance with and support 42 CFR § 441.301(c)(4)(iii) Final Rule and the state continues to comply with our approved Statewide Transition Plan. Compliance with the Final Rule is monitored through quality interviews with participants and post-payment audits outlined in Appendix I of this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☒ **Social Worker**
Specify qualifications:

Licensed social workers employed by the Division of Medicaid.
Qualifications for the social worker include:
1) Maintain an active, unencumbered and current license to practice social work in Mississippi
2) A bachelor's degree in social work from an accredited university and,
3) Two (2) years of full time experience in direct services to aged and disabled clients.
4) Be certified as a qualified assessor for the comprehensive long term services and supports tool.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

After the applicant understands the criteria for the waiver, has made an Informed Choice, and meets clinical eligibility, as determined by the LTSS assessment process, the person-centered planning is initiated. The case manager engages the person, caregivers and other interested parties, as requested by the person, in the development of the Plan of Services and Supports (PSS). The PSS development includes discussing options, desires, individual strengths, personal goals, emergency preparedness needs, specific needs of the person, and how those needs can be best met. The meeting is held at a time and location of the person's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The LTSS assessment and the PSS development process is driven by the person with their informed consent and is conducted by the case manager(s). The person may freely choose to allow anyone (friends, family, caregivers, etc.) to be present and/or contribute to the process of developing the PSS. The initial PSS is developed at the time of the completion of the LTSS core standardized assessment with the case manager(s).

Persons found clinically eligible for long term services and supports are provided information about available services and supports. The person is given a description and explanation of the services provided by the waiver along with any specific qualifications that apply to each service. The applicant is then allowed to make an informed choice between institutional care and community-based services and among waiver services and providers.
The LTSS assessment includes information about the person's health status, needs, preferences and goals. The development of the PSS utilizes this information and addresses all service options, desires, personal goals, emergency preparedness needs, other specific needs of the person and how those needs can be met. The PSS also reflects and identifies the existing services and supports, along with who provides them.

DOM is responsible for implementing and monitoring the PSS. The case manager is responsible for coordination of waiver services, in addition to facilitating referrals to State Plan services and services provided through other funding sources/service agencies as needed.

The PSS is developed at the time of the completion of the LTSS assessment, reviewed quarterly and updated annually or at the request of the person. The PSS is signed by all of the individuals who participated in its development. Each person and/or their designee is given a copy of the PSS along with other people involved in the plan. Also, each person is given the phone number for the case manager and their supervisor, should they have any questions or concerns regarding their services. The PSS may be updated to meet the needs of the individual at the request of the person or if changes in the person's circumstances and needs are identified.

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.

The presence and effect of risk factors are determined during the LTSS assessment and PSS process. The assessment is specifically designed to assess and document risks an individual may possess. The PSS includes identified potential risk to the person's health and welfare. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. Risk factors include documented instances of abuse/neglect/exploitation, socially inappropriate behavior, communication deficits, nutrition concerns, environmental security and safety issues, falls, disorientation, emotional/mental functioning deficits, and lack of informal support. The person's involvement and choice are used to develop mitigation strategies for all identified risk. The person, along with caregivers/supports, is included in developing strategies and are encouraged to comply with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the case manager. Monthly and quarterly actions are required to review/assess the person's service needs, with a new PSS developed every twelve months.

Back up plans are developed by the case manager(s) in partnership with the person and their family/caregiver upon admission. The PSS must include back up providers chosen by the participant who will provide services when the assigned provider is unable to provide care. The person and/or their caregiver identify family members and/or friends who are able to provide services/support in the event of an emergency. During a community disaster or emergency, the case manager notifies the case manager supervisor, who then notifies the local first response team (i.e. the Mississippi State Department of Health) of persons with special needs who may require special attention.

The development of the PSS also includes developing an emergency preparedness plan (EPP) for all persons. The EPP includes emergency contact information as well as outlining the individual's evacuation plan/needs in case of a fire or natural disaster.

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 one 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. The selected provider is documented on the PSS which is then signed by the person or caregiver acknowledging their free choice of provider.

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 person understands the criteria for the waiver, has made an informed choice, and meets clinical eligibility, the LTSS assessment along with the PSS are submitted to the DOM electronically which includes all of the service needs, personal goals and preferences of the person. A registered nurse at DOM will review the LTSS assessment and the PSS, and notify case manager(s) in a timely manner of the approval/disapproval of services requested.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

and update of the service plan:

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PSS is the fundamental tool by which the State ensures the health and welfare of waiver persons enrolled in the 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 manager(s) along with the person and others as requested by the person are jointly responsible for the development of the PSS.

Quarterly 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. Additional monthly contacts, either face-to-face or by phone/video, 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, DOM 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:*

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 persons whose PSS was 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM 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:
Financial and Performance Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Statistically Valid Sample Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: Every 24 hours

c. ***Sub-assurance: Service plans are updated/revised 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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 reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. N. Number of persons reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. D. Total number of persons reviewed who reported receiving services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA Home Visits/Telephone Interviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: 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 providers. N: Number of persons reviewed with documented presentation of available service options and freedom of choice providers. D: Total number of PSSs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Compliance & Financial 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 = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

In any instance in which it is discovered that the person-centered service plan was not developed, reviewed/updated, or implemented in accordance with the procedures outlined in Appendix D of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. In these instances, DOM will implement a corrective action plan (CAP) and conduct necessary follow up to determine the effectiveness of remediation actions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

With DOM approval, a person may 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.

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. Applicant is informed of Fair Hearing process during entrance to waiver by the Case Manager.

A case manager sends a Notice of Action (NOA) to the person by certified mail (signature return requested) on any adverse action related to choice of provider or service; or denial, reduction, suspension or termination of service. Fair Hearing Notices are maintained in person’s file at the DOM Central Office.

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 participant has the right to file an appeal;
d. Procedures for filing an appeal;
e. Notification of participant’s right to request a Fair Hearing;
f. Notice that the participant 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 manager or other 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, DOM 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. Case management staff will notify person if services will remain in place during the appeal process. 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 manager(s) 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 are encouraged to report disputes to their case manager(s). However, dispute resolution can start at any level in the process. If a resolution is not reached by the person and the case manager within seventy-two (72) hours of the initial report by the person, the case manager(s) reports the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. In the event the dispute is with the case manager(s) then the case management agency and DOM work with the person to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the person's satisfaction with the new case management staff within the following month and documents the final resolution. DOM is responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by the case manager 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 is 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 manager(s), but may address any complaint/grievance to DOM at any time. The case manager(s) begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case manager(s) reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. In the event the complaint/grievance is with the case manager, then DOM will work with the participant to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the participant's satisfaction with the new case management staff within the following month and documents 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 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).

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.

Complaints of abuse, neglect or exploitation of a participant such as in an Assisted Living Waiver provider are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community-based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of assisted living waiver providers.

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.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:
(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any care facility that complies in good faith with the requirements of this section to report the abuse or exploitation of a waiver participant in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both

such fine and imprisonment.
(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all.

The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.

The Attorney General's (AG) office is legislatively mandated to investigate and enforce the law regarding alleged abuse, neglect and exploitation in licensed health care facilities. Specific enforcement guidelines are depicted in the Mississippi Vulnerable Persons Act of 1986, §43-47-1 of the Mississippi Code of 1972, as amended. The AGs office receives allegations both electronically and orally via a toll free long distance number. Once allegations are received, the chief investigator reviews each complaint to determine if the allegation falls within their jurisdiction or purview to investigate. The facility has seventy-two (72) hours to provide the Mississippi Attorney General's (MFCU) and the Mississippi State Department of Health with a written report regarding their investigation of the alleged incident. Once the review is completed the allegation is assigned to an investigator according to its scope and severity of the issue. The Chief Investigator or the Investigator assigned to the case will follow up with the facility to ensure that the facility has provided the Mississippi Attorney General's Office (MFCU) with the written report. The investigator assigned to the case has 72 hours to contact the provider or individual reporting the alleged incident which prompts a written report of facility findings. Investigations consist of a variety of information gathering techniques including, but not limited to, interviewing, observation, medical record review, and record analysis. At the request of the DOM, the Mississippi Attorney General's Office (Medicaid Fraud and Control Unit) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation.

DOM and the AG's office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.

The Mississippi Department of Health has a complaint hotline that allows for individuals to file complaints against assisted living facilities. An individual staffs this telephonic hotline Monday - Friday during normal business hours, an answering machine is activated for coverage allowing complainants to record their concerns/complaint, thus triggering follow up or a call back from the hotline coordinator with a target response of twenty-four (24) hours. This hotline allows facilities to self-report critical incidents and or complaints of alleged abuse, neglect and exploitation.

Critical incidents and complaints are triaged via an intake triage committee which consists of a nurse and representatives for long term care and other staff members. Based on the scope and severity of the allegations, the complaint will be scheduled accordingly. There are seven action levels of triage as follows:
a) Immediate Jeopardy (Investigations begin within two [2] working days of the notification)
b) Non-Immediate Jeopardy (Investigations begin within ten [10] working days of the notification)
c) High, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification)
d) Medium, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification)
e) Low, Administrative Review/Off Site Investigation (Investigations begin within forty-five [45] working days of the notification)
f) Referral
g) No Action Necessary

Assisted Living facilities are required to report incidents of alleged abuse, neglect or exploitation orally or telephonically within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays and in writing within seventy-two (72) hours of discovery. If the facility fails to report in accordance with this regulation, the investigator will investigate for potential noncompliance with this regulatory requirement.

Incidents are evaluated to determine the degree of harm to the waiver participant, the thoroughness of the facility to investigate the circumstances related to the event, the facilities implemented corrective action and the effectiveness of the corrective actions. If the investigator determines the facility has not taken appropriate action and a serious situation is

ongoing, an investigation will occur.

Investigations are conducted by making an onsite visit, record review (charts, policies, procedures, minutes, etc.), interviews with staff, family, waiver participants, and personal observations. Within 10 days of exiting the facility, the investigator must provide a written report to the facility that includes the investigative findings. These findings are presented as a legal document with a cover letter. When negative findings are cited, the facility must submit an acceptable plan of correction. Once the facility has had a chance to implement changes necessary to rectify the negative findings, the investigator will return to the facility to determine if the facility is back in compliance.

The Mississippi State Department of Health works closely with the Division of Medicaid to assure the process of protecting the health and welfare of our waiver participants is maintained. Each agency shares information freely regarding critical incidents including the types of complaints, investigations and outcomes. This free flow of communication allows the state to develop a system in which all allegations are tracked as well as allows the DOM to determine if trends exist. Working collaboratively, the two agencies address ways to improve detection and prevent abuse, neglect and exploitation of our waiver participants.

The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.

When participants are initially assessed for the Assisted Living Waiver program, they are informed of the contact information of the case manager. The CM maintains monthly contact with each participant and/or responsible party by telephone or visit to the Assisted Living facility. Face-to-face visits are made to the participant at their residence in the Assisted Living waiver provider or other home and community-based setting on a quarterly basis. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or responsible party has notified the CM of their concern, a visit to the facility is made as soon as can be arranged. The purpose of the visit to the facility is to assess the participant and the environment, document an account of the occurrences and notify the proper authorities. The CM determines if the environment is free of harm or perceived threat for the waiver participant.

The facility must develop and maintain policies and procedures to guide staff in the early detection and prevention of abuse, neglect and exploitation. These policies and procedures must be implemented to assure the safety and welfare of the waiver participants. When an allegation of abuse has occurred, the facility must provide evidence that the safety and welfare of all waiver participants is protected by removal of the accused perpetrator from the facility until such time that a thorough investigation has been completed.

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.

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff. Upon initial entry into the waiver, case manager(s) 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. At that time, they are provided the names and phone numbers of their case manager(s). The person is contacted by the case manager(s) on a monthly basis (by phone or face-to face visit). 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 by phone, a face-to-face visit is conducted. The purpose of this visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM is notified of any suspected abuse, neglect, exploitation cases as they occur, and is available to provider support in ensuring a prompt resolution, if feasible.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.

Complaints of abuse, neglect or exploitation of a participant such as in an assisted living facility are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community-based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of Assisted Living waiver providers.

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.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:
(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any Assisted Living provider that complies in good faith with the requirements of this section to report the abuse or exploitation of a patient or resident in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five

Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both such fine and imprisonment.
(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all

The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.

For allegations deemed potentially immediate jeopardy situations, an Investigation will be initiated with two (2) working days of receipt of the complaint. The purpose of the onsite visit is to assure that all participants who could be affected by the reported situation are adequately protected from harm and to verify the provider's ability to correct the circumstances creating the immediate jeopardy.
For allegations that are considered non-immediate jeopardy- high risk, an investigation will be initiated within ten (10) working days of receipt of the complaint.
For allegations that are considered non-immediate jeopardy –medium risk, an investigation will be initiated within forty-five (45) working days of the receipt of the complaint.
For allegations that are considered Non-Immediate jeopardy—low risks, an onsite investigation may not be scheduled, but the allegation will be reviewed at the next onsite visit.

The assigned complaint investigator will contact the participant during the course of the on-site investigation to advise them that the investigation is in progress and to validate details of the reported allegation. Following completion of the investigation and the processing of required documents, the participant will be notified. Timeframes of notification vary depending on the amount of time it takes to complete an investigation but notification occurs once the investigation is completed

The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.

When an allegation of abuse, neglect or exploitation occurs, the Assisted Living waiver provider staff is required to report to the Department of Health and the Attorney General's office.

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.

DOM has procedures in place to assure that all Assisted Living waiver providers, waiver participants and care givers are trained in the reporting of critical incidents. A database is maintained by DOM to collect, record, and trend critical events. This information is used to identify opportunities for improvement involving early detection and prevention.

The Mississippi Attorney General's office, Mississippi Department of Health and the Department of Human Services work with the Mississippi Division of Medicaid to communicate information and oversight activities of critical events and incidents. Each agency provides a free flow of information to the Division of Medicaid including the specific names of individuals involved in reported incidents, the status of investigations along with outcomes. Each agency works with the Division of Medicaid to identify strategies to reduce the occurrence of critical events.

The Mississippi Department of Human Services entered into an interagency agreement allowing the sharing of critical incident information that includes types of incidents reported, participant characteristics, providers, how quickly reports are reviewed and investigated, follow up, results of investigations and whether waiver participants are informed of the investigative results.

The case managers and the case manager supervisor(s) work closely with the investigators from the Mississippi Attorney General's office to follow up on reports of abuse, neglect or exploitation. The Mississippi Attorney General's Office (MFCU) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation. DOM and the AGs office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation
for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.

The Mississippi Department of Health has an interagency agreement with the Division of Medicaid which allows for free flow of information regarding all allegations and their findings. Their investigation results include a review of the facilities over all compliance with the overall licensure regulations as related to the occurrence of critical incidents. DOM's oversight of the incident management system occurs on an ongoing and continuous basis. When investigations are in progress, DOM is notified and assists as requested and there is free flow of communication between agencies.

Information compiled from the oversight agencies allows the DOM to analyze the incidents to determine trends/patterns to assist in the development of strategies to reduce future occurrences of critical incident events. An excellent example of how information is used from analyzing critical incident reports resulted in the Division of Medicaid identifying the need for additional training for care staff related to dealing with difficult residents and resident rights. The review determined that confirmed abuse occurred in a facility and that staff were not fully trained and competent to deal with residents with acting our behavior. The facility had to provide an acceptable corrective action plan to resolve the issues.

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 during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that restraints are not used for waiver participants. The case manager(s) 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 prohibits the use of restrictive interventions during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The case manager(s) 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 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 prohibits the use of seclusion during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that seclusion is not used for waiver participants. The case manager(s) 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 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.

The Licensing agency of the Assisted Living provider is responsible for oversight of medication management and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for participants in this waiver is vested in a licensed physician. Each Assisted Living provider must employ appropriately trained or professionally qualified staff to administer medications if an individual requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to service recipients have daily and ongoing responsibility for medication monitoring to ensure that medications are correctly administered, and that medication administration is appropriately documented in accordance with DOM requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DOM on-site compliance reviews.

First line responsibility for monitoring an individual's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Assisted Living setting. Staff monitoring focuses on areas identified by the physician and/or pharmacist which may be of concern. Each waiver provider must have policies and procedures that identify the frequency of monitoring. Individuals have a choice of physicians and pharmacies but are encouraged to be consistent in their use of these professionals in order to ensure continuity of care and to prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated with another medication prescribed.

Additionally, the Division of Medicaid makes available a provider portal called Provider Access so that prescribing physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries.

All participants' medications must be stored in a secure area and not accessible to anyone other than whom the medication is prescribed. A refrigerator must be provided for storage of medications requiring refrigeration.

A non-resident employee, appointed by the operator of the facility, must be responsible for the following:
1. Storage of medication
2. Maintenance of a current prescription medication list, the including frequency and dosage of medications and known allergies, which shall be updated at least every 30 days or when there is a change in the medication. Managing this medication list is used to guard against medication errors.
3. Disposal of outdated or other unused medications in accordance with the regulations of the Mississippi Board of Pharmacy.

Scheduled drugs may only be allowed in an Assisted Living provider if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.

The Assisted Living provider must keep accurate records to demonstrate that waiver participants have adequate amounts of medication on hand and that necessary oversight is provided for medication administration. The nurse must review the medication list for each participant to assure that waiver participants are neither over nor inappropriately medicated.

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.

Mississippi State Department of Health Licensure and Certification is responsible for follow up and oversight.

The Mississippi State Department of Health conducts annual onsite visits reviewing the overall operation of the facilities to assure compliance to regulatory requirements. This agency visits more frequently in the event of a complaint or report of a negative finding. The agency communicates information and findings regularly to the Department of Medicaid after the annual visits and after any complaint investigation. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies.

Waiver case managers provide monthly contacts, either by phone or face-to-face, with the waiver participant to assure services are being provided in accordance with the plan of care. Face-to-face visits are made quarterly. During these visits, the State gathers information concerning potentially harmful practices and uses the information to develop quality improvement measures to address the issue.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

HCBS/Assisted Living Waiver administrative code states that Assisted Living Services may include Medication Oversight/Medication administration (to the extent permitted under State Law).

Medication administration is limited to the decisions, made by someone other than the person for whom the medication has been prescribed, regarding (1) which medication is to be taken, (2) the dosage of the medication, or (3) the time at which the medication is to be taken.

Medication Assistance is any form of delivering medication which has been prescribed which is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing.

Nursing activities must comply with Mississippi Board of Nursing Administrative Code, Part 2830, Chapter 1, Section 1.3 Supervision and Delegation, Part 2830.

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:

Mississippi State Department of Health Licensure and Certification.

Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

(b) Specify the types of medication errors that providers are required to *record:*

All avoidable, serious or life-threatening errors shall be reported by telephone to Mississippi State Department of Health Licensure and Certification Branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

(c) Specify the types of medication errors that providers must *report* to the state:

All avoidable, serious or life threatening errors shall be reported to Mississippi State Department of Health Licensure and Certification branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

○ **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.

Mississippi Department of Health Licensure and Certification branch of the licensing agency is the state agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Monitoring is performed according to the Minimum Standards for Personal Care Homes Assisted Living. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.

The agency communicates information and findings regularly to the Division of Medicaid after the annual visit which includes an evaluation of medication administration. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event the facility is out of compliance at the annual survey or in the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies.

The Division of Medicaid conducts annual onsite compliance audit of waiver providers as part of the oversight responsibility. The findings from this compliance audit along with reports from the Department of Health are evaluated to determine if negative findings are such that remediation is required. Data collected during annual visit by the Department of Health and the Division of Medicaid is analyzed to identify evidence of trends and patterns which require a need for policy, procedure and systems changes.

Data are collected during the annual visits by the Department of Health and Division of Medicaid. Additionally, case managers acquire data during the monthly, quarterly and annual visits regarding medication errors. All of this data collectively is reviewed to determine the occurrence of trends and patters or the possibility of isolated incidents. After the data is analyzed, the information is synthesized to determine is improvement strategies need to be implemented across this waiver as well as the possibility of a more global approach across all of the State waivers.

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 instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
PM 1: Number and percent of all critical incidents that were reported or remediated in accordance with waiver policy. N: Number of all critical incidents that were

reported or remediated in accordance with waiver policy. 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM 2: Number and percent of 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 3: Number and percent of 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):
Other
If 'Other' is selected, specify:

LTC QA Reviews

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 = Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

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 as approved in the waiver. N: Number of complaints that were addressed/resolved as approved in the waiver. D: Total number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:

PM 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 reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

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

Data Aggregation and Analysis:

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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.

In any instance in which it is discovered that t the critical incident management or complaint system systems or the participant safeguard monitoring processes are not implemented in accordance with the procedures outlined in Appendix G of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. In these instances, DOM will implement a corrective action plan (CAP) and conduct necessary follow up to determine the effectiveness of remediation actions.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed, to develop system change requests, review progress, and test system changes. The meetings involve participation from the DOM Offices of Information Technology (iTech) and Long Term Services and Supports (LTSS), along with any other stakeholders deemed appropriate depending on the issue for discussion. Meetings with LTSS staff including QA nurses are held routinely for the purpose of addressing needs and resolving issues that may involve systems changes.

When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to participants or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff to address issues that require system changes. Additionally, the State has monthly internal Advisory meetings to identify, correct, and implement system changes to improve the State's ability to adhere to state and federal regulations, policies and procedures. System changes have been implemented to allow for electronically capturing data and identifying trends related to the performance measures. Findings are discussed during collaborative Quality Improvement Strategy meetings with the operating agency and DOM. Reporting information from the eLTSS case management system is also utilized in quality improvement strategies as a source of reporting data for multiple quality measures.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Ongoing and as needed

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Division of Medicaid (DOM) monitors the quality improvement strategy on a monthly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of the sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the quality improvement strategy is necessary, DOM makes necessary changes to meet waiver reporting requirements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Evaluation of the quality improvement strategy is a continuous and ongoing endeavor. It is reviewed annually to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible. The operating agency and DOM will meet quarterly to review the overall waiver operation including the QIS strategy for waiver improvement.

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).*

Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis. DOM, therefore, does not require an independent audit of waiver service providers.

The Mississippi Office of the State Auditor is responsible for annual audits in compliance with the provisions of the Single Audit Act.

Claims for all waiver services are submitted to the Division's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits before payment.

The Mississippi Division of Medicaid operates three audit units within the Office of Compliance to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud or abuse reported or identified. They also review payment records of Medicaid providers continually and on an ongoing basis. The Office of Financial and Performance Audit conducts routine monitoring of cost reports and contracts with other agencies as well as waiver provider specific audits. The Office of Compliance audits coordinated care organizations, state agencies, and other entities as necessary to ensure program compliance.

In all audit units, staff set audit priorities each year based upon established criteria. Random sampling is done using a stratified random sample method based on statistically valid methodology. Any estimate of overpayment within Program Integrity is made utilizing a simple extrapolation with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.

Post-payment audits of all waiver services can be conducted through a medical record request desk audit or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation. Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):
• No further action – No issues uncovered warranting further action.
• Provider education – No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.
• Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with DOM guidelines. Providers are allowed thirty (30) days to submit the requested information.
• Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. DOM staff, including clinical staff if appropriate, are included in on-site reviews and assist with conducting interviews.
• Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation to determine the appropriate next steps, if any.

Audit reports/management letters provide detailed information on identified deficiencies, including but not limited to, accuracy-related issues, missing documentation, internal control deficiencies, and training issues and are presented to the provider at the end of the audit. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider administrators and appropriate staff at DOM and the operating agency.

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 coded and paid correctly 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 =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 2: Number and percent of waiver service claims reviewed that were submitted for services within the 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:
Financial and Performance Audit

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

Data Aggregation and Analysis:

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

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:* *Every 24 months*

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 =*

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

Data Aggregation and Analysis:

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

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.*

In any instance in which it is discovered that financial accountability activities are not implemented in accordance with the policies/procedures outlined in Appendix I of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions. DOM will report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery and recoup money paid erroneously to providers.

ii. Remediation Data Aggregation

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

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

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology outlined below in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. Once the comprehensive studies are completed, DOM will submit waiver amendments to further update rates/methodologies where appropriate.

To set the context for developing waiver service rates, the service descriptions for each service were carefully considered. Costs analysis surveys were sent to various assisted Living providers to obtain a realistic view of actual costs and expenditures for a baseline of comparison of rates. Additionally, a review of each provider service rates was performed for comparison. For the Assisted Living waiver rate development, the following items were considered:

> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hours practitioners are at work
> Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, 2018 provider surveys, and DOM and Milliman experience. Once the initial service rates were calculated, a comparison was made to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. 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.

The rate for Adult Residential was negotiated with qualified providers who meet the necessary criteria.

Once service rates were calculated, a comparison was made of them to the current service rates along with consideration for other aspects of the service provision environment. DOM solicited public comments on the rates through stakeholder meetings, public notices, and notification to the tribal government.

Information about payment rates is made available to waiver participants via the DOM website and rates are also included in person-centered Plans of Services and Supports. Additionally, rate determination methods outlined in this appendix were posted for public input with the renewal application as outlined in Main, Section 6-I of this application.

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:*

Billings for all waiver services flow directly from providers to the State's claims payment system (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Billing validation is accomplished primarily by the Division's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. DOM may subsequently validate billings post-payment in accordance with the audit strategy outlined in I-2-a. Recovery action is undertaken by the Division for any identified overpayments and the federal share of identified overpayments is returned to the Federal Government.

The Mississippi Eligibility Determination System (MEDS) is a unified system for data collection and eligibility determinations. Electronic files from MEDS are loaded daily into the MMIS in order to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the member is eligible for Medicaid services. Subsequent MMIS edits verify that the member has a valid waiver specific lock-in span that is entered on the member's MMIS record upon approval and recertification. Claims submitted for members who are not eligible on the date of service are denied.

All waiver services included in the participant's service plan must be prior approved by DOM. Approved Plans of Services and Supports (PSSs) are electronically tracked in the DOM electronic Long Term Services and Supports System (eLTSS).

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***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.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:*

This waiver is for participants residing in residential, home and community based care facilities. The Assisted Living waiver services rendered in this waiver do not include coverage for room and board. Waiver participant records, to demonstrate the facility is not charging for room and board, are required to be maintained within Assisted living waiver providers and are available to representatives of the Medicaid agency at all times. Such records include admission agreements which must contain provisions specifically setting forth services and accommodations to be provided by the Assisted Living provider. The admission agreements must include the following items:
1) Basic charges agreed upon, separating costs for room and board and personal care services
2) Period of time to be covered in charges
3) List of itemized charges,
4) Agreement regarding refunds for payments.

Participant admission agreements are subject to review to ensure that no Medicaid payment is made for room and board charges.

The costs for room and board may not fluctuate based on the amount of Medicaid reimbursement each month. Admission agreements must be reviewed and approved by the Division of Medicaid prior to admission into the waiver and subsequently every time there is a change or update to the agreement. Regardless of any agreement between the participant or the participant's family or guardian, the provider must not charge for services over and above what Medicaid has agreed to pay.

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	14026.00	7377.26	21403.26	44221.24	6859.85	51081.09	29677.83
2	14049.06	7583.82	21632.88	45459.43	7051.93	52511.36	30878.48
3	14049.06	7796.17	21845.23	46732.30	7249.38	53981.68	32136.45
4	14049.06	8014.46	22063.52	48040.80	7452.36	55493.16	33429.64
5	14049.06	8238.86	22287.92	49385.94	7661.03	57046.97	34759.05

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	*1100*	1100
Year 2	*1200*	1200

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 3	*1200*	*1200*
Year 4	*1200*	*1200*
Year 5	*1200*	*1200*

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.*

Based on the FY2022 CMS 372 Report data, the average length of stay for this waiver is 240 days. Based on this information, it is estimated that average length of stay for waiver participants during the course of the waiver renewal period is approximately 8 months.

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 waiver were based upon the sum of the current unduplicated count and the estimated need for Year 1. The estimates for number of users, average units per user, and average cost per unit are based on the SFY 2022 CMS 372 report data. The numbers were then projected as stable for each waiver year.

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 2022 CMS 372 report data and is trended forward to FY2024 using a 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q3 2023. The estimate was applied for year one and every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

Factor G' is projected higher than Factor D' as utilization of some state plan services including hospital benefits and therapy codes may be higher for members in nursing facility settings who have more chronic health conditions that cannot be managed at home on the waiver.

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 FY2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The specific nursing home expenditures analyzed were actual paid claims per Medicaid beneficiaries with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

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 2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

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 Residential for Care for Acquired Traumatic Brain Injury Participants	
Assisted Living	

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						***917983.36***
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	*per day*	*8*	*236.00*	*486.22*	***917983.36***	
Assisted Living Total:						***14510616.12***

GRAND TOTAL:	***15428599.48***
Total Estimated Unduplicated Participants:	***1100***
Factor D (Divide total by number of participants):	***14026.00***
Average Length of Stay on the Waiver:	*240*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living	per day	1092	201.00	66.11	14510616.12	
			GRAND TOTAL:			15428599.48
			Total Estimated Unduplicated Participants:			1100
			Factor D (Divide total by number of participants):			14026.00
			Average Length of Stay on the Waiver:			240

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						1032731.28
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	9	236.00	486.22	1032731.28	
Assisted Living Total:						15826139.01
Assisted Living	per day	1191	201.00	66.11	15826139.01	
			GRAND TOTAL:			16858870.29
			Total Estimated Unduplicated Participants:			1200
			Factor D (Divide total by number of participants):			14049.06
			Average Length of Stay on the Waiver:			240

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**1032731.28**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	9	236.00	486.22	**1032731.28**	
Assisted Living Total:						**15826139.01**
Assisted Living	per day	1191	201.00	66.11	**15826139.01**	
				GRAND TOTAL:		**16858870.29**
				Total Estimated Unduplicated Participants:		**1200**
				Factor D (Divide total by number of participants):		**14049.06**
				Average Length of Stay on the Waiver:		240

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**1032731.28**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	9	236.00	486.22	**1032731.28**	
Assisted Living Total:						**15826139.01**
Assisted Living	per day	1191	201.00	66.11	**15826139.01**	
				GRAND TOTAL:		**16858870.29**
				Total Estimated Unduplicated Participants:		**1200**
				Factor D (Divide total by number of participants):		**14049.06**
				Average Length of Stay on the Waiver:		240

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						***1032731.28***
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	*per day*	*9*	*236.00*	*486.22*	***1032731.28***	
Assisted Living Total:						***15826139.01***
Assisted Living	*per day*	*1191*	*201.00*	*66.11*	***15826139.01***	

GRAND TOTAL:	***16858870.29***
Total Estimated Unduplicated Participants:	***1200***
Factor D (Divide total by number of participants):	***14049.06***
Average Length of Stay on the Waiver:	*240*

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

~~The following changes have been incorporated into this renewal application:~~

~~Appendix A:~~
~~a. i. Performance Measures updated to include administrative authority measures.~~

~~Appendix B:~~
~~B-3a. Update to Unduplicated Number of Participants for years 2 and 4 to best reflect annual projections.~~
~~B-3. Reference to increase funding removed. Reserved Capacity for Nursing Facility transitions remain at 25 per year.~~
~~B-6.c. Updated qualifications of social workers performing assessments for evaluation of level of care.~~
~~B-6.d. and f. Updated to reflect use of assessment tool utilizing a comprehensive long term services and supports (LTSS) assessment instrument.~~
~~B-6.e. Changed selection to reflect a different instrument is used to determine level of care the waiver than for institutional care.~~
~~B-6.i. Language included reflecting the use of alerts in the LTSS system and monthly eligibility reports to ensure timely recertification and avoid lapse in services.~~
~~B-6.j. Update to reflect records are maintained electronically in the LTSS system.~~
~~B. Quality Improvement: Level of Care. Performance Measures updated.~~
~~B-7. Included the process of obtaining the person's or their legal representative's signature attesting to choice of waiver or institutional care.~~

~~Appendix C:~~
~~C-1/C-3 Language updated to clarify bundle services includes therapy services, transportation services and to define normal daily personal hygiene items included at no additional cost to the waiver participant.~~
~~C-1/C-3 Language updated to include setting requirements and, "facilities must ensure the health, safety and welfare of all residents, they may refuse visitation of guests determined to be disruptive or unsafe with appropriate documentation." Also updates to specify requirements, including training, for all staff and other additional requirements for non-licenses staff.~~
~~C-1/C-3 Updated to include, "At no time should more than two (2) participants occupy a single unit." Also, the requirement of the Attendant call system to be "functionally operating" and be in proximity to a button "in both the bathroom and the living area/bathroom". Additionally, the requirement that the facility must have a security protocol in place to alert the attendant if the participant wanders from the facility was updated.~~
~~C-1/C-3 Updated to include all setting requirements for Home and Community Based Settings Rule. Also updates to specify requirements, including training, for all staff and other additional requirements for non-licenses staff.~~
~~C-1.c. Language added to include qualifications for the DOM social worker/case manager.~~
~~C-2, a. Updated to include the requirement for providers to complete OIG and Mississippi Nurse Aide Abuse Registry checks of employees monthly.~~
~~C. Quality Improvement. Performance Measurements Updated.~~

~~Appendix D:~~
~~D-1a. Social Worker qualification updated.~~
~~D-1b-e. Person Centered language updated and strengthened.~~
~~D-1f. Added language to define legally responsible person.~~
~~D: Quality Improvement. Performance Measures updated.~~

~~Appendix F:~~
~~F-1. State Fair Hearing Appeals including dispute resolution language updated.~~

~~Appendix G:~~
~~G-1b. Definition of Critical incidents updated.~~
~~G-2a. Include language to "ensure an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint."~~
~~G-3b.i. Added language referencing DOM's pharmacy provider portal for prescribing physicians and other providers.~~
~~G-3c.ii. Included specific language from the MS Board of Nursing Administrative Code regarding administration of medications.~~

~~G-Participant Safeguards. Performance Measures updated.~~

~~Appendix I:~~
~~I-Financial Accountability. Quality Improvement. Updated Performance Measures.~~
~~Updated language to include provider rate setting methodology included an actuary firm to thoroughly evaluate service rates.~~

~~Appendix J:~~
~~Updated to reflect annual estimates of waiver operation for next 5 years. See Appendix J.~~

This renewal application includes the following major changes:

• Updates to Factor C to project unduplicated enrollment limits.

• Addition of language to allow reserved capacity for priority admission to the waiver for high acuity members.

• Updates to auditing methodology to reflect new risk-based methodology.

• Updates to service rates and rate methodologies.

• Updates to quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.

• Updates to language to streamline provider qualifications.

• Updates to Case Management services specifications and provider qualifications to allow for additional flexibilities in staff credentials and service provision.

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

1. Request Information (1 of 3)

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

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

Assisted Living Waiver

C. Type of Request: renewal

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.0355
Waiver Number:MS.0355.R04.00
Draft ID: MS.008.04.00

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

Regular Waiver

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

~~10/01/18~~07/01/23

Approved Effective Date: 10/01/18

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

~~Individuals must be 21 and over.~~

The State additionally limits the waiver to individuals who are 21 and over.

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

☐

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **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 Assisted Living Waiver is a statewide program designed to allow Medicaid eligible beneficiaries requiring nursing facility level of care the choice to receive personal care, supervision, therapeutic care and social services in a home and community based setting as opposed to an institutional setting. This waiver also promotes rebalancing resources between institutional and community services by facilitating community transition of institutionalized persons.~~

~~Waiver participants reside in a Personal Care Home-Assisted Living facility that is licensed by the Mississippi State Department of Health or other licensed adult residential care home/community living setting as deemed acceptable by the Division of Medicaid. Waiver participants must be 21 years or older, aged, disabled and require one or more waiver services in order to function in the community. The participant exercises freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. Services provided in this waiver complement the State plan services already provided for Medicaid eligible beneficiaries.~~

~~A waiver participant may select any willing provider, provided they meet the Division of Medicaid's provider requirements, to furnish waiver services included in the service plan. This waiver provides a variety of services including personal care services, homemaker services, medication oversight, medication administration (to the extent permitted under state law), social and recreational care, intermittent skilled nursing services, transportation and therapeutic needs as specified in the plan of care.~~

~~Services are provided in a home-like, residential or community living environment. Personal assistance and supervision is provided twenty-four (24) hours a day to meet scheduled or unpredictable needs in a manner that promotes maximum dignity and independence while meeting the safety and welfare needs of the waiver participants. Other individuals or agencies may also furnish care directly, or under agreement with the facility but may not provide services in lieu of those furnished under this waiver. The waiver does not include the costs of room and board expenses for waiver participants. Room and board expenses must be met from participant resources or through other venues.~~

~~The Assisted Living Waiver is administered and operated by the Division of Medicaid (DOM) Office of Long Term Care. DOM exercises full responsibility of developing policies, procedures, rules and regulations for the administration of the program.~~

~~Case Management is an administrative function provided by DOM to assist the waiver participant and/or their designated representative by thoroughly assessing the waiver participant to determine the participant's preferences, needs, and goals. Once the assessment is completed, the case manager works with the waiver participant and/or their designated representative to develop a plan of services and supports that best meets their needs and preferences using waiver and non-waiver services regardless of the funding. The main objective of the case management service is to assure the waiver participant receives consistent quality of care while avoiding unnecessary or premature institutionalization.~~

The Assisted Living (AL) waiver provides individuals seeking Long Term Services and Supports with meaningful choices to support residency in a Home and Community Based setting. The waiver strives to identify the needs of the person and provide services in the most cost-efficient manner possible with the highest quality of care. This is accomplished through the utilization of a comprehensive Long Term Services and Supports (LTSS) assessment process that includes a single point of entry for individuals seeking services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term services and supports across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services. This waiver is administered and operated by the Division of Medicaid (otherwise known as the State or DOM). The following are services provided under the AL Waiver: case management, assisted living, and adult residential care for acquired traumatic brain injury participants.

3. Components of the Waiver Request

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

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

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

care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

Public input regarding the content and operation of the Assisted Living (AL) Waiver is constantly sought & obtained by the Division of Medicaid (DOM). Staff from DOM attend & present at a variety of workshops & training venues which allows/encourages a means of generating input from multiple sources. On 3/26/18, DOM held a collaborative stakeholder group meeting, consisting of providers, case managers, advocacy organizations, partner State agencies, beneficiaries, caregivers & other interested parties to seek input regarding the scope/nature of services offered during the development of this renewal document. Comments & input were accepted both in person & via telephone conference. Direct input from waiver participants & their representative parties was solicited throughout the development of this waiver renewal process. Participants were provided with a flyer documenting the renewal process & providing information on how to submit input. Additionally, the flyers were posted in common areas at each facility. DOM also obtains public input through the Waiver review & audit process. DOM regularly performs unannounced audits of each AL Waiver service providers. This process includes home visits of a sample population for participants served across the state. During the home visit, direct feedback is received from the waiver participant and/or their representatives regarding the participant's satisfaction with their services, their case management, and any comments related to additional beneficial services. This feedback is then utilized to improve and/or further develop waiver services. Another mechanism through which public input is obtained is from telephone contacts 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 October 1, 2018 waiver renewal the MBCI was notified on April 27, 2018.

Summary of Public Comments & Responses for the AL Waiver Renewal:
Public comments were received regarding the need for increased transparency surrounding the waiting list for waiver admission.
Response: DOM has streamlined the management of waitlist processes to allow for additional transparency and ensure timely & appropriate admissions to the waiver.
Public comments were received from stakeholders requesting DOM explore extending the enhanced transition program (B2I/MFP) program into the waiver renewal.
Response: DOM does not plan to adopt this recommendation at this time due to resource limitations.
A stakeholder comment was received requesting additional supports for AL Waiver providers in assisting participants with mental health diagnoses.
Response: DOM encourages all waiver providers to work in collaboration with case managers to meet the needs of waiver participants throughout the person-centered planning process, and to seek input from the DOM Office of Mental Health for guidance in circumstances where specific assistance or knowledge is required.
A stakeholder comment was received requesting a rate increase.
Response: DOM performed a thorough provider rate development in conjunction with an actuarial firm, Milliman. Assisted Living Waiver service rates incorporated in the waiver application were based on a survey of current providers as well as BLS statistics and rate development assumptions regarding service specifications, overhead costs, staffing, average length of stay, etc. for use with the Mississippi HCBS environment. Once Milliman completed their rate analysis, DOM solicited public comments on the rates through public notices & notification to the tribal government.
Stakeholder comments were received requesting the addition of unduplicated slots for the Assisted Living Waiver.
Response: DOM continues to request approval of, and funding to support, the capacity necessary to provide services to all of the population determined to be requesting AL Waiver services.
A stakeholder comment was received requesting DOM allow providers to submit claims more than once per month.
Response: To ensure appropriate billing of claims & allow continued monitoring of utilization, DOM does not plan to adopt this recommendation at this time.
A stakeholder comment was received regarding concerns with waiver language limiting the number of participants per room to 2 & the requirement that the attendant call system alert an attendant if a participant wanders from the facility.
Response: Language in the current waiver states that rooms may only be "dually" occupied. Therefore, any updates which specified a maximum of 2 participants per room are intended to clarify an existing requirement. DOM must ensure that services are provided in a person-centered manor which ensures participants' health, safety & privacy; therefore, DOM will not adopt the recommendation for increased number of participants per room. DOM has updated the language regarding wandering alerts to state that "the facility must have a security protocol in place which alerts an attendant if a participant wanders from the facility."
A stakeholder comment was received regarding allowing participants to receive AL Waiver services in their own community homes & to allow services to be provided by a family member.

~~Response: DOM does not plan to accept these recommendations at this time. The AL Waiver was designed to offer individuals a bundle of assistive services in a licensed facility of their choosing by facility staff. The state administers several other waivers which allow participants the opportunity to receive services in their own homes by individual personal care attendants of their choosing.~~

Mississippi actively sought public input during the development of this waiver renewal by seeking comments, conducting group meetings, and meeting with providers and stakeholders. A Public Input meeting was held on December 14, 2022. Attendees included providers, waiver participants, advocates and representatives of the operating agency. Sixty days prior to submission of the waiver renewal application to CMS, the Mississippi Band of Choctaw Indians was notified via certified mail of the renewal process including proposed changes and considerations. Thirty days prior to submission of the waiver renewal application to CMS, the full draft was posted for public notice at https://medicaid.ms.gov/news-andnotices/public-notices/. DOM obtains ongoing public input through the waiver quality interviews conducted by the State staff. During these interviews, direct feedback is received from the participant and/or their representatives. Specific feedback is obtained regarding the participants satisfaction with their services, their satisfaction with their case manager, and any additional services that they believe could be of benefit to them. This feedback is utilized to improve and/or further develop waiver services. Public input is also obtained through calls from providers, applicants/participants and their designated representatives, regarding inquiries, complaints, or appeals. Summary of Public Comments and Responses: Public comments were received regarding the need for additional AL waiver funding/capacity and additional transparency for providers into waiting list status. DOM Response: DOM will determine if there is a way to increase transparency at a very high-level summary of data. Please keep in mind that the wait list is managed from a statewide perspective. If a person is discharged from a facility, the next person on the statewide waitlist will be assessed. Public comments were received regarding options/limitations related to rate increases for AL services. State's Response: DOM is conducting a workforce study including a comprehensive provider survey that will gather data regarding provider costs, employee recruitment and retention policies, and other best practices to be utilized in rate updates across the waiver during this renewal. Public comments were received regarding special services needs of individuals with behavioral health conditions which may not be addressed in the bundled rate. State's Response: Participants have access to many behavioral health services through their State Plan benefits. If additional services are needed at the facility, providers can propose additional services to DOM that will be considered for incorporation in a future amendment/renewal. Public comments were received regarding the possibility of implementing cost-based reimbursement similar to nursing facility providers and bed hold days in the AL facility when a participant is admitted to the hospital. State's Response: At this time, DOM does not plan to convert to cost based reimbursement for assisted living waiver services. Public comments were received with regards to pharmacy coverage for members admitted to the AL facility while still on the waiver waiting list. State's Response: Pharmacy is not covered benefit under the assisted living waiver. Depending on their category of eligibility, applicant's may be eligible for pharmacy benefits under the Medicaid State Plan. Public comments were received with regards to whether waiver eligibility could be retroactive to the date that the person was admitted to the facility. State's Response: The person must be assessed to determine that they meet nursing facility level of care. Eligibility cannot be prior to the level of care effective date. Public comments were received regarding options regarding the removal of administrative burdens including the requirement for a physician to sign the LOC certification form or the requirement to print and submit billing for verification each month.to allow Nurse Practitioner to sign the certification form? State's Response: Administrative Code updates associated with this renewal will address these flexibility requests.

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

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

7. Contact Person(s)

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

Last Name:

Johnson

First Name:

Paulette

Title:
Nurse Office Director, Long Term Care

Agency:
Mississippi Division of Medicaid

Address:
Walter Sillers Building, Suite 1000

Address 2:
550 High Street

City:
Jackson

State:
Mississippi

Zip:
39201

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

Fax:
(601) 359-9521

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: ~~Margaret Wilson~~

State Medicaid Director or Designee

Submission Date: ~~Sep 14, 2018~~

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:

Nurse Office Director, Long Term Care

Agency:

Mississippi Division of Medicaid

Address:

Walter Sillers Building, Suite 1000

Address 2:

550 High Street

City:

Jackson

State: **Mississippi**

Zip:

39201

Phone:

(601) 359-5514 **Ext:** ☐ **TTY**

Fax:

(601) 359-9521

E-mail:

Paulette.Johnson@medicaid.ms.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

No transition plan is requested.

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.

4. 1915(c) Assisted Living (AL) Waiver:
AL Waiver services are provided to residents living in a personal care home/assisted living facility and a neurological rehabilitative living center in a residential setting which must meet the requirements of the HCB settings and include:
• Case management,
• Personal care,
• Homemaker services,
• Attendant care,
• Medication oversight,
• Medication administration,
• Therapeutic social recreational programming,
• Intermittent skilled nursing services,
• Assisted residential care for acquired traumatic brain injury,
• Transportation, and
• Attendant call system.

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:
• Assisted Living (AL) Waiver – 9 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 AL Waiver received during the 30 day comment period from March 11, 2015, through April 10, 2015:
• 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 AL Waiver during the thirty (30) day comment period from November 28, 2016, through December 28, 2016, were from Micah Dutro 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 of a POC to the Division of Medicaid detailing changes in HCB settings validated as non-compliant and the timelines the provider will be in full compliance with the final rule. Providers must have their completed POC submitted within forty five (45) days of receipt of the WRF. The Division of Medicaid will review all submitted POCs for approval or request for additional information, if necessary, within forty five (45) days of receipt. A compilation list showing which category each provider falls into and the reasons for being placed into that category will be posted on the Division of Medicaid's website for public information. All non-compliant providers will be re-assessed through an on-site validation visit and a sample of person re-surveys according to their submitted POC during the calendar year 2017 to determine if they have met the requirements of their POC. If the provider is still assessed to be non-compliant the provider will receive another WRF. Another POC must be completed and submitted to the Division of Medicaid within forty five (45) days after the receipt of the WRF. The Division of Medicaid will review the submitted POC for approval or request for additional information if necessary within forty five (45) days of receipt. A second on-site validation visit will be conducted following receipt the receipt of the POC during the calendar year 2017.

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

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

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

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

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

~~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.~~

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Office of Long Term Services and Supports ~~Care~~

(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*):

○ **X 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 Level of Care determinations and service requests that cannot be approved by the automated algorithm or the DOM nurses. The UM/QIO physicians provide clinical recommendations to DOM who is responsible for final determinations

◉ **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 is responsible for contract monitoring of the services performed by the contracted 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 submitted by the contractor and reviewed by DOM 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
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	☒

Function	Medicaid Agency
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. Numerator: Number of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. Denominator: Total number of enrollment reports.**~~

PM1: Number and percent of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. Numerator: Number of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. Denominator: Total number of enrollment reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**LTSS**~~ **QIS Tracking Spreadsheet**

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	☒ X Monthly	☐ Less than 100% Review

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.**~~

PM2: Number and percent of monthly waiver expenditures reports received that, on average, are at or below the projected expenditure levels for the month. N: Number of monthly waiver expenditure reports received that. on average, are at or below the projected expenditure levels for the month. D: Number of required monthly waiver expenditure reports received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☒ **X 100% Review**
☐ **Operating Agency**	☐ **X Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ ~~**Quarterly**~~	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

☒ ☐

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

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

Performance Measure:

~~**PM 3: Number and percent of assisted living providers who met HCB setting requirements as defined by federal regulations. N: Number of assisted living providers who met HCB setting requirements as defined by federal regulations. D: Total number of assisted living providers reviewed.**~~

PM3: Number and percent of participants' who received services in an HCB setting as defined by federal regulations. N: Number of participants' who received services in an HCB setting as defined by federal regulations. D: Total number of participants who received services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**Compliance Review**~~ **QA Telephone Interviews**

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☐ ~~**100% Review**~~
☐ **Operating Agency**	☐ **Monthly**	☒ **X Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	**X Representative Sample** Confidence Interval = ~~Confidence Interval =~~ 95%
Other Specify:	**X Annually**	**Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 assisted living provider immediately; and (b) require the provider to correct deficiencies within 30 days.~~

When individual and/or system-wide remediation activities are warranted based on discovery and analysis, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systemically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions.

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	21	64	
	☒	Disabled (Other)	21	64	
☐ 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:

~~For the five (5) slots specifically set aside for acquired traumatic brain injury participants, participants must be in a crisis/high stress situation at risk for institutionalization. These participants require 24 hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury. Acquired Traumatic Brain Injury is defined as a traumatically acquired non-degenerative structural brain damage. This term does not apply to brain injuries that are congenital or to brain injuries induced by birth trauma.~~

~~Others with brain injuries, who do not require 24 hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury, could also be served in the waiver along with others with disabilities.~~

For the ten (10) slots specifically set aside for acquired traumatic brain injury participants, participants must be in a crisis/high stress situation at risk for institutionalization. These participants require 24 hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury. Acquired Traumatic Brain Injury is defined as a traumatically acquired non-degenerative structural brain damage. This term does not apply to brain injuries that are congenital or to brain injuries induced by birth trauma. Others with brain injuries, who do not require 24-hour supervision related to behavioral issues associated with a diagnosis of acquired Traumatic Brain Injury, could also be served in the waiver along with others with disabilities.

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 did not allow us to check 'non applicable'.~~

There is no maximum age limit for this waiver. The waiver application will not allow the selection of "No maximum age limit" for the Disabled (Physical) or Disabled (Other) target groups.

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:

○ **X 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:

Prior to admission to this waiver, the case manager(s) completes a thorough comprehensive Long Term Support Services (LTSS) assessment. Along with the core standardized assessment, the case manager(s) submits a person-centered plan of services and supports (PSS) outlining the specific service needs of the individual and providing an estimated projection of the total cost for services to DOM. An oversight review is conducted by a registered nurse at DOM to ensure the person's needs are able to be met by the specified services/frequencies. If a person's needs cannot be met within the capacity of the waiver, it is explained to the applicant and a Notice of Action for a Fair Hearing is sent to them. Suggestions are given for other long term services and supports alternatives. On average, the cost for a person's waiver services must not be above the average estimated cost for nursing home level of care approved by CMS for the current waiver year. DOM ensures the waiver remains cost neutral.

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.**

☐ **XAdditional 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:

Upon a change in the participant's condition, the case manager(s) assesses the person to determine if their health and welfare can continue to be assured through the provision of waiver services in the community. If so, a change request PSS is submitted for review. Each additional service request is thoroughly reviewed by a DOM nurse. If the service is deemed appropriate and does not threaten overall cost neutrality, the DOM nurse will approve the request and will notify the case manager(s) of the approval. If the additional services requested are determined to exceed the average estimated cost, then the request may be denied and the applicant/person will be notified of their right to a State Fair Hearing (Appendix F). The denial must not compromise the overall quality of care for the individual. If it is determined that the denial compromises the quality of care, an approval may be granted by management of DOM thereby overturning the denial. If an increase in services is denied, the person will be informed and notified of their right to request a Fair Hearing.

☐ **XOther safeguard(s)**

Specify:

DOM works to ensure the person's needs are met. This process includes examining third-party resources, possible transition to another waiver, or institutional services. Medicaid waiver funds are to be utilized as a payer of last resort.

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	

Waiver Year	Unduplicated Number of Participants
	~~900~~1100
Year 2	~~950~~1100
Year 3	~~1000~~1100
Year 4	~~1050~~1100
Year 5	1100

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
~~Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries~~ Priority Admission of Applicants with Emergent Need to Prevent Institutionalization
~~Transition of Participants from Nursing Home to Community~~ Transition of Persons from Other Mississippi 1915(c) HCBS Waivers

Priority Admission to Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries

Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting

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):*

~~Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries~~

Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

Purpose *(describe):*

~~A limited number of slots (5) will be reserved for caring for those individuals with an acquired traumatic brain injury who are in a crisis/high stress environment with behavioral issues requiring services that if not for the supervision and care provided by this waiver, would require institutional care.~~

The state reserves capacity within the waiver for the priority admission of applicants meeting the eligibility criteria outlined in Appendix B-1 in combination with one or more of the following criteria that may result in imminent institutionalization: - Have experienced the death, long-term incapacitation, or loss of their primary live-in caregiver directly affecting the person's ability to remain in their home within the prior 90 days. - Referred by the MS Department of Human Services Office of Adult/Child Protective Services following a substantiated incident of abuse, exploitation, abandonment, and/or neglect resulting in an ongoing risk to their health and safety without immediate services and supports through the waiver. - Diagnosed by a physician with a terminal illness and in jeopardy of entering a non-Hospice institution because their care needs cannot be met with current supportive services. - Diagnosed by a physician with progressive debilitating disease that has resulted in the need for at least moderate physical assistance with 3 or more activities of daily living (ADLs). Examples may include, but not be limited to, Amyotrophic Lateral Sclerosis (ALS), primary progressive multiple sclerosis (PPMS), Alzheimer's, or Parkinson's. If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

~~The number of reserved capacity is based upon the identified number of individuals made known to the Medicaid Agency in need of such care. The reserved capacity is a baseline for initiating this service and may be reevaluated as the need for this service increases.~~

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals requesting priority admission.

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

Waiver Year	Capacity Reserved		
Year 1		~~5~~	10
Year 2		~~5~~	10
Year 3		~~5~~	10
Year 4		~~5~~	10
Year 5		~~5~~	10

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~~

Transition of Persons from Other Mississippi 1915(c) HCBS Waivers

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 AL Waiver services.~~

The state reserves capacity within the waiver for individuals transferring from an alternate MS 1915(c) waiver or aging out of the

Disabled Child Living at Home (DCLH) waiver. Individuals must have been enrolled in the original waiver for at least 30 days and be requesting immediate transfer because that waiver can no longer meet their needs. If the original waiver meets their needs and the switch is preference based, the individual does not meet the criteria for reserved capacity. If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

~~DOM evaluated the number of referrals received for transition from nursing facilities to a community setting for FY15 and FY16. It was determined that maintaining the reserve capacity of 25 AL waiver slots, in addition to capacity reserved in other waivers, would be sufficient to meet the needs of individuals wishing to transition out of nursing facilities into a Home and Community setting.~~

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals requesting transfer to an alternate waiver.

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

Waiver Year	Capacity Reserved	
Year 1	~~25~~	10

Waiver Year	Capacity Reserved		
Year 2		~~25~~	10
Year 3		~~25~~	10
Year 4		~~25~~	10
Year 5		~~25~~	10

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):

Priority Admission to Residential Care for Waiver Participants with Acquired Traumatic Brain Injuries

Purpose (describe):

The state reserves capacity within the waiver for the priority admission of applicants with an acquired traumatic brain injury who are in a crisis/high stress environment with behavioral issues requiring services that if not for the supervision and care provided by this waiver, would require institutional care. Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below would be allocated to meet the needs of individuals requesting priority admission

Waiver Year	Capacity Reserved		
Year 1		10	
Year 2		10	
Year 3		10	
Year 4		10	
Year 5		10	

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 Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting

Purpose (describe):

The state reserves capacity within the waiver for individuals transitioning from institutional long term care settings to a home and community-based services (HCBS) setting. Individuals must have resided in the institutional setting for a minimum of thirty (30) days with at least one (1) of those days being covered in full by Mississippi Medicaid. If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals wishing to transition out of institutional facilities into a Home and Community setting.

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

Waiver Year	Capacity Reserved

Year 1		10	
Year 2		10	
Year 3		10	
Year 4		10	
Year 5		10	

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 Administrative Code, Title 23: Medicaid, Part 208, Chapter 3: Home and Community Based Services Assisted Living Waiver Rule 3.1 3.11.~~

Entrance into the Waiver will be on a first come-first served basis for those who meet the criteria outlined in Appendix B. The exception to this first come-first served policy is those individuals who meet the reserved capacity criteria for priority admission. Entry into the Waiver will be offered to individuals based on their date of referral for the Waiver. Individuals who are referred in excess of the waiver capacity within any given year will be placed on a waiting list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( )

209(b) State

2. Miller Trust State.

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

- ○ **No**
- ◉ **Yes**

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

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

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

  Select one:

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

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

  Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

The 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:

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

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

Specify:

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

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

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

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

Specify:

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

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

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

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

Specify:

- ○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

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

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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:

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 Mississippi licensed social workers (LSW). 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.~~

The comprehensive preadmission screening process is conducted by a DOM case manager. Case managers must be a Mississippi licensed social workers (LSW). 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. Qualified assessors perform the core standardized assessment at the time of evaluation, and enter the person's pertinent data into the eLTSS system. In eLTSS, an automated scoring algorithm is applied to the core standardized assessment data generating a numerical score, the level of care (LOC) score. Case managers do not determine an applicant's LOC

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 Assisted Living 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.~~

Level of care (LOC) is determined through the application of a comprehensive long term services and supports (LTSS) assessment instrument by qualified assessors. The assessment encompasses activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. The LTSS assessment data is then 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. Persons scoring below the threshold may qualify for a secondary review and a tertiary review by a physician before waiver services are denied. If a person is denied waiver services based on failure to meet the level of care, he/she will be notified of the reason for denial along with information, and assistance if needed, to request and arrange for a State Fair Hearing.

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 Assisted Living 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.~~

DOM utilizes a comprehensive long term services and supports (LTSS) assessment tool supported by algorithms developed in conjunction with our eLTSS vendor and AIS (InterRAI Home Care) across its LTSS system to determine nursing facility level of care (LOC). For the HCBS populations, the full assessment is utilized to determine LOC and inform care planning. For institutional populations, a subset of those questions is utilized as the pre-admission screening tool for institutional admissions. Crosswalks and validation testing were done to ensure that the algorithms resulted in appropriate scoring mechanisms based on defined level of care requirements.

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

~~The level of care of enrolled participants is reevaluated at least annually.~~

~~Level of care for the Assisted Living Waiver is re-evaluated 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.~~

Initially and at recertification, the core standardized assessment tool is completed by the case manager to ensure the needs of the person are fully captured. This process is a collection of clinical eligibility criteria that is used across all HCBS services. A scoring algorithm is used to establish an eligibility threshold per DOM policy.

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):*

~~The Division of Medicaid has manual and automated monitoring systems to ensure that a re-certification is completed timely. These procedures include:~~
~~1. Tickler files and~~
~~2. Edits in the computer system~~

~~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. Case managers are provided with a monthly Eligibility Report, which includes the name of each participant, the end date of the certification period, and the end date for Medicaid financial eligibility. These processes ensure timely recertification to avoid lapses in service.~~

In the eLTSS system, a recertification packet is initiated, and the case manager is sent an alert 90 days prior to the expiration of the current certification period. This prompt encourages case manager(s) to begin recertification activities in advance to ensure recertifications and prevent lapses in eligibility. Also, DOM provides the case manager with a monthly Eligibility Report, which includes person's name, the end date of the certification period, and the end date for Medicaid financial eligibility. The report ensures that case managers are aware of any person that is about to lose eligibility or waiver services. The report is reviewed by the case manager(s) and any discrepancies are reported to DOM for resolution.

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 original participant's records are housed in the Division of Medicaid Office of Long Term Care. The LTSS system maintains an electronic record of all assessments and application packets, which is accessible by DOM.~~

The person's original record is maintained at the DOM Central Office. The core standardized assessment along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. DOM is required to maintain the entire document, either electronically or in paper, for the period of time specified under the current federal guidelines.

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.**~~

PM 1: Number and percent of waiver applicants, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. N: Number of waiver applicants, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. D: Total number of waiver applicants.

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):*
☒ **X State Medicaid Agency**	☐ ~~**Weekly**~~	☒ **X 100% Review**
☐ **Operating Agency**	☒ **X Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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.~~

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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~~.~~

~~**ii.**~~

~~For PM 1, DOM will (a) obtain correct documentation; and (b) have the Case Manager 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, if necessary.~~
~~For PM 2, DOM will (a) require a new LOC evaluation to be conducted by a qualified assessor within seven business days; and (b) conduct training on requirements for qualified assessors.~~

In any instance in which it is discovered that a participant was not evaluated/reevaluated by a qualified assessor in accordance with the procedures outlined in Appendix B of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systemically. DOM will ensure a qualified assessor conducts a comprehensive LTSS assessment within fifteen (15) days of the discovery. If it is identified at that time that the participant does not meet the criteria, the participant will be disenrolled from the waiver and receive notice of their appeal rights in accordance with Appendix F of this waiver. The case manager will be required to explore other community or public funded services that may be available to the individual and assist with any referrals to those resources. Provider cClaims for the period of ineligibility identified will be reviewed and recouped appropriately.

~~**iii.**~~**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):*
☒	☐
☐	☒

X State Medicaid Agency	**~~Weekly~~**
Operating Agency	**X Monthly**
Sub-State Entity	**Quarterly**
Other	**Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

~~Long term care program options, including institutional care, waiver services and other State plan services, are explained by the case manager. The case manager assists in providing information to match the participant's care needs, strengths, and desires with DOM covered long term care programs, to ensure the participants, and participant's family, are able to make an informed choice from the available DOM covered options prior to the enrollment into the waiver program. This process requires the person or their legal representative to sign and attest to their choice of placement on an Informed Choice form.~~ The LTSS assessment process requires the person or their legal representative to sign and attest to their choice of setting and waiver on an Informed Choice form. Long term services and supports options are explained by the case manager(s) prior to enrollment, and the person indicates their choice of waiver services or institutional services by evidence of their selection and signature.

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 LTSS system maintains copies of the Informed Choice forms within an electronic database which is available to the DOM.~~ The person's original record is maintained at the DOM Central Office. The Informed Choice along with other

Appendix B: Participant Access and Eligibility

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

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

~~The State subscribes to a language line service that provides interpretation services for incoming calls. The subscribed interpretation service provides access in minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code. A Limited English Proficient (LEP) Policy has been established. All essential staff has received training on the use of the Language Line Service. All necessary steps have been taken to ensure that staff understand the established LEP policy and are capable of carrying it out.~~

~~The key to the telephone language interpreter service is to provide meaningful access to benefits and services for the LEP persons and to ensure that the language assistance provided results in accurate and effective communication between the Division of Medicaid and applicants/beneficiaries about the type of services and/or benefits available and about the applicants and/or beneficiaries circumstances.~~

The State subscribes to a language line service that provides interpretation services for incoming calls from the person with limited English proficiency (LEP). The subscribed interpretation service provides access in minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code. An LEP Policy has been established. All essential staff have 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 the Division of Medicaid and individuals about the types of services and/or benefits available, and about the person's 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
Other Service	Adult Residential for Care for Acquired Traumatic Brain Injury Participants
Other Service	Assisted Living

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:

Adult Residential for Care for Acquired Traumatic Brain Injury Participants

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These are bundled services provided in a residential environment to individuals with an acquired traumatic brain injury in the need of long term care services to avoid institutionalization. Services may include personal assistance or supervision for a period of twenty-four (24) hours continuously per day in a residential and community setting. This environment provides for a range of choices through personal preference, self- determination and dignity with full consideration of identified risks. Services provide for an environment of peer support that is conducive to enhancing the functional abilities of the individual with a brain injury. The physical environment must be conducive to enhancing the functional abilities of the waiver participant.

Waiver participants in the Assisted Living waiver who are receiving services in the TBI-residential care facilities are eligible for Medicaid coverage of physical therapy, occupational services, speech therapy and behavioral services provided as part of the bundle of services included in a comprehensive rate. They will not be eligible for Medicaid coverage for physical therapy, occupational services and behavioral services outside of the waiver. Necessary therapeutic services must be available as needed. These services include, but are not limited to, social work, behavioral services, speech therapy, physical therapy, occupational therapy, vocational services, cognitive activities, medication oversight or administration, transportation escort service, essential shopping, housekeeping service, laundry service, dining service and therapeutic recreational services. All therapeutic providers must be licensed by the appropriate state and national boards. When provided to the participant, the above services are included in the comprehensive rate paid to the provider and the Medicaid agency will not be billed separately. The provider agrees not to bill the waiver participant or their responsible party beyond what Medicaid has agreed to pay.

Nursing or skilled services are incidental, rather than an integral, to the provision of these services. A nurse must be available minimally eight (8) hours per day, and must practice in accordance with the applicable nurse practice law and in accordance with acceptable standards of practice.

Escort service is defined as providing assistance accompanying, or physically assisting, a waiver participant who is unable to travel or wait alone for medical appointments.

An Acquired Traumatic Brain Injury means an insult to the brain, not of a degenerative or congenital nature, that may produce a diminished or altered state of consciousness, which results in an impairment of cognition abilities or physical functioning. It can also result in the disturbance of behaviors or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functioning disability, or psychosocial maladjustment.

Providers must provide:
1) A private living quarter with bath consisting of a toilet and sink,
2) Normal daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial paper, tissue, laundry soap and dental hygiene products at no additional cost to the participant.

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

Therapy services must not be duplicative of available state plan therapy benefits.

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	Adult Residential Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential for Care for Acquired Traumatic Brain Injury Participants

Provider Category:

Agency

Provider Type:

~~Adult Residential Care~~

MS Medicaid Enrolled AL Waiver TBI Residential Assisted Living Facility Providers

Provider Qualifications

License *(specify)*:

~~The entity providing services to the Acquired Traumatic Brain Injury (TBI) waiver participants must be a licensed entity deemed acceptable by the Division of Medicaid to meet minimum requirements specific for care of individuals with an acquired TBI. Each facility located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each licensed facility shall comply with all applicable state and federal laws including, but not limited to, Nursing Practice Laws and the laws governed by the Board of Pharmacy. Any requirement, for participation as a provider of health care services under a Federal health care program, that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law pursuant to 25 U.S.C. 1647(a)(2).~~

Providers must maintain a current and active Mississippi license to function as a Personal Care Home – Assisted Living Facility (PCH-AL).

Certificate *(specify)*:

N/A

Other Standard *(specify)*:

Additional requirements:
1. The setting must be integrated in, and facilitate the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities;
2. The setting is selected by the individual from amongst all available alternatives, and is identified in the person-centered plan of services and supports;
3. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
4. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;
5. Individual choice regarding services and supports, and who provides them, is facilitated;
6. Safety needs of an individual with dementia must be supported by a specific assessed need and addressed in the plan of care;
7. The waiver participant's unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement;
8. Each waiver participant has privacy in their sleeping or living unit:
a. Units have lockable entrance doors with appropriate staff having keys to doors;
b. Waiver participants share units only at the participant's choice; and
c. Participants have the freedom to furnish and decorate their sleeping or living units;
9. Waiver participants have the freedom and support to control their own schedules and activities and have access to food at any time;
10. Participants are able to have visitors of their choosing at any time;
11. The setting is physically accessible to the participant; and
12. The setting must not be on the grounds of, or adjacent to:
a. A nursing facility;
b. An institution for mental diseases;
c. An intermediate care facility for individuals with intellectual or developmental disabilities;
d. A hospital providing long-term care services; or
e. Any other location that have qualities of an institutional setting.

The Waiver provider must comply with the following standards:
1) Maintain a current, signed and dated copy of an admission agreement for each waiver participant. At a minimum, the agreement must contain:
a) Basic charges agreed upon separating costs for room and board and personal care services,
b) Period of time to be covered in the charges,
c) List of itemized charges,
d) Agreement regarding refunds for payments.

As facilities must ensure the health, safety and welfare of all residents, they may refuse visitation of guests determined to be disruptive or unsafe with appropriate documentation.

The admission agreement must explain in detail the costs associated with, and agreed upon, for care services provided to the waiver participant. The costs for room and board must be clearly reflected in the agreement. At no time, should the facility charge the waiver participant for the costs of care services over and beyond the reimbursable amount paid by Medicaid.

The admission agreement must be approved by the Division of Medicaid prior to the provision of waiver services. Any new or amended admission agreement must be submitted, and approved by the Division of Medicaid, prior to implementation.

2) Must provide a licensed nurse at the facility for a minimum of eight (8) hours a day to assist the participants with medication administration or oversight. The nurse must have an active and unencumbered license. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facility must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate

~~the Nursing Practice Law or Administrative Code in any manner.~~

~~3) Waiver providers must provide training as follows:~~
~~-All staff must be provided with orientation training upon hire, and annually thereafter, in the following areas, including but not limited to:~~
~~a) Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation in accordance with the MS Vulnerable Person's Act~~
~~b) Rights and Dignity~~
~~c) HIPAA Compliance~~
~~d) Assisted Living Waiver Requirements~~
~~e) Emergency Preparedness~~
~~f) Stress Reduction~~
~~g) Behavior Programs~~
~~h) Rational/Behavioral Therapy~~

~~- All staff must maintain CPR and First Aid certifications.~~

~~- Direct care staff, excluding any RN, LPN, or CNA who maintains an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, must successfully complete a curriculum training course upon hire prior to rendering services and annually thereafter, as designated by DOM.~~

~~- Each provider must have a program manager who is nationally certified as Brain Injury Specialist.~~

~~- 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.~~

~~- Documentation of completed training must be maintained at the facility and made available to DOM upon request. Failure to comply with training requirements will require an acceptable plan of correction by the provider. Continued non-compliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.~~

~~4) Each provider must:~~
~~a) Conduct a national criminal background check with fingerprints on all employees prior to employment, and every two (2) years thereafter, and maintain the record in the employee personnel file.~~
~~b) Conduct checks, prior to employment and monthly thereafter, to ensure employees are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion List and maintain the record in the employee personnel file.~~
~~c) Not have been, or employ individuals who 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.~~

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements are detailed in Part 208 of the code.

Verification of Provider Qualifications

Entity Responsible for Verification:

~~DOM~~

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider is responsible for verifying the

qualifications are met for all facility staff.

Frequency of Verification:

~~Initially Prior to Enrollment and Annually Thereafter~~

Qualifications are verified upon enrollment/hire and thereafter as needed

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:

Assisted Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assisted Living services include personal care services, chore services, attendant care, medication oversight and administration (to the extent permitted under State Law), therapeutic, social and recreational programming, in an environment that is home like and provides the participant full access to the typical facilities in a home while providing for privacy and easy access to resources and unscheduled activities in the community. The setting allows for participants to have visitors at times of preference and convenience to them. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Nursing and skilled therapy services (except periodic nursing evaluations, if specified above) are incidental, rather than integral, to the provision of assisted living services. Payment will not be made for 24-hour skilled nursing care or supervision. The Division of Medicaid will neither reimburse the waiver participant, nor the care facility, for the cost of room and board.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. At no time should more than two (2) participants occupy a single unit. The participant has a right to privacy. Living units must have lockable doors with appropriate staff having keys. (This requirement does not apply where it conflicts with fire code). Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) which may also serve as living or dining rooms.

The waiver participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.

Attendant Call Systems are functionally operating emergency response systems required to be available for each participant. The attendant call system must enable the participant to summon emergency help from an assisted living attendant via a wearable electronic device (e.g., a medallion or a bracelet) or call buttons located in each living area (i.e. restroom, living room, and bedroom). Additionally, the facility must have a security protocol in place which alerts an attendant if a participant wanders from the facility.

Providers must provide:
1) Normal daily personal hygiene items including at a minimum, deodorant, soap, shampoo, toilet paper, facial paper, tissue, laundry soap and dental hygiene products at no additional cost to the participant.

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	~~Assisted Living~~

MS Medicaid Enrolled AL Waiver Assisted Living Facility Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living

MS Medicaid Enrolled AL Waiver Assisted Living Facility Providers

Provider Qualifications

License *(specify):*

~~Each Assisted Living waiver provider must be licensed, in accordance with the regulations of the Mississippi Department of Health Health Facilities Licensure and Certification Minimum Standards for Personal Care Homes Assisted Living, or other licensing entity as deemed acceptable by the Division of Medicaid. Every licensed facility located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each licensed facility shall comply with all applicable state and federal laws including, but not limited to, the Mississippi Nursing Practice Law and the Laws governed by the Mississippi Board of Pharmacy. Any requirement, for participation as a provider of health care services under a Federal health care program, that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services, shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law pursuant to 25 U.S.C. 1647(a)(2).~~

~~Based on the Mississippi Board of Nursing Administrative Code, Part 2830 Chapter 2: Functions of the Licensed Practical Nurse, Rule 2.1 LPN Supervision: The LPN gives nursing care under the direction of the RN, advanced practice registered nurse (APRN), licensed physician.~~

Providers must maintain a current and active Mississippi license to function as a Personal Care Home – Assisted Living Facility (PCH-AL).

Certificate *(specify):*

Other Standard *(specify):*

~~Additional requirements:~~
~~1. The setting must be integrated in, and facilitate the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities;~~
~~2. The setting is selected by the individual from amongst all available alternatives, and is identified in the person-centered plan of services and supports;~~
~~3. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;~~
~~4. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;~~
~~5. Individual choice regarding services and supports, and who provides them, is facilitated;~~
~~6. Safety needs of an individual with dementia must be supported by a specific assessed need and addressed in the plan of care;~~
~~7. The waiver participant's unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement;~~
~~8. Each waiver participant has privacy in their sleeping or living unit:~~
~~a. Units have lockable entrance doors with appropriate staff having keys to doors;~~
~~b. Waiver participants share units only at the participant's choice; and~~
~~c. Participants have the freedom to furnish and decorate their sleeping or living units;~~
~~9. Waiver participants have the freedom and support to control their own schedules and activities and have access to food at any time;~~
~~10. Participants are able to have visitors of their choosing at any time;~~
~~11. The setting is physically accessible to the participant; and~~
~~12. The setting must not be on the grounds of, or adjacent to:~~
~~a. A nursing facility;~~
~~b. An institution for mental diseases;~~
~~c. An intermediate care facility for individuals with intellectual or developmental disabilities;~~
~~d. A hospital providing long-term care services; or~~
~~e. Any other location that have qualities of an institutional setting.~~

~~As facilities must ensure the health, safety and welfare of all residents, they may refuse visitation of guests determined to be disruptive or unsafe with appropriate documentation.~~

~~The Assisted Living Waiver provider must comply with the following standards:~~
~~1) Maintain a current, signed and dated copy of an admission agreement for each waiver participant. At a minimum, the agreement must contain:~~
~~a) Basic charges agreed upon separating costs for room and board and personal care services,~~
~~b) Period of time to be covered in the charges,~~
~~c) List of itemized charges, and~~
~~d) Agreement regarding refunds for payments~~

~~The admission agreement must explain in detail the costs associated with, and agreed upon, for care services provided to the waiver participant. The costs for room and board must be clearly reflected in the agreement. The facility may not charge the waiver participant for the costs of care services over and beyond the reimbursable amount paid by Medicaid.~~

~~The admission agreement must be approved by the Division of Medicaid prior to the provision of waiver services. Any new or amended admission agreement must be submitted, and approved by the Division of Medicaid, prior to implementation.~~

~~2) Must provide a licensed nurse at the facility for a minimum of eight (8) hours a day to assist the residents with medication administration or oversight. The nurse must have an active and unencumbered license. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facility must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate~~

~~the Mississippi Nursing Practice Law or Administrative Code in any manner.~~

~~3) Waiver providers must provide training as follows:~~
~~- All staff must be provided with orientation training upon hire, and annually thereafter, in the following areas, including but not limited to:~~
~~a) Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation in accordance with the MS Vulnerable Person's Act~~
~~b) Rights and Dignity~~
~~c) HIPAA Compliance~~
~~d) Assisted Living Waiver Requirements~~
~~e) Emergency Preparedness~~

~~- All staff must maintain CPR and First Aid certifications.~~

~~- Direct care staff, excluding any RN, LPN, or CNA who maintains an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, must successfully complete a curriculum training course upon hire prior to rendering services and annually thereafter, as designated by DOM.~~

~~- 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.~~

~~- Documentation of completed training must be maintained at the facility and made available to DOM upon request. Failure to comply with training requirements will require an acceptable plan of correction by the provider. Continued non-compliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.~~

~~5) Must keep accurate documentation that reflects the care and services provided to the participant while in the facility. The record should clearly demonstrate when the resident leaves the facility for an overnight stay, whether it be for a hospitalization, visit with the family or any other occasion. This documentation is vital for Medicaid to reimburse for care. Failure to maintain the documentation may result in recoupment of funds by the Division of Medicaid.~~

~~6) Must maintain compliance with all requirements, regulatory rules and regulations and administrative codes as specified by the licensing agency. If a facility fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the facility demonstrates compliance with the regulatory agency. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the DOM.~~

~~7) Each provider must:~~
~~a) Conduct a national criminal background check with fingerprints on all employees prior to employment, and every two (2) years thereafter, and maintain the record in the employee personnel file.~~
~~b) Conduct checks, prior to employment and monthly thereafter, to ensure employees are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion List and maintain the record in the employee personnel file.~~
~~c) Not have been, or employ individuals who 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.~~

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements are detailed in Part 208 of the code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider is responsible for verifying the qualifications are met for all facility staff

~~DOM~~

Frequency of Verification:

~~Initially Prior to Enrollment and Annually Thereafter~~

Qualifications are verified upon enrollment/hire and thereafter as needed.

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:

~~Licensed social workers (LSW) employed by the Division of Medicaid are responsible for case management functions.~~

~~Qualifications for the social worker include:~~
~~1) Maintain an active, unencumbered and current license to practice social work in Mississippi~~
~~2) Have obtained a bachelor's degree in social work from an accredited university and,~~
~~3) Have two (2) years of full time experience in direct services to aged and disabled clients.~~
~~4)~~1) ~~Be certified as a qualified assessor for the comprehensive long term services and supports tool.~~

Licensed social workers (LSWs) employed by the Division of Medicaid are responsible for case management functions.

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 AL Waiver services must conduct national criminal background checks with fingerprints on all employees prior to employment, and every two (2) years thereafter. Prior to provider enrollment approval, the potential providers must submit documentation regarding the manner in which the national CBC was performed. Providers must not have been, nor employ individuals who have been, convicted of, or plead 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.~~

A national criminal background check with fingerprints must be conducted on all individuals providing case management, assisted living, or adult residential care for acquired traumatic brain injury participants in accordance with Title 23 of the Mississippi Administrative Code. Waiver specific provider compliance requirements are detailed in Part 208 of the code. Compliance with mandatory background check requirements is ensured through post payment audit activities as outlined in Appendix I of this 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):

~~The entity responsible for maintaining the Mississippi Nurse Aide abuse registry is the Mississippi Department of Health, Division of Licensure and Certification. The types of positions for which abuse registry screenings must be conducted include any individual providing direct care or supervision to the residents, owners, operators, and transportation drivers. The facility must assure that the Mississippi Nurse Aide Abuse Registry is checked prior to employment of the above mentioned employees, and monthly thereafter. The facility must maintain documented evidence in the personnel files of each employee to demonstrate to the Division of Medicaid that such checks have been made.~~

~~The Division of Medicaid ensures that mandatory screenings have been conducted by verification of documented evidence found during the on-site annual compliance review. Part of the on-site monitoring process includes reviewing personnel records of staff providing services. One of the elements reviewed is whether the abuse registry screening was conducted and returned indicating no history of abuse before the staff person began providing services. If it is found that an abuse registry screening was not conducted for a particular staff member or member(s), the staff member(s) are prohibited from providing services and the provider is required to develop a corrective action plan. The maximum length of time for the submission of a corrective action plan is 30 days, which may be altered by the Division of Medicaid given the nature and severity of the concern. Plans must demonstrate how the provider will correct the negative finding as well as address any systematic issues with timelines for each remedial activity. The Division of Medicaid (DOM) staff reviews and approves or disapproves all Plans. In order to ensure remedial activities have been completed, DOM requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance.~~

Screenings of the Mississippi Nurse Aide Registry and the Office of Inspector General's Exclusion Database must be conducted on all individuals providing ccase management, assisted living, or adult residential care for acquired traumatic brain injury participants in accordance with Title 23 of the Mississippi Administrative Code. Waiver specific provider compliance requirements are detailed in Part 208 of the code. Compliance with mandatory screening requirements is ensured through post payment audit activities as outlined in Appendix I of this waiver.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home - Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	☐
Assisted Living	☒

Facility Capacity Limit:

Mississippi Department of Health - Minimum Standards for Personal Care Homes Assisted Living. The maximum number of beds for which the facility is licensed shall not be exceeded.

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	☒
Assisted Living	☒

Facility Capacity Limit:

The maximum number of beds for which the facility is licensed shall not be exceeded.

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

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

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

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

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

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

☐ **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.

○ **XOther policy.**

Specify:

When a participant selects a provider facility 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 family is not normally considered a caregiver nor are they legally responsible for the participant. A person's spouse, a guardian/conservator, the executor of a person’s estate and/or an individual with durable/medical power of attorney for the person are considered legally responsible for the person.

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:

~~With respect to the waiver participant's free choice provisions, the Division of Medicaid (DOM) allows for a continuous, open enrollment period for Assisted Living waiver providers. The DOM website has information regarding the requirements and procedures for becoming a DOM approved provider allowing for continuous availability. The DOM Office of Long Term Care has a designated staff member available to provide assistance and guidance regarding the Assisted Living waiver provider application process. Provider proposal packets are available upon request.~~

All willing and qualified providers of Medicaid services may apply to the state to become a Medicaid provider. Medicaid providers agree to abide by Medicaid policy, procedure, rules and guidance. Provider enrollment information along with the credentialing requirements for each provider type and timeframes are available via the DOM website.

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.**~~

PM1: # and % of providers by provider type who met, and continue to meet, required credential standards in accordance with waiver qualifications throughout service provision. N: # 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 reviewed by provider type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**MMIS/Cognos**~~ **Financial and Performance Audit**

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):*
☒	☐	☒

X State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	X Less than 100% Review

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **X Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **X Other** Specify: Statistically Valid Sample Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **X Other** Specify: Every 24 months

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.

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 2: 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.**~~

PM 2: Number and percent of enrolled provider staff, trained in accordance with state requirements and the approved waiver. N: Number of of enrolled providers staff, trained in accordance with state requirements and the approved waiver. D: Total number of enrolled providers staff reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**Compliance Review**~~ **Financial and Performance Audit**

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **X Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval = Confidence Interval = 95%
Other	**X Annually**	**Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **X Other** Specify: Statistically Valid Sample Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ ~~**Annually**~~
	☐ **Continuously and Ongoing**
	☐ **X Other** Specify: Every 24 months

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.~~

DOM requires verification of credentials/qualifications for all providers prior to enrollment in accordance with Part 200 of the Medicaid Administrative Code. If an approved provider has failed to maintain required credentials and/or is deemed non-compliant with qualifications, DOM will hold a quality improvement strategy meeting within thirty (30) days to examine if any changes need to be implemented systemically. DOM will further investigate and notify providers of findings of non-compliance along with any remediation requirements, which may include the submission of a written corrective action plan (CAP) for DOM review and approval. If it is identified that a staff member at a provider facility does not meet the qualifications or training requirements outlined in Part 208 of the Medicaid Administrative Code, the provider will be notified of the finding and required to submit a CAP. In instances in which a CAP is required, the provider will have thirty (30) days to submit the written corrective action plan detailing the actions that will be taken to ensure immediate and ongoing compliance with requirements. Once DOM approves the submitted corrective action plan, the provider will have a defined timeframe to implement the plan fully. DOM will follow up to determine the effectiveness of remediation actions. If a provider does not submit an approved CAP or fails to implement the approved CAP, DOM may suspend and/or terminate the Medicaid provider number. Upon any discovery that a provider or their staff no longer meets qualifications, affected participants will be offered the opportunity to choose an alternate qualified provider.

ii. Remediation Data Aggregation

iii.

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

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

~~AL Waiver services are provided in a non-residential setting which must meet the requirements of the HCB settings.~~

~~Part 208, Chapter 3: HCBS Assisted Living (AL) Waiver~~
~~Rule 3.4: Freedom of Choice~~
~~Medicaid beneficiaries have the right to freedom of choice of approved Medicaid providers for services as outlined in Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.~~
~~Current language is in compliance with the final rule but is silent on the verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 3.4.B. with the Admin. Code filing effective January 1, 2017:~~
~~B. 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 3: HCBS Assisted Living (AL) Waiver~~
~~Rule 3.6: Covered Services~~
~~C. AL Waiver providers must provide:~~
~~1. A setting physically accessible to the participant but is not located in:~~
~~a) A nursing facility,~~
~~b) An institution for mental diseases,~~
~~c) An intermediate care facility for individuals with intellectual disabilities (ICF-IID),~~
~~d) A hospital providing long-term care services, or~~
~~e) Any other location that has qualities of an institutional setting.~~
~~2. A private, home-like living quarter with a bathroom consisting of a toilet and sink and must:~~
~~a) Be a unit or room in a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the waiver participant, and the participant has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity.~~
~~Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(5) which will be added to the following with the Admin. Code filing effective January 1, 2017:~~
~~Rule 3.6. C.1.e):~~
~~e)Any other location that has qualities of an institutional setting, as determined by the Division of Medicaid including, but not limited to, any setting:~~
~~1) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,~~
~~2)Located in a building on the grounds of or immediately adjacent to a public institution , or~~
~~3) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).~~
~~Rule 3.6.C.2.a)~~
~~C. For settings in which landlord tenant laws do not apply, the Division of Medicaid must ensure that:~~
~~(1) A lease, residency agreement or other form of written agreement will be in place for each HCBS person, and~~
~~(2) That the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.~~

~~The state provides ongoing monitoring to ensure that all settings comply with requirements through annual unannounced on-site compliance audits.~~

Assisted Living Waiver services are provided in a non-residential setting which must meet the requirements of the HCB settings. Part 208, Chapter 3 of the Medicaid Administrative Code requires enrolled AL waiver providers to ensure settings are fully integrated with opportunities for full access to the greater community and meet the requirements of the Home and CommunityBased (HCB) settings. It further defines that the Division of Medicaid does not cover AL waiver services to persons in 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). All AL provider requirements are in compliance with and support 42 CFR § 441.301(c)(4)(iii) Final Rule and the state continues to comply with our approved Statewide Transition Plan. Compliance with the Final Rule is monitored through quality interviews with participants and post-payment audits outlined in Appendix I of this waiver

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☒ **Social Worker**

Specify qualifications:

~~Licensed social workers employed by the Division of Medicaid.~~
~~Qualifications for the social worker include:~~
~~1) Maintain an active, unencumbered and current license to practice social work in Mississippi~~
~~2) A bachelor's degree in social work from an accredited university and,~~
~~3) Two (2) years of full time experience in direct services to aged and disabled clients.~~
~~4)~~1) ~~Be certified as a qualified assessor for the comprehensive long term services and supports tool.~~

Licensed social workers employed by the Division of Medicaid. Qualifications for the social worker include:

1) Maintain an active, unencumbered and current license to practice social work in Mississippi
2) A bachelor's degree in social work from an accredited university and,
3) Two (2) years of full time experience in direct services to aged and disabled clients.
4) Be certified as a qualified assessor for the comprehensive long term services and supports tool.

Other

☐

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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 Division of Medicaid (DOM) provides case management to the waiver participants in this waiver. The case manager strives to engage the waiver participant, and if desired, a chosen representative in the development of the plan of services and supports (PSS). Prior to admission to the waiver, the case manager provides the participant, or his/her representative, information regarding all available services and waiver providers. The participant, or his/her representative, makes an informed choice between receiving long term care services in an institutional setting or waiver services in the home and community based residential setting. They also choose the assisted living facility where they want to reside and receive services. Once the participant has made an informed choice for waiver services, the case manager assesses for clinical eligibility. When it is determined that the participant meets both clinical and financial eligibility, the case manager works with the waiver participant, and if so desired, his or her representative to develop a PSS that best meets the participant's needs, goals and personal preferences. The participant is actively involved in developing the PSS and also has the authority to engage responsible parties or others to help as desired.~~

After the applicant understands the criteria for the waiver, has made an Informed Choice, and meets clinical eligibility, as determined by the LTSS assessment process, the person-centered planning is initiated. The case manager engages the person, caregivers and other interested parties, as requested by the person, in the development of the Plan of Services and Supports (PSS). The PSS development includes discussing options, desires, individual strengths, personal goals, emergency preparedness needs, specific needs of the person, and how those needs can be best met. The meeting is held at a time and location of the person's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

~~The State uses a comprehensive long-term services and supports process to ensure that the plan of services and supports is participant-centered, and that it fully captures the waiver participant's needs, strengths, preferences, goals and risk factors. The comprehensive long-term services and supports tool is a collection of objective clinical eligibility criteria that is applied uniformly. Incorporated in the process is a mechanism to assure the waiver participant makes an informed choice between institutional and community-based services. The process also supports nursing facility transition into the community.~~

~~A DOM case manager, who is a licensed social worker, the waiver participant, their caregivers and or others chosen by the participant, collectively work to identify the participant's personal goals, health care needs and preferences. The case manager is responsible for informing the waiver participant and others chosen by the participant, about State Plan services and other programs furnished through other State and Federal programs. The case manager coordinates waiver services and non-waiver services to meet the needs of the waiver participant.~~

~~The case manager is responsible for continued and ongoing monitoring of the waiver participant's needs and the effectiveness of the plan of services and supports (PSS). The plan is reevaluated on a regular basis through monthly contacts with the participant. However, a quarterly review of the PSS is required. If a change in the PSS is warranted or desired by the waiver participant, the waiver participant and other persons of their choice will confer with the case manager to identify potential changes. The PSS is updated annually or more frequently based on the individual needs, desires and goals of the waiver participant.~~

~~Informed Choice is ensured by the case manager by informing the waiver participant and/or person of their choice of the available Medicaid-covered long-term care options, including alternatives to Nursing Facility placement. The waiver participant acknowledges their participation in the care planning process by signature or initials and attests to having the long-term care program options explained to him/her.~~

~~The person-centered plan development meetings are scheduled at times and locations that are convenient for the waiver applicant/participant and or their representative. Upon initial enrollment into the waiver, the case manager contacts the applicant, and or their designated representative, via telephone to schedule a convenient time and meeting location. This contact is made immediately upon notice of an available waiver slot. At the time of recertification, the case manager notifies the waiver participant, and/or their designated representative, at least a month prior to the recertification deadline to schedule a convenient time and meeting location.~~

The LTSS assessment and the PSS development process is driven by the person with their informed consent and is conducted by the case manager(s). The person may freely choose to allow anyone (friends, family, caregivers, etc.) to be present and/or contribute to the process of developing the PSS. The initial PSS is developed at the time of the completion of the LTSS core standardized assessment with the case manager(s). Persons found clinically eligible for long term services and supports are provided information about available services and supports. The person is given a description and explanation of the services provided by the waiver along with any specific qualifications that apply to each service. The applicant is then allowed to make an informed choice between institutional care and community-based services and among waiver services and providers. The LTSS assessment includes information about the person's health status, needs, preferences and goals. The development of the PSS utilizes this information and addresses all service options, desires, personal goals, emergency preparedness needs, other specific needs of the person and how those needs can be met. The PSS also reflects and identifies the existing services and supports, along with who provides them. DOM is responsible for implementing and monitoring the PSS. The case manager is responsible for coordination of waiver services, in addition to facilitating referrals to State Plan services and services provided through other funding sources/service agencies as needed. The PSS is developed at the time of the completion of the LTSS assessment, reviewed quarterly and updated annually or at the request of the person. The PSS is signed by all of the individuals who participated in its development. Each person and/or their designee is given a copy of the PSS along with other people involved in the plan. Also, each person is given the phone number for the case manager and their supervisor, should they have any questions or concerns regarding their services. The PSS may be updated to meet the needs of the individual at the request of the person or if changes in the person's circumstances and needs are identified.

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.

Risks are assessed based upon the following processes:

Upon initial enrollment into the waiver, the Case Manager meets with the participant, and/or designated responsible parties and representatives, to identify and/or confirm the presence of, or potential for, risks. A risk assessment tool is used to capture the specific risks as related to the community living, health, work, and leisure. The risk assessment tool captures the following:
a) What is the team's (Case Manager, provider and designated parties) evaluation of the risks?
b) What can be done differently to prevent these risks?
c) What strengths/assets does the participant have toward prevention?
d) Who can help with prevention measures?
e) What supports would minimize the risks?
f) Who can provide the supports?

A person-centered approach is developed with a focus on the waiver participant's needs, goals and preferences. Following enrollment into the waiver, the case manager continues assessing for risks during the monthly and quarterly visits.

The identified risks are addressed through coordination with the Assisted Living waiver provider, the participant and others, as designated, being fully involved in developing measures to resolve and manage apparent risks and to reduce future risk development. Participant-specific risk plans, included in the plan of services and supports (PSS) proactively and reactively address the risk issue. Annually, the person centered PSS is reevaluated during the recertification process and updated accordingly based on needs identified during the risk assessment.

It is the case managers responsibility to monitor each participant's potential for risk and to assist with developing mitigation strategies. Case managers are evaluated based on their documentation of participant needs and care. This includes evaluations of follow up on incident reports, and a review of information gathered from case managers' routine visits including documentation of how providers are implementing a participant's risk management plan.

Risk factors to be considered are:
1. Potential for abuse, neglect and exploitation.
2. Deviant behavior from that which is commonly regarded as acceptable by societal norms. These specific behaviors are wandering, inappropriate sexual behavior, assaultive behavior, and resistance to physical care. This also includes "thought impairment" such as hallucination, delusion, or suicidal ideation that is not related to a severe and persistent mental illness.
3. The inability to communicate information in a manner that is understandable.
4. Incontinence or the inability to control his/her body to empty the bladder and/or bowel with the inability to self-manage related needs.
5. Falling, or a history of falls occurring at least twice in the past 60 days resulting in injury which required physician treatment or hospitalization.
6. Inability to manage hydration or nutritional needs.
7. A history of the waiver participant having placed him/herself at risk through an action or inaction which resulted in Adult Protective Services or law enforcement referral, hospitalization, increased service need, or decrease in physical or mental capability.
8. The participants' lack of caring friends/relatives/neighbors/staff or non-waiver providers who are physically, mentally, and psychologically able and willing to provide any care or support.

Backup plans are developed on an individual participant basis. Backup risk mitigation plans must include staffing requirements for 24 hour coverage as outlined in state Administration Code, Minimum Standards for Personal Care Homes, Assisted Living, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart1: Health Facilities and Certification:

The following staff ratio shall apply:
One (1) resident attendant per fifteen (15) or fewer residents for the hours of 7:00 a.m. until 7:00 p.m.
One (1) resident attendant per twenty-five (25) or fewer residents for the hours of 7:00 p.m. until 7:00 a.m.. There shall be designated, in writing and posted in a conspicuous place, on-call personnel in the event of an emergency, during this shift.
There shall be, at minimum, a licensed nurse on the premises for eight (8) hours a day. Licensed nurses cannot be

~~included in the resident attendant ratio. Licensed practical nurses must furnish care in accordance with the Mississippi Nurse Practice Law in regards to required supervision.~~

~~The assisted living waiver provider must also have disaster preparedness and management procedures to ensure that waiver participant's care, safety, and well- being is maintained during and following instances of natural disasters, disease outbreaks, or similar situations.~~

~~In the event of the closure of an Assisted Living waiver provider, the Division of Medicaid, the participants and their designated representatives, along with the licensing agency will work collaboratively to arrange for the appropriate transfer of waiver participants to other Medicaid approved providers of the participant's choice.~~

~~Upon admission to the waiver and during the annual re-assessment, the case manager documents who should be notified in the case of an emergency, disaster- or when there is an unforeseen need for back up arrangements. Additionally, the case managers keep easily accessible a list of other available Medicaid approved providers preferred by the waiver participant. This information is also included in the overall PSS.~~

The presence and effect of risk factors are determined during the LTSS assessment and PSS process. The assessment is specifically designed to assess and document risks an individual may possess. The PSS includes identified potential risk to the person's health and welfare. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. Risk factors include documented instances of abuse/neglect/exploitation, socially inappropriate behavior, communication deficits, nutrition concerns, environmental security and safety issues, falls, disorientation, emotional/mental functioning deficits, and lack of informal support. The person's involvement and choice are used to develop mitigation strategies for all identified risk. The person, along with caregivers/supports, is included in developing strategies and are encouraged to comply with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the case manager. Monthly and quarterly actions are required to review/assess the person's service needs, with a new PSS developed every twelve months. Back up plans are developed by the case manager(s) in partnership with the person and their family/caregiver upon admission. The PSS must include back up providers chosen by the participant who will provide services when the assigned provider is unable to provide care. The person and/or their caregiver identify family members and/or friends who are able to provide services/support in the event of an emergency. During a community disaster or emergency, the case manager notifies the case manager supervisor, who then notifies the local first response team (i.e. the Mississippi State Department of Health) of persons with special needs who may require special attention. The development of the PSS also includes developing an emergency preparedness plan (EPP) for all persons. The EPP includes emergency contact information as well as outlining the individual's evacuation plan/needs in case of a fire or natural disaster.

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.

~~The waiver participant and/or others as chosen by the waiver participant, are given a list of qualified providers. They, along with the case manager, review the list to determine which provider would best meet the needs, goals and desires of the waiver participant. The waiver participant and/or their other chosen party is given an opportunity to meet the provider prior to the selection in order to make a more informed choice. Once all the options are taken into consideration, the waiver participant and/or chosen party selects the provider they feel best meets the needs of the participant. On an ongoing basis, the case manager provides ready access to information about qualified providers.~~

~~When a participant selects a company 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 company is not normally considered a caregiver nor is legally responsible for the participant. 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.~~

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 one 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. The selected provider is documented on the PSS which is then signed by the person or caregiver acknowledging their free choice of provider.

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):

~~Prior to submitting the proposed plan of services and supports(PSS) to the Division of Medicaid for review and approval, the participant and or their chosen parties, the Assisted Living waiver provider staff and the case manager, discuss all of the available options, the specific needs, goals and desires of the participant, and how the needs can met. Once this collaboration occurs, the PSS is forwarded to the Division of Medicaid electronically for the review and approval process. Once the PSS is approved by DOM qualified staff, an overall decision is forwarded to the case manager. The case manager is required to make monthly contacts with the participant and/or responsible party and quarterly face to face visits to the participant in the Assisted Living facility.~~

~~Each participant and his/her designated representative is given contact information for the case manager should they have any questions or concerns regarding services or care.~~

~~The Division of Medicaid exercises oversight of plans of services and supports on a routine basis through the monthly and quarterly review process conducted by case managers.~~

After the person understands the criteria for the waiver, has made an informed choice, and meets clinical eligibility, the LTSS assessment along with the PSS are submitted to the DOM electronically which includes all of the service needs, personal goals and preferences of the person. A registered nurse at DOM will review the LTSS assessment and the PSS, and notify case manager(s) in a timely manner of the approval/disapproval of services requested.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

~~The plan of services and supports (PSS) is the fundamental tool by which the State assures the health and welfare of waiver participants in the Assisted Living waiver. The State's process for developing a waiver participant's PSS requires the plan to be based on a comprehensive long-term services and supports process which identifies the needs, preferences and goals of the participant. The approved waiver specifies that a licensed social worker in conjunction with the waiver participant and others as requested by the participant are jointly responsible for plan development. PSSs are reviewed and approved by a licensed registered nurse at the Division of Medicaid. Monthly contacts with the waiver participants by the case manager are conducted to determine the appropriateness and effectiveness of the waiver services, and to ensure that the services furnished are consistent with the participant's needs, goals and preferences. A monthly contact with the waiver participant provides oversight for utilization review to determine if services are provided in accordance with the approved PSS. The minimum time frame for conducting the face-to-face interview is every 3 months. The quarterly visit is to ensure that services are on-going and also to identify any problems or changes that may be required.~~

~~If implementation of the PSS is in question during the monitoring process, the DOM reviewer will follow up with the appropriate case manager and/or supervisor to resolve issues. If a systematic problem is identified, DOM will review the policies and procedures to determine how best to intervene and rectify the problem. Resolution may require a change in policy or possibly can be corrected through training and education.~~

~~On an ongoing, continuous basis, the case managers are evaluating and monitoring the implementation of the PSS as well as service delivery. Case managers are sensitive to waiver participant's right to exercise their free choice of providers and will assist the participant if or when they choose to change assisted living providers. Likewise, case managers monitor the backup plans and access to non-waiver services in the state plan on an ongoing basis to assure the participant's welfare is maintained and their needs are met. When non-waiver service needs are identified, such as, the need for diapers or medical equipment, it is the case manager's responsibility to assist the participant in meeting these needs through the State Plan coverage or other available resources. The case manager assures the participant is knowledge of services that are available through the State Plan or other resources.~~

The PSS is the fundamental tool by which the State ensures the health and welfare of waiver persons enrolled in the 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 manager(s) along with the person and others as requested by the person are jointly responsible for the development of the PSS. Quarterly 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. Additional monthly contacts, either face-to-face or by phone/video, 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, DOM 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:*

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 persons whose PSS was reviewed.**~~

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 persons whose PSS was 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):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☒ **X 100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **X Continuously and Ongoing**	**Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
~~**PM 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.**~~

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

Data Aggregation and Analysis:

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

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.**~~

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**~~ **Financial and Performance Audit**

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):*
☒ **X State Medicaid Agency** ☐	☐ **Weekly** ☐	☐ **100% Review** ☒
☐ **Operating Agency**	☐ **Monthly**	☒ **X Less than 100% Review**
Sub-State Entity ☐	**Quarterly** ☒	~~**Representative Sample**~~ ~~Confidence Interval =~~ ☐ ~~Confidence Interval = 95%~~
Other Specify:	**X Annually** ☐	**Stratified** Describe Group: ☐
	Continuously and	**X Other**

	Ongoing	Specify: Statistically Valid Sample Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ ~~**Annually**~~
	☐ **Continuously and Ongoing**
	☐ **X Other** Specify: Every 24 months

c. ***Sub-assurance: Service plans are updated/revised 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☒ **X 100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
~~**PM 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.**~~

PM 5: Number and percent of persons reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. N. Number of persons reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. D. Total number of persons reviewed who reported receiving services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**Compliance Review**~~ **QA Home Visits/Telephone Interviews**

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):*

☒ **X State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **X Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = ~~Confidence Interval =~~ 95% with a +/- 5% margin of error
Other Specify:	☐ **X Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

☐

Other Specify:	**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):*
	☐ **X Other** Specify: 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' PSS reviewed with documented presentation of available service options and freedom of choice of providers. N: Number of persons' PSS reviewed with documented presentation of available service options and freedom of choice of providers. D: Total number of PSS reviewed.**~~

PM 6: Number and percent of persons reviewed with documented presentation of available service options and freedom of choice providers. N: Number of persons reviewed with documented presentation of available service options and freedom of choice providers. D: Total number of PSSs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~**LTSS**~~ **Financial and Performance Audit**

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**	☐ **X Less than 100% Review**
Sub-State Entity ☐	**Quarterly** ☐	**Representative Sample** Confidence Interval = ☐
Other	**X Annually**	**Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **X Other** Specify: Statistically Valid Sample as Determined by an Independent Statistician
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 Manager of deficiency via clarification request; (b) require Case Manager 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 Manager of deficiency via clarification request; (b) require Case Manager to respond to deficiency within seven business days; (c) conduct Case Manager training 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 Manager to complete quarterly update; (b) require Case Manager supervisor to submit a corrective action plan within thirty days; (c) provide Case Manager training annually to educate them on DOM waiver requirements for case management.~~

~~For PM 4, DOM will (a) immediately notify Case Manager of deficiency via clarification request; (b) require Case Manager 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 case manager training on waiver requirements.~~

~~For PM 5, DOM will (a) notify Case Manager of identified PSS where services were provided outside of the type, scope, amount, duration, and frequency (b) require Case Manager 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 Manager 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 Manager 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.~~

In any instance in which it is discovered that the person-centered service plan was not developed, reviewed/updated, or implemented in accordance with the procedures outlined in Appendix D of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. In these instances, DOM will implement a corrective action plan (CAP) and conduct necessary follow up to determine the effectiveness of remediation actions.

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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 Division of Medicaid.

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 requires, 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 manager 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 manager supervisor in the Office of Long Term Care 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.

Waiver participants may be discharged from the waiver for the following reasons:
(1) The participant and/or their legal representative requests termination;
(2) After intervention is provided, the participant refuses to be served;
(3) The participant has been found to no longer meet the program eligibility criteria;
(4) The participant is not available for services at the Assisted Living waiver provider facility for more than thirty (30) days. This is usually the case when a participant enters a Medicaid covered institution or when a participant leaves the assisted living

~~provider for more than thirty days at a time;~~
~~(5) The participant is a threat to him/herself or others;~~
~~(6) The participant is in a hazardous environment that is found to be unsafe for the participant and/or caregivers. When it is found to be an unsafe environment for the participant, the State notifies the Mississippi State Department of Health Facilities Licensure and Certification Division, the State Attorney General's Office and the Department of Human Services to assist with an investigation and to seek a safer environment for the participant. The case manager is the first line of contact with the participant and these cases are reported to Division of Medicaid and consideration of a decision to terminate services is ultimately the responsibility of DOM.~~

~~All records that pertain to adverse actions, the opportunity to request a fair hearing, appeal documentation and final determinations are maintained by the Office of Long Term Care at the Division of Medicaid.~~

With DOM approval, a person may 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. 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. Applicant is informed of Fair Hearing process during entrance to waiver by the Case Manager. A case manager sends a Notice of Action (NOA) to the person by certified mail (signature return requested) on any adverse action related to choice of provider or service; or denial, reduction, suspension or termination of service. Fair Hearing Notices are maintained in person's file at the DOM Central Office. 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 participant has the right to file an appeal; d. Procedures for filing an appeal; e. Notification of participant's right to request a Fair Hearing; f. Notice that the participant 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 manager or other 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, DOM 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. Case management staff will notify person if services will remain in place during the appeal process. 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 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 are encouraged to attempt to resolve disputes with the Assisted Living waiver provider. When participants are unable to resolve disputes with the provider, they are advised and encouraged to report the issue to their case manager(CM), who is a licensed social worker. The CM responds to the participant within 24 hours. If a resolution is not reached within 72 hours, the CM reports the issue to the CM Supervisor. The CM 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 the Director of the Office of Long Term Care at the Division of Medicaid.. The Office Director, along with the CM Supervisor and the CM, will work towards a resolution within seven days. In the event the dispute is with the CM, then the CM Supervisor works with the participant to assign a new CM. Once a new CM is assigned, the CM Supervisor evaluates the participant's satisfaction with the new CM within the following month and notifies Office Director of the final resolution. The Office Director and the CM Supervisor are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the CM at the time they are enrolled in the waiver of 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 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.~~

The informal dispute resolution process is initiated with the case manager(s) 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 are encouraged to report disputes to their case manager(s). However, dispute resolution can start at any level in the process. If a resolution is not reached by the person and the case manager within seventy-two (72) hours of the initial report by the person, the case manager(s) reports the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. In the event the dispute is with the case manager(s) then the case management agency and DOM work with the person to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the person's satisfaction with the new case management staff within the following month and documents the final resolution. DOM is responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by the case manager 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 CM Supervisor 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 disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants are encouraged to attempt to resolve disputes with the Assisted Living waiver provider. When participants are unable to resolve disputes with the provider, they are advised and encouraged to report the issue to their case manager(CM), who is a licensed social worker. The CM responds to the participant within 24 hours. If a resolution is not reached within 72 hours, the CM reports the issue to the CM Supervisor. The CM 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 the Director of the Office of Long Term Care at the Division of Medicaid. The Office Director, along with the CM Supervisor and the CM, will work towards a resolution within seven days. In the event the dispute is with the CM, then the CM Supervisor works with the participant to assign a new CM. Once a new CM is assigned, the CM Supervisor evaluates the participant's satisfaction with the new CM within the following month and notifies Office Director of the final resolution. The Office Director and the CM Supervisor are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the CM 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 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.~~

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 manager(s), but may address any complaint/grievance to DOM at any time. The case manager(s) begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case manager(s) reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. In the event the complaint/grievance is with the case manager, then DOM will work with the participant to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the participant's satisfaction with the new case management staff within the following month and documents 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 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).

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.

Complaints of abuse, neglect or exploitation of a participant such as in an Assisted Living Waiver provider are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of assisted living waiver providers.

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.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:
(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any care facility that complies in good faith with the requirements of this section to report the abuse or exploitation of a waiver participant in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both

such fine and imprisonment.
(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all.

The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.

The Attorney General's (AG) office is legislatively mandated to investigate and enforce the law regarding alleged abuse, neglect and exploitation in licensed health care facilities. Specific enforcement guidelines are depicted in the Mississippi Vulnerable Persons Act of 1986, §43-47-1 of the Mississippi Code of 1972, as amended. The AGs office receives allegations both electronically and orally via a toll free long distance number. Once allegations are received, the chief investigator reviews each complaint to determine if the allegation falls within their jurisdiction or purview to investigate. The facility has seventy-two (72) hours to provide the Mississippi Attorney General's (MFCU) and the Mississippi State Department of Health with a written report regarding their investigation of the alleged incident. Once the review is completed the allegation is assigned to an investigator according to its scope and severity of the issue. The Chief Investigator or the Investigator assigned to the case will follow up with the facility to ensure that the facility has provided the Mississippi Attorney General's Office (MFCU) with the written report. The investigator assigned to the case has 72 hours to contact the provider or individual reporting the alleged incident which prompts a written report of facility findings. Investigations consist of a variety of information gathering techniques including, but not limited to, interviewing, observation, medical record review, and record analysis. At the request of the DOM, the Mississippi Attorney General's Office (Medicaid Fraud and Control Unit) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation.

DOM and the AG's office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.

The Mississippi Department of Health has a complaint hotline that allows for individuals to file complaints against assisted living facilities. An individual staffs this telephonic hotline Monday – Friday during normal business hours, an answering machine is activated for coverage allowing complainants to record their concerns/complaint, thus triggering follow up or a call back from the hotline coordinator with a target response of twenty-four (24) hours. This hotline allows facilities to self-report critical incidents and or complaints of alleged abuse, neglect and exploitation.

Critical incidents and complaints are triaged via an intake triage committee which consists of a nurse and representatives for long-term care and other staff members. Based on the scope and severity of the allegations, the complaint will be scheduled accordingly. There are seven action levels of triage as follows:
a) Immediate Jeopardy (Investigations begin within two [2] working days of the notification)
b) Non-Immediate Jeopardy (Investigations begin within ten [10] working days of the notification)
c) High, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification)
d) Medium, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification)
e) Low, Administrative Review/Off Site Investigation (Investigations begin within forty-five [45] working days of the notification)
f) Referral
g) No Action Necessary

Assisted Living facilities are required to report incidents of alleged abuse, neglect or exploitation orally or telephonically within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays and in writing within seventy-two (72) hours of discovery. If the facility fails to report in accordance with this regulation, the investigator will investigate for potential noncompliance with this regulatory requirement.

Incidents are evaluated to determine the degree of harm to the waiver participant, the thoroughness of the facility to investigate the circumstances related to the event, the facilities implemented corrective action and the effectiveness of the corrective actions. If the investigator determines the facility has not taken appropriate action and a serious situation is

~~ongoing, an investigation will occur.~~

~~Investigations are conducted by making an onsite visit, record review (charts, policies, procedures, minutes, etc.), interviews with staff, family, waiver participants, and personal observations. Within 10 days of exiting the facility, the investigator must provide a written report to the facility that includes the investigative findings. These findings are presented as a legal document with a cover letter. When negative findings are cited, the facility must submit an acceptable plan of correction. Once the facility has had a chance to implement changes necessary to rectify the negative findings, the investigator will return to the facility to determine if the facility is back in compliance.~~

~~The Mississippi State Department of Health works closely with the Division of Medicaid to assure the process of protecting the health and welfare of our waiver participants is maintained. Each agency shares information freely regarding critical incidents including the types of complaints, investigations and outcomes. This free flow of communication allows the state to develop a system in which all allegations are tracked as well as allows the DOM to determine if trends exist. Working collaboratively, the two agencies address ways to improve detection and prevent abuse, neglect and exploitation of our waiver participants.~~

~~The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.~~

~~When participants are initially assessed for the Assisted Living Waiver program, they are informed of the contact information of the case manager. The CM maintains monthly contact with each participant and/or responsible party by telephone or visit to the Assisted Living facility. Face-to-face visits are made to the participant at their residence in the Assisted Living waiver provider or other home and community-based setting on a quarterly basis. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or responsible party has notified the CM of their concern, a visit to the facility is made as soon as can be arranged. The purpose of the visit to the facility is to assess the participant and the environment, document an account of the occurrences and notify the proper authorities. The CM determines if the environment is free of harm or perceived threat for the waiver participant.~~

~~The facility must develop and maintain policies and procedures to guide staff in the early detection and prevention of abuse, neglect and exploitation. These policies and procedures must be implemented to assure the safety and welfare of the waiver participants. When an allegation of abuse has occurred, the facility must provide evidence that the safety and welfare of all waiver participants is protected by removal of the accused perpetrator from the facility until such time that a thorough investigation has been completed.~~

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant. Complaints of abuse, neglect or exploitation of a participant such as in an Assisted Living Waiver provider are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General’s Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community-based settings would be reported to the Mississippi Department of Human Services. The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of assisted living waiver providers. 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. Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows: (1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation. (2) The reporting of conduct shall be made: (a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office. (b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit. (2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting: (a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting; (b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation; (c) The details, observations and beliefs concerning the incident; (d) Any statements relating to incident made by the patient or resident; (e)

The date, time and place of the incident; (f) The name of any individual(s) believed to have knowledge of the incident; (g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and (h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested. (3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit. (4) Any care facility that complies in good faith with the requirements of this section to report the abuse or exploitation of a waiver participant in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility. (5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both

such fine and imprisonment. (6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all. The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection. The Attorney General's (AG) office is legislatively mandated to investigate and enforce the law regarding alleged abuse, neglect and exploitation in licensed health care facilities. Specific enforcement guidelines are depicted in the Mississippi Vulnerable Persons Act of 1986, §43-47-1 of the Mississippi Code of 1972, as amended. The AGs office receives allegations both electronically and orally via a toll free long distance number. Once allegations are received, the chief investigator reviews each complaint to determine if the allegation falls within their jurisdiction or purview to investigate. The facility has seventy-two (72) hours to provide the Mississippi Attorney General's (MFCU) and the Mississippi State Department of Health with a written report regarding their investigation of the alleged incident. Once the review is completed the allegation is assigned to an investigator according to its scope and severity of the issue. The Chief Investigator or the Investigator assigned to the case will follow up with the facility to ensure that the facility has provided the Mississippi Attorney General's Office (MFCU) with the written report. The investigator assigned to the case has 72 hours to contact the provider or individual reporting the alleged incident which prompts a written report of facility findings. Investigations consist of a variety of information gathering techniques including, but not limited to, interviewing, observation, medical record review, and record analysis. At the request of the DOM, the Mississippi Attorney General's Office (Medicaid Fraud and Control Unit) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation. DOM and the AG's office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected. The Mississippi Department of Health has a complaint hotline that allows for individuals to file complaints against assisted living facilities. An individual staffs this telephonic hotline Monday - Friday during normal business hours, an answering machine is activated for coverage allowing complainants to record their concerns/complaint, thus triggering follow up or a call back from the hotline coordinator with a target response of twenty-four (24) hours. This hotline allows facilities to self-report critical incidents and or complaints of alleged abuse, neglect and exploitation. Critical incidents and complaints are triaged via an intake triage committee which consists of a nurse and representatives for long term care and other staff members. Based on the scope and severity of the allegations, the complaint will be scheduled accordingly. There are seven action levels of triage as follows: a) Immediate Jeopardy (Investigations begin within two [2] working days of the notification) b) Non-Immediate Jeopardy (Investigations begin within ten [10] working days of the notification) c) High, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification) d) Medium, Non-Immediate Jeopardy (Investigations begin within forty-five [45] working days of the notification) e) Low, Administrative Review/Off Site Investigation (Investigations begin within forty-five [45] working days of the notification) f) Referral g) No Action Necessary Assisted Living facilities are required to report incidents of alleged abuse, neglect or exploitation orally or telephonically within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays and in writing within seventy-two (72) hours of discovery. If the facility fails to report in accordance with this regulation, the investigator will investigate for potential noncompliance with this regulatory requirement. Incidents are evaluated to determine the degree of harm to the waiver participant, the thoroughness of the facility to investigate the circumstances related to the event, the facilities implemented corrective action and the effectiveness of the corrective actions. If the investigator determines the facility has not taken appropriate action and a serious situation is

ongoing, an investigation will occur. Investigations are conducted by making an onsite visit, record review (charts, policies, procedures, minutes, etc.), interviews with staff, family, waiver participants, and personal observations. Within 10 days of exiting the facility, the investigator must provide a written report to the facility that includes the investigative findings. These findings are presented as a legal document with a cover letter. When negative findings are cited, the facility must submit an acceptable plan of correction. Once the facility has had a chance to implement changes necessary to rectify the negative findings, the investigator will return to the facility to determine if the facility is back in compliance. The Mississippi State Department of Health works closely with the Division of Medicaid to assure the process of protecting the health and welfare of our waiver participants is maintained. Each agency shares information freely regarding critical incidents including the types of complaints, investigations and outcomes. This free flow of communication allows the state to develop a system in which all allegations are tracked as well as allows the DOM to determine if trends exist. Working collaboratively, the two agencies address ways to improve detection and prevent abuse, neglect and exploitation of our waiver participants. The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and

exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported. When participants are initially assessed for the Assisted Living Waiver program, they are informed of the contact information of the case manager. The CM maintains monthly contact with each participant and/or responsible party by telephone or visit to the Assisted Living facility. Face-to-face visits are made to the participant at their residence in the Assisted Living waiver provider or other home and community-based setting on a quarterly basis. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or responsible party has notified the CM of their concern, a visit to the facility is made as soon as can be arranged. The purpose of the visit to the facility is to assess the participant and the environment, document an account of the occurrences and notify the proper authorities. The CM determines if the environment is free of harm or perceived threat for the waiver participant. The facility must develop and maintain policies and procedures to guide staff in the early detection and prevention of abuse, neglect and exploitation. These policies and procedures must be implemented to assure the safety and welfare of the waiver participants. When an allegation of abuse has occurred, the facility must provide evidence that the safety and welfare of all waiver participants is protected by removal of the accused perpetrator from the facility until such time that a thorough investigation has been completed.

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.

~~The State assures that training is provided to the waiver participants and others, as designated by the participant, concerning the State's protection from abuse, neglect, and exploitation, including how these individuals can notify appropriate authorities or entities when the alleged abuse has occurred. Case managers will be responsible for providing this training and information upon admission to the waiver and then annually thereafter. This information is provided verbally and in written form to the participant and other involved individuals.~~

~~When participants are initially assessed for the Assisted Living Waiver program, they are informed of the contact information of the case manager. The CM maintains monthly contact with each participant and/or responsible party by telephone or visit to the Assisted Living facility. Face-to-face visits are made to the participant at their residence in the Assisted Living waiver provider or other home and community-based setting on a quarterly basis. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or responsible party has notified the CM of their concern, a visit to the facility is made as soon as can be arranged. The purpose of the visit to the facility is to assess the participant and the environment, document an account of the occurrences and notify the proper authorities. The CM determines if the environment is free of harm or perceived threat for the waiver participant.~~

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff. Upon initial entry into the waiver, case manager(s) 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. At that time, they are provided the names and phone numbers of their case manager(s). The person is contacted by the case manager(s) on a monthly basis (by phone or face-to face visit). 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 by phone, a face-to-face visit is conducted. The purpose of this visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM is notified of any suspected abuse, neglect, exploitation cases as they occur, and is available to provider support in ensuring a prompt resolution, if feasible.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives

reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant.

Complaints of abuse, neglect or exploitation of a participant such as in an assisted living facility are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community based settings would be reported to the Mississippi Department of Human Services.

The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of Assisted Living waiver providers.

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.

Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows:
(1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation.
(2) The reporting of conduct shall be made:
(a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office.
(b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit.
(2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting:
(a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting;
(b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation;
(c) The details, observations and beliefs concerning the incident;
(d) Any statements relating to incident made by the patient or resident;
(e) The date, time and place of the incident;
(f) The name of any individual(s) believed to have knowledge of the incident;
(g) The name of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and
(h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested.
(3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit.
(4) Any Assisted Living provider that complies in good faith with the requirements of this section to report the abuse or exploitation of a patient or resident in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility.
(5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding Five

~~Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both such fine and imprisonment.~~
~~(6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all~~

~~The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection.~~

~~For allegations deemed potentially immediate jeopardy situations, an Investigation will be initiated with two (2) working days of receipt of the complaint. The purpose of the onsite visit is to assure that all participants who could be affected by the reported situation are adequately protected from harm and to verify the provider's ability to correct the circumstances creating the immediate jeopardy.~~
~~For allegations that are considered non-immediate jeopardy- high risk, an investigation will be initiated within ten (10) working days of receipt of the complaint.~~
~~For allegations that are considered non-immediate jeopardy - medium risk, an investigation will be initiated within forty-five (45) working days of the receipt of the complaint.~~
~~For allegations that are considered Non-Immediate jeopardy - low risks, an onsite investigation may not be scheduled, but the allegation will be reviewed at the next onsite visit.~~

~~The assigned complaint investigator will contact the participant during the course of the on-site investigation to advise them that the investigation is in progress and to validate details of the reported allegation. Following completion of the investigation and the processing of required documents, the participant will be notified. Timeframes of notification vary depending on the amount of time it takes to complete an investigation but notification occurs once the investigation is completed~~

~~The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported.~~

~~When an allegation of abuse, neglect or exploitation occurs, the Assisted Living waiver provider staff is required to report to the Department of Health and the Attorney General's office.~~

The State has systems in place to focus on identification and follow up to critical events or incidents that have potential to bring or create harm to a waiver participant. Complaints of abuse, neglect or exploitation of a participant such as in an assisted living facility are statutorily required to be reported to the Medicaid Fraud Unit of the Attorney General's Office and to the Department of Health, Division of Licensure and Certification. Allegations of persons in other community-based settings would be reported to the Mississippi Department of Human Services. The State defines a vulnerable person as any person whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, and physical or development disability or dysfunction, or brain damage or the infirmities of aging. This includes all waiver participants of Assisted Living waiver providers. 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. Based on Mississippi Code § 43-47-37. Reporting of abuse, neglect and exploitation of waiver participants in licensed care facilities is as follows: (1) Any person who, within the scope of his employment at a licensed care facility or in his professional or personal capacity, has knowledge of or reasonable cause to believe that any waiver participant of a care facility has been the victim of abuse, neglect or exploitation shall report immediately the abuse, neglect or exploitation. (2) The reporting of conduct shall be made: (a) Orally or telephonically, within twenty-four (24) hours of discovery, excluding Saturdays, Sundays and legal holidays, to the State Department of Health and the Medicaid Fraud Control Unit of the Attorney General's office. (b) In writing, within seventy-two (72) hours of the discovery, to the State Department of Health and the Medicaid Fraud Control Unit. (2) The contents of the reports shall contain the following information unless the information is unobtainable by the person reporting: (a) The name, address, telephone number, occupation and employer's address and telephone number of the person reporting; (b) The name and address of the patient or resident who is believed to be the victim of abuse or exploitation; (c) The details, observations and beliefs concerning the incident; (d) Any statements relating to incident made by the patient or resident; (e) The date, time and place of the incident; (f) The name of any individual(s) believed to have knowledge of the incident; (g) The name

of the individual(s) believed to be responsible for the incident and their connection to the patient or resident; and (h) Such other information that may be required by the State Department of Health and/or the Medicaid Fraud Control Unit, as requested. (3) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of an assisted living facility has been the victim of abuse, exploitation or any other criminal offense may make a report to the State Department of Health and the Medicaid Fraud Control Unit. (4) Any Assisted Living provider that complies in good faith with the requirements of this section to report the abuse or exploitation of a patient or resident in the care facility shall not be sanctioned by the State Department of Health for the occurrence of such abuse or exploitation if the care facility demonstrates that it adequately trained its employees and that the abuse or exploitation was caused by factors beyond the control of the care facility. (5) Every person who knowingly fails to make the report as required by subsections (1), (2) and (3) of this section or attempts to induce another, by threat or otherwise, to fail to make a report as required by subsections (1), (2) and (3) of this section shall, upon conviction, be guilty of a misdemeanor and shall be punished by a fine of not exceeding FiveHundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or both such fine and imprisonment. (6) Copies of the vulnerable persons act must be displayed prominently in the facility easily viewed by all The Mississippi Division of Medicaid works closely with the Medicaid Fraud Unit and the Department of Health, Division of Licensure and Certification with notification and reporting of allegations of suspected abuse, neglect or exploitation. There is a free flow of information regarding status of cases, outcome and follow up with resolution. Information that is shared includes, the types of abuse or serious incidents, information regarding the alleged perpetrator, the course and outcome of the investigation. Allegations of abuse are recorded for ease in compiling data for analysis related to trends, prevention and detection. For allegations deemed potentially immediate jeopardy situations, an Investigation will be initiated with two (2) working days of receipt of the complaint. The purpose of the onsite visit is to assure that all participants who could be affected by the reported situation are adequately protected from harm and to verify the provider's ability to correct the circumstances creating the immediate jeopardy. For allegations that are considered non-immediate jeopardy- high risk, an investigation will be initiated within ten (10) working days of receipt of the complaint. For allegations that are considered non-immediate jeopardy –medium risk, an investigation will be initiated within fortyfive (45) working days of the receipt of the complaint. For allegations that are considered Non-Immediate jeopardy—low risks, an onsite investigation may not be scheduled, but the allegation will be reviewed at the next onsite visit. The assigned complaint investigator will contact the participant during the course of the on-site investigation to advise them that the investigation is in progress and to validate details of the reported allegation. Following completion of the investigation and the processing of required documents, the participant will be notified. Timeframes of notification vary depending on the amount of time it takes to complete an investigation but notification occurs once the investigation is completed The State entered into an interagency agreement between the sister agency, the Department of Human Services, to assure the proper reporting and investigations of major and serious incidents of abuse, neglect and exploitation (at a minimum) across all waivers. This agreement defines the types of critical events or incidents that must be reported. When an allegation of abuse, neglect or exploitation occurs, the Assisted Living waiver provider staff is required to report to the Department of Health and the Attorney General's office.

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.

~~DOM has procedures in place to assure that all Assisted Living waiver providers, waiver participants and care givers are trained in the reporting of critical incidents. A database is maintained by DOM to collect, record, and trend critical events. This information is used to identify opportunities for improvement involving early detection and prevention.~~

~~The Mississippi Attorney General's office, Mississippi Department of Health and the Department of Human Services work with the Mississippi Division of Medicaid to communicate information and oversight activities of critical events and incidents. Each agency provides a free flow of information to the Division of Medicaid including the specific names of individuals involved in reported incidents, the status of investigations along with outcomes. Each agency works with the Division of Medicaid to identify strategies to reduce the occurrence of critical events.~~

~~The Mississippi Department of Human Services entered into an interagency agreement allowing the sharing of critical incident information that includes types of incidents reported, participant characteristics, providers, how quickly reports are reviewed and investigated, follow up, results of investigations and whether waiver participants are informed of the investigative results.~~

~~The case managers and the case manager supervisor(s) work closely with the investigators from the Mississippi Attorney General's office to follow up on reports of abuse, neglect or exploitation. The Mississippi Attorney General's Office (MFCU) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation. DOM and the AGs office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation~~
~~for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected.~~

~~The Mississippi Department of Health has an interagency agreement with the Division of Medicaid which allows for free flow of information regarding all allegations and their findings. Their investigation results include a review of the facilities over all compliance with the overall licensure regulations as related to the occurrence of critical incidents. DOM's oversight of the incident management system occurs on an ongoing and continuous basis. When investigations are in progress, DOM is notified and assists as requested and there is free flow of communication between agencies.~~

~~Information compiled from the oversight agencies allows the DOM to analyze the incidents to determine trends/patterns to assist in the development of strategies to reduce future occurrences of critical incident events. An excellent example of how information is used from analyzing critical incident reports resulted in the Division of Medicaid identifying the need for additional training for care staff related to dealing with difficult residents and resident rights. The review determined that confirmed abuse occurred in a facility and that staff were not fully trained and competent to deal with residents with acting our behavior. The facility had to provide an acceptable corrective action plan to resolve the issues.~~

DOM has procedures in place to assure that all Assisted Living waiver providers, waiver participants and care givers are trained in the reporting of critical incidents. A database is maintained by DOM to collect, record, and trend critical events. This information is used to identify opportunities for improvement involving early detection and prevention. The Mississippi Attorney General's office, Mississippi Department of Health and the Department of Human Services work with the Mississippi Division of Medicaid to communicate information and oversight activities of critical events and incidents. Each agency provides a free flow of information to the Division of Medicaid including the specific names of individuals involved in reported incidents, the status of investigations along with outcomes. Each agency works with the Division of Medicaid to identify strategies to reduce the occurrence of critical events. The Mississippi Department of Human Services entered into an interagency agreement allowing the sharing of critical incident information that includes types of incidents reported, participant characteristics, providers, how quickly reports are reviewed and investigated, follow up, results of investigations and whether waiver participants are informed of the investigative results. The case managers and the case manager supervisor(s) work closely with the investigators from the Mississippi Attorney General's office to follow up on reports of abuse, neglect or exploitation. The Mississippi Attorney General's Office (MFCU) provides the DOM with the types of allegations received and the status of the investigation as well as the final disposition of the investigation. DOM and the AGs office work very closely sharing information about cases throughout the investigative process. The AG has the electronic capability to provide DOM with a listing of all allegations regarding abuse, neglect and exploitation for each individual Assisted Living facility at any given time. This reporting capability allows DOM to oversee and monitor that the health and welfare of our waiver participants is being protected. The Mississippi Department of Health has an interagency agreement with the Division of Medicaid which allows for free flow of information regarding all allegations and their findings. Their investigation results include a review of the facilities over all compliance with the overall licensure regulations as related to the occurrence of critical incidents. DOM's oversight of the incident management system occurs on an ongoing and continuous

basis. When investigations are in progress, DOM is notified and assists as requested and there is free flow of communication between agencies. Information compiled from the oversight agencies allows the DOM to analyze the incidents to determine trends/patterns to assist in the development of strategies to reduce future occurrences of critical incident events. An excellent example of how information is used from analyzing critical incident reports resulted in the Division of Medicaid identifying the need for additional training for care staff related to dealing with difficult residents and resident rights. The review determined that confirmed abuse occurred in a facility and that staff were not fully trained and competent to deal with residents with acting our behavior. The facility had to provide an acceptable corrective action plan to resolve the issues.

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 Mississippi State Department of Health Licensure and Certification Division are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The CM is responsible for monthly contact with the waiver participant and/or caregiver to ensure safety. The CM is also responsible for conducting a quarterly face-to-face visit with the participant to ensure quality of services. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.~~

The State prohibits the use of restraints during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that restraints are not used for waiver participants. The case manager(s) 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 Mississippi State Department of Health Licensure and Certification Division are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The CM is responsible for monthly contact with the waiver participant and/or caregiver to ensure safety. The CM is also responsible for quarterly face-to-face visits with the participant to ensure quality of service. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.~~

The State prohibits the use of restrictive interventions during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The case manager(s) 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 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 Mississippi State Department of Health Licensure and Certification Division are jointly responsible for ensuring that seclusion is not used for waiver participants. The CM is responsible for monthly contact with the waiver participant and/or caregiver to ensure safety. The CM is also responsible for quarterly face-to-face visits with the participant to ensure quality of service. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.~~

The State prohibits the use of seclusion during the course of the delivery of waiver services. DOM and the MSDH Licensure and Certification Division are jointly responsible for ensuring that seclusion is not used for waiver participants. The case manager(s) 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 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.

~~The Licensing agency of the Assisted Living provider is responsible for oversight of medication management and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for participants in this waiver is vested in a licensed physician. Each Assisted Living provider must employ appropriately trained or professionally qualified staff to administer medications if an individual requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to service recipients have daily and ongoing responsibility for medication monitoring to ensure that medications are correctly administered and that medication administration is appropriately documented in accordance with DOM requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DOM on-site compliance reviews. First line responsibility for monitoring an individual's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Assisted Living setting. Staff monitoring focuses on areas identified by the physician and/or pharmacist which may be of concern. Each waiver provider must have policies and procedures that identify the frequency of monitoring. Individuals have a choice of physicians and pharmacies, but are encouraged to be consistent in their use of these professionals in order to ensure continuity of care and to prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated with another medication prescribed.~~

~~Additionally, the Division of Medicaid makes available a provider portal called Provider Access so that prescribing physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries.~~

~~All participants' medications must be stored in a secure area and not accessible to anyone other than whom the medication is prescribed. A refrigerator must be provided for storage of medications requiring refrigeration.~~

~~A non-resident employee, appointed by the operator of the facility, must be responsible for the following:~~
~~1. Storage of medication~~
~~2. Maintenance of a current prescription medication list, the including frequency and dosage of medications and known allergies, which shall be updated at least every 30 days or when there is a change in the medication. Managing this medication list is used to guard against medication errors.~~
~~3. Disposal of outdated or other unused medications in accordance with the regulations of the Mississippi Board of Pharmacy.~~

~~Scheduled drugs may only be allowed in an Assisted Living provider if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.~~
~~The Assisted Living provider must keep accurate records to demonstrate that waiver participants have adequate amounts of medication on hand and that necessary oversight is provided for medication administration. The nurse must review the medication list for each participant to assure that waiver participants are neither over nor inappropriately medicated.~~

The Licensing agency of the Assisted Living provider is responsible for oversight of medication management and conducts annual on-site compliance reviews to monitor medication administration. The medical responsibility for participants in this waiver is vested in a licensed physician. Each Assisted Living provider must employ appropriately trained or professionally qualified staff to administer medications if an individual requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to service recipients have daily and ongoing responsibility for medication monitoring to ensure that medications are correctly administered, and that medication administration is appropriately documented in accordance with DOM requirements. Providers must have written policies and procedures for

medication administration and implementation of such policies is evaluated during annual DOM on-site compliance reviews. First line responsibility for monitoring an individual's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Assisted Living setting. Staff monitoring focuses on areas identified by the physician and/or pharmacist which may be of concern. Each waiver provider must have policies and procedures that identify the frequency of monitoring. Individuals have a choice of physicians and pharmacies but are encouraged to be consistent in their use of these professionals in order to ensure continuity of care and to prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated with another medication prescribed. Additionally, the Division of Medicaid makes available a provider portal called Provider Access so that prescribing physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries. All participants' medications must be stored in a secure area and not accessible to anyone other than whom the medication is prescribed. A refrigerator must be provided for storage of medications requiring refrigeration. A non-resident employee, appointed by the operator of the facility, must be responsible for the following: 1. Storage of medication 2. Maintenance of a current prescription medication list, the including frequency and dosage of medications and known allergies, which shall be updated at least every 30 days or when there is a change in the medication. Managing this medication list is used to guard against medication errors. 3. Disposal of outdated or other unused medications in accordance with the regulations of the Mississippi Board of Pharmacy. Scheduled drugs may only be allowed in an Assisted Living provider if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse. The Assisted Living provider must keep accurate records to demonstrate that waiver participants have adequate amounts of medication on hand and that necessary oversight is provided for medication administration. The nurse must review the medication list for each participant to assure that waiver participants are neither over nor inappropriately medicated.

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.

~~Mississippi State Department of Health Licensure and Certification is responsible for follow-up and oversight.~~

~~The Mississippi State Department of Health conducts annual onsite visits reviewing the overall operation of the facilities to assure compliance to regulatory requirements. This agency visits more frequently in the event of a complaint or report of a negative finding. The agency communicates information and findings regularly to the Department of Medicaid after the annual visits and after any complaint investigation. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies.~~

~~Waiver case managers provide monthly contacts, either by phone or face-to-face, with the waiver participant to assure services are being provided in accordance with the plan of care. Face-to-face visits are made quarterly. During these visits, the State gathers information concerning potentially harmful practices and uses the information to develop quality improvement measures to address the issue.~~

Mississippi State Department of Health Licensure and Certification is responsible for follow up and oversight. The Mississippi State Department of Health conducts annual onsite visits reviewing the overall operation of the facilities to assure compliance to regulatory requirements. This agency visits more frequently in the event of a complaint or report of a negative finding. The agency communicates information and findings regularly to the Department of Medicaid after the annual visits and after any complaint investigation. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies. Waiver case managers provide monthly contacts, either by phone or face-to-face, with the waiver participant to assure services are being provided in accordance with the plan of care. Face-to-face visits are made quarterly. During these visits, the State gathers information concerning potentially harmful practices and uses the information to develop quality improvement measures to address the issue.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

~~HCBS/Assisted Living Waiver administrative code states that Assisted Living Services may include Medication Oversight/Medication administration (to the extent permitted under State Law).~~

~~Medication administration is limited to the decisions, made by someone other than the person for whom the medication has been prescribed, regarding (1) which medication is to be taken, (2) the dosage of the medication, or (3) the time at which the medication is to be taken.~~

~~Medication Assistance is any form of delivering medication which has been prescribed which is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing.~~

~~Nursing activities must comply with Mississippi Board of Nursing Administrative Code, Part 2830, Chapter 1, Section 1.3 Supervision and Delegation, Part 2830 Chapter 1: The registered nurse may:~~
~~(1) Assign specific nursing duties and/or patients to other qualified personnel based on educational preparation, experience, knowledge credentials, competency, and physical and emotional ability to perform the duties.~~
~~(2) Assign duties of administration of patient medication to other licensed nurses only (either a RN or LPN) except as set out in Mississippi Board of Nursing Administrative Code, Part 2830.~~

~~Thus, medication administration may only be delegated to another registered nurse or licensed practical nurse and not to an unlicensed person.~~

HCBS/Assisted Living Waiver administrative code states that Assisted Living Services may include Medication Oversight/Medication administration (to the extent permitted under State Law). Medication administration is limited to the decisions, made by someone other than the person for whom the medication has been prescribed, regarding (1) which medication is to be taken, (2) the dosage of the medication, or (3) the time at which the medication is to be taken. Medication Assistance is any form of delivering medication which has been prescribed which is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing. Nursing activities must comply with Mississippi Board of Nursing Administrative Code, Part 2830, Chapter 1, Section 1.3 Supervision and Delegation, Part 2830.

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:

~~Mississippi State Department of Health Licensure and Certification.~~

~~Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.~~

Mississippi State Department of Health Licensure and Certification. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

(b) Specify the types of medication errors that providers are required to *record:*

~~All avoidable, serious or life-threatening errors shall be reported by telephone to Mississippi State Department of Health Licensure and Certification Branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.~~

All avoidable, serious or life-threatening errors shall be reported by telephone to Mississippi State Department of Health Licensure and Certification Branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

(c) Specify the types of medication errors that providers must *report* to the state:

~~All avoidable, serious or life threatening errors shall be reported to Mississippi State Department of Health Licensure and Certification branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.~~

All avoidable, serious or life threatening errors shall be reported to Mississippi State Department of Health Licensure and Certification branch of the licensing agency by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

○ **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.

~~Mississippi Department of Health Licensure and Certification branch of the licensing agency is the state agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Monitoring is performed according to the Minimum Standards for Personal Care Homes Assisted Living. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing.~~

~~The agency communicates information and findings regularly to the Division of Medicaid after the annual visit which includes an evaluation of medication administration. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event the facility is out of compliance at the annual survey or in the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies.~~

~~The Division of Medicaid conducts annual onsite compliance audit of waiver providers as part of the oversight responsibility. The findings from this compliance audit along with reports from the Department of Health are evaluated to determine if negative findings are such that remediation is required. Data collected during annual visit by the Department of Health and the Division of Medicaid is analyzed to identify evidence of trends and patterns which require a need for policy, procedure and systems changes.~~

~~Data are collected during the annual visits by the Department of Health and Division of Medicaid. Additionally, case managers acquire data during the monthly, quarterly and annual visits regarding medication errors. All of this data collectively is reviewed to determine the occurrence of trends and patters or the possibility of isolated incidents. After the data is analyzed, the information is synthesized to determine is improvement strategies need to be implemented across this waiver as well as the possibility of a more global approach across all of the State waivers.~~

Mississippi Department of Health Licensure and Certification branch of the licensing agency is the state agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Monitoring is performed according to the Minimum Standards for Personal Care Homes Assisted Living. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing. The agency communicates information and findings regularly to the Division of Medicaid after the annual visit which includes an evaluation of medication administration. Annually, the agency provides DOM with a copy of the provider's current license verifying the facility is in compliance with the licensing rules and regulations. In the event the facility is out of compliance at the annual survey or in the event of a complaint investigation or unscheduled visit, the agency provides DOM with copies of cited deficiencies. The Division of Medicaid conducts annual onsite compliance audit of waiver providers as part of the oversight responsibility. The findings from this compliance audit along with reports from the Department of Health are evaluated to determine if negative findings are such that remediation is required. Data collected during annual visit by the Department of Health and the Division of Medicaid is analyzed to identify evidence of trends and patterns which require a need for policy, procedure and systems changes. Data are collected during the annual visits by the Department of Health and Division of Medicaid. Additionally, case managers acquire data during the monthly, quarterly and annual visits regarding medication errors. All of this data collectively is reviewed to determine the occurrence of trends and patters or the possibility of isolated incidents. After the data is analyzed, the information is synthesized to determine is improvement strategies need to be implemented across this waiver as well as the possibility of a more global approach across all of the State waivers.

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 instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

~~**PM 1: Number and percent of 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.~~

PM 1: Number and percent of all critical incidents that were reported or remediated in accordance with waiver policy. N: Number of all critical incidents that were reported or remediated in accordance with waiver policy. 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **X State Medicaid Agency**	☐ ~~**Weekly**~~	☒ **X 100% Review**
☐ **Operating Agency**	☒ **X Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

X State Medicaid Agency	Weekly

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

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.**~~

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

Other	Annually	Stratified

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 3: Number and percent of 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):
Other
If 'Other' is selected, specify:

LTC QA Reviews

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**	☐ **~~100% Review~~**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **~~Quarterly~~**	**X Representative Sample** Confidence Interval = Confidence Interval = ~~95%~~
☐ **Other** Specify:	☒ **X Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.**~~

PM 4: Number and percent of complaints that were addressed/resolved as approved in the waiver. N: Number of complaints that were addressed/resolved as approved in the waiver. D: Total number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

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

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

Data Aggregation and Analysis:

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

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.**~~

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 reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

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

Data Aggregation and Analysis:

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

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 or 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):*

☒ **X State Medicaid Agency**	☐ **Weekly**	☒ **X 100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **X Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 alleged instances of abuse, neglect, exploitation, and unexplained/suspicious deaths within the required timeframe to be addressed 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 Health; (d) request documentation from MSDH within 30 days, for those reported critical incidents with late follow-up.~~

~~For PM 2, DOM will (a) immediately notify Case Manager of deficiency via clarification request; (b) require Case Manager 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 Manager 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 Manager to report unauthorized use of restrictive interventions via email notification within 24 hours of knowledge of the incident; (c) 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 Manager of deficiency via clarification request; and (b) have the Case Manager conduct a core standardized assessment which assesses a persons preventative health care standards within fifteen (15) days.~~

In any instance in which it is discovered that t the critical incident management or complaint system systems or the participant safeguard monitoring processes are not implemented in accordance with the procedures outlined in Appendix G of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. In these instances, DOM will implement a corrective action plan (CAP) and conduct necessary follow up to determine the effectiveness of remediation actions.

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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

~~Mississippi has taken a global approach towards the development of a Quality Improvement strategy that encompasses all waivers. Continuous quality improvement is based on the processes of discovery and remediation and the aggregated data produced by those activities. Quality improvement takes place on the participant, provider and system wide levels.~~

~~Quality improvement at the participant level is focused on monitoring and improving care and outcomes for the participant. The participant's case manager is primarily responsible oversight of the quality improvement at the participant level. Participant level discovery takes place through the monthly and quarterly contacts that a case manager makes with the participant and his/her providers. When a case manager discovers an issue related to the participant's Plan Services and Supports, he/she is responsible for addressing the issue with the participant's provider and developing remedial actions to address the issue. If a provider is not responsive to participant level remediation, a case manager is responsible for reporting the issue to the case manager supervisor with the Division of Medicaid who intervenes as necessary to achieve remediation.~~

~~Quality improvement at the provider level is focused on monitoring and improving services delivered by providers. The Mississippi State Department of Health (MSDH), Division of Licensure and Certification is responsible for oversight and development of provider regulations and licensing. All providers are surveyed annually. Additionally, the Division of Medicaid conducts annual unannounced on-site compliance audits to assure compliance with Medicaid rules and requirements and waiver assurances. DOM conducts initial visits to new applicant providers to ensure compliance with DOM operational Standards. As issues are identified through on-site monitoring, providers are required to submit Plans of Corrections for remediation. Provider level data is collected through the discovery processes of on-site monitoring, reporting of serious incidents, and reporting of grievances.~~

~~Quality improvement at the systemic level is designed to improve the overall system's delivery of care. System level discovery incorporates data from multiple sources to develop a comprehensive view of service provision. Data from the discovery processes at the participant and provider levels is utilized for system level quality improvement activities.~~

~~As part of the administrative oversight of the Division of Medicaid, DOM conducts on-site compliance reviews. The compliance reviews examines adherence to the sub-assurances of the waiver. DOM issues a report of findings that identifies issues found during the compliance audit. Through regular meetings between MSDH and DOM, the two agencies share decision making concerning corrective action. As a mitigation strategy, DOM informs all providers that might be affected by warranted corrective action so that all providers can examine the issue and put mitigation strategies in place to prevent a future occurrence.~~

The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed, to develop system change requests, review progress, and test system changes. The meetings involve participation from the DOM Offices of Information Technology (iTech) and Long Term Services and Supports (LTSS), along with any other stakeholders deemed appropriate depending on the issue for discussion. Meetings with LTSS staff including QA nurses are held routinely for the purpose of addressing needs and resolving issues that may involve systems changes. When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to participants or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff to address issues that require system changes. Additionally, the State has monthly internal Advisory meetings to identify, correct, and implement system changes to improve the State's ability to adhere to state and federal regulations, policies and procedures. System changes have been implemented to allow for electronically capturing data and identifying trends related to the performance

measures. Findings are discussed during collaborative Quality Improvement Strategy meetings with the operating agency and DOM. Reporting information from the eLTSS case management system is also utilized in quality improvement strategies as a source of reporting data for multiple quality measures.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
Quality Improvement Committee	**Annually**

Responsible Party*(check each that applies):*	Frequency of Monitoring and Analysis*(check each that applies):*
☐ **Other** Specify:	☒ **Other** Specify: Continuously and ongoing.

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.

~~Mississippi has taken a global approach towards the development of a Quality Improvement strategy that encompasses all waivers. Continuous quality improvement is based on the processes of discovery and remediation and the aggregated data produced by those activities. Quality improvement takes place on the participant, provider and system wide levels.~~

~~Quality improvement at the participant level is focused on monitoring and improving care and outcomes for the participant. The participant's case manager is primarily responsible oversight of the quality improvement at the participant level. Participant level discovery takes place through the monthly and quarterly contacts that a case manager makes with the participant and his/her providers. When a case manager discovers an issue related to the participant's Plan Services and Supports, he/she is responsible for addressing the issue with the participant's provider and developing remedial actions to address the issue. If a provider is not responsive to participant level remediation, a case manager is responsible for reporting the issue to the case manager supervisor with the Division of Medicaid who intervenes as necessary to achieve remediation.~~

~~Quality improvement at the provider level is focused on monitoring and improving services delivered by providers. The Mississippi State Department of Health (MSDH), Division of Licensure and Certification is responsible for oversight and development of provider regulations and licensing. All providers are surveyed annually. Additionally, the Division of Medicaid conducts annual on-site compliance audits to assure compliance with Medicaid rules and requirements and waiver assurances. DOM conducts initial visits to new applicant providers to ensure compliance with DOM operational Standards. As issues are identified through on-site monitoring, providers are required to submit Plans of Corrections for remediation. Provider level data is collected through the discovery processes of on-site monitoring, reporting of serious incidents, and reporting of grievances.~~

~~Quality improvement at the systemic level is designed to improve the overall system's delivery of care. System level discovery incorporates data from multiple sources to develop a comprehensive view of service provision. Data from the discovery processes at the participant and provider levels is utilized for system level quality improvement activities.~~

~~As part of the administrative oversight of the Division of Medicaid, DOM conducts on-site compliance reviews. The compliance reviews examines adherence to the sub-assurances of the waiver. DOM issues a report of findings that identifies issues found during the compliance audit. Through regular meetings between MSDH and DOM, the two agencies share decision making concerning corrective action. As a mitigation strategy, DOM informs all providers that might be affected by warranted corrective action so that all providers can examine the issue and put mitigation strategies in place to prevent a future occurrence.~~

Division of Medicaid (DOM) monitors the quality improvement strategy on a monthly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of the sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the quality improvement strategy is necessary, DOM makes necessary changes to meet waiver reporting requirements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy is continuously evaluated to ensure the strategy is accomplishing the intended goal of improving outcomes for waiver participants. Annually, the Division of Medicaid reviews the performance measures to ensure data collection is occurring as planned and intended outcomes are being achieved.

Evaluation of the quality improvement strategy is a continuous and ongoing endeavor. It is reviewed annually to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible. The operating agency and DOM will meet quarterly to review the overall waiver operation including the QIS strategy for waiver improvement.

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):*

- ○ **X 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).*

~~*The State does not require Assisted Living providers to secure an independent audit of their financial statements.*~~

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

~~*Claims for Federal financial participation in the costs of waiver services are based on state payment for waiver services that have been rendered to individuals enrolled in the waiver, authorized in the Plan of Services and Supports, and properly billed by certified waiver providers in accordance with the approved waiver.*~~

~~*The Mississippi Division of Medicaid maintains responsibility for ensuring financial audits of Assisted Living Waiver providers are conducted. 100% of the providers who receive payments during the review period are reviewed. Claims are sampled as required by the waiver application. A 95% confidence level sample (+/- 5%) of the claims paid for the representative sample of participants is chosen as a random sample utilizing a sample calculator such as Raosoft or Rat-Stats. This allows for a comprehensive review of claims substantiated by the participant cases sampled. The Division will also generate all required financial reporting for each Assisted Living Waiver service provided. The audit will verify the maintenance of appropriate financial records and review claims to verify coding and accuracy of the payments made. Immediate action will be taken when necessary to address any financial irregularities identified in the review.*~~

~~*The Mississippi Office of the State Auditor is responsible for annual audits in compliance with the provisions of the Single Audit Act. Additionally, every 3 years an additional audit is completed by the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER).*~~

Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis. DOM, therefore, does not require an independent audit of waiver service providers. The Mississippi Office of the State Auditor is responsible for annual audits in compliance with the provisions of the Single Audit Act. Claims for all waiver services are submitted to the Division's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits before payment. The Mississippi Division of Medicaid operates three audit units within the Office of Compliance to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud or abuse reported or identified. They also review payment records of Medicaid providers continually and on an ongoing basis. The Office of Financial and Performance Audit conducts routine monitoring of cost reports and contracts with other agencies as well as waiver provider specific audits. The Office of Compliance audits coordinated care organizations, state agencies, and other entities as necessary to ensure program compliance. In all audit units, staff set audit priorities each year based upon established criteria. Random sampling is done using a stratified random sample method based on statistically valid methodology. Any estimate of overpayment within Program Integrity is made utilizing a simple extrapolation with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata. Post-payment audits of all waiver services can be conducted through a medical record request desk audit or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation. Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment): • No further action – No issues uncovered warranting further action. • Provider education – No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices. • Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with DOM guidelines. Providers are allowed thirty (30) days to submit the requested information. • Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. DOM staff, including clinical staff if appropriate, are

included in on-site reviews and assist with conducting interviews. • Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation to determine the appropriate next steps, if any. Audit reports/management letters provide detailed information on identified deficiencies, including but not limited to, accuracy-related issues, missing documentation, internal control deficiencies, and training issues and are presented to the provider at the end of the audit. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider administrators and appropriate staff at DOM and the operating agency.

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 coded and paid correctly 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):*
☒ ***X State Medicaid Agency***	☐ ***Weekly***	☒ ***X 100% Review***
☐ ***Operating Agency***	☐ ~~***Monthly***~~	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***X Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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~~ Financial and Performance Audit

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):*
☒ ***X State Medicaid Agency***	☐ ***Weekly***	☐ ***~~100% Review~~***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***X Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Confidence Interval = 95%*
☐ ***Other*** *Specify:*	☒ ***X Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing*** ☐	☐ ***X*** ***Other*** *Specify: Statistically Valid Sample Determined by an Independent Statistician*
	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***X State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ~~***Annually***~~
	☐ ***Continuously and Ongoing***
	☐ ***X Other*** *Specify: Every 24 months*

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):*
☒ ***X State Medicaid Agency***	☐ ***Weekly***	☒ ***X 100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ~~***Quarterly***~~	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***X Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 & 2, DOM will (a) recoup money paid erroneously to providers within 30 days of notification; (b)Submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; (c) Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.*~~

~~*For PM 3, DOM will (a) review provider payment rates to ensure that they are consistent with rate methodology in the approved waiver application or subsequent amendment.*~~

In any instance in which it is discovered that financial accountability activities are not implemented in accordance with the policies/procedures outlined in Appendix I of this waiver, DOM will hold a quality improvement strategy meeting within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions. DOM will report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery and recoup money paid erroneously to providers.

ii. Remediation Data Aggregation

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

☐

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

X State Medicaid Agency	***Weekly***
Operating Agency	***~~Monthly~~***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***X Other*** *Specify: 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 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 for Assisted Living.*~~

~~*To set the context for developing the Assisted Living waiver service rates, the service descriptions for each waiver service were carefully considered. Costs analysis surveys were sent to various assisted Living providers to obtain a realistic view of actual costs and expenditures for a baseline of comparison of rates. Additionally, a review of each provider service rates was performed for comparison. For the Assisted Living waiver rate development, the following items were considered:*~~
~~*> Direct service provider salaries and benefits*~~
~~*> Direct service related expense and overhead costs*~~
~~*> Annual number of hours practitioners are at work*~~
~~*> Percentage of time an at work practitioner is able to convert to billable units (productivity)*~~

~~*The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, 2018 Assisted Living facility surveys, and DOM and Milliman experience.*~~

~~*Once the initial service rates were calculated, a comparison was made to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates.*~~

~~*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.*~~

~~*The rate for Adult Residential was negotiated with a qualified out of state provider as there is no in-state provider who meets the necessary criteria.*~~

~~*Information about payment rates is made available to waiver participants through the DOM website. Additionally, case managers discuss the waiver payment rates with the Assisted Living participants upon enrollment into the waiver and at any change. Personal care service costs are included in the bundled rate paid by DOM. Those costs are listed on the Plan of Services and Supports signed by the participant.*~~

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology outlined below in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. Once the comprehensive studies are completed, DOM will submit waiver amendments to further update rates/methodologies where appropriate. To set the context for developing waiver service rates, the service descriptions for each service were carefully considered. Costs analysis surveys were sent to various assisted Living providers to obtain a realistic view of actual costs and expenditures for a baseline of comparison of rates. Additionally, a review of each provider service rates was performed for comparison. For the Assisted Living waiver rate development, the following items were considered: > Direct service provider salaries and benefits > Direct service-related expense and overhead costs > Annual number of hours practitioners are at work > Percentage of time an at work practitioner is able to convert to billable units (productivity) The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, 2018 provider surveys, and DOM and Milliman experience. Once the initial service rates were calculated, a comparison was made to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. 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. The rate for Adult Residential was negotiated with qualified providers who meet the necessary criteria. Once service rates were calculated, a comparison was made of them to the current service rates along with consideration for other aspects of the service provision environment. DOM solicited public comments on the rates through stakeholder meetings, public notices, and notification to the tribal government. Information about payment rates is made available to waiver participants via the DOM website and rates are also included in person-centered Plans of Services and Supports. Additionally, rate determination methods outlined in this appendix were posted for public input with the renewal application as outlined in Main, Section 6-I of this application.

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:

~~*Assisted Living Waiver providers bill their claims directly to the State's claims payment system. This system is housed and managed by the State's fiscal agent.*~~

Billings for all waiver services flow directly from providers to the State's claims payment system (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

~~*The MMIS houses claims data and information and 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 fiscal agent system requires an individual to be an approved, eligible Medicaid waiver beneficiary, documented in the MMIS system, in order for the claim to pay. The lock-in function is housed in the fiscal agent system under the recipient (participant) file and is performed by Medicaid HCBS or the Medicaid fiscal agent. All payments for waiver and state plan services furnished to the program participant will be made via the process of provider claims through MMIS. Waiver services will be assigned specific procedure codes.*~~

~~*DOM conducts post utilization reviews to ensure the services were delivered on the dates reflected on the participant's approved plan of services supports and required billing documentation.*~~

Billing validation is accomplished primarily by the Division's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. DOM may subsequently validate billings post-payment in accordance with the audit strategy outlined in I-2-a. Recovery action is undertaken by the Division for any identified overpayments and the federal share of identified overpayments is returned to the Federal Government. The Mississippi Eligibility Determination System (MEDS) is a unified system for data collection and eligibility determinations. Electronic files from MEDS are loaded daily into the MMIS in order to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the member is eligible for Medicaid services. Subsequent MMIS edits verify that the member has a valid waiver specific lock-in span that is entered on the member's MMIS record upon approval and recertification. Claims submitted for members who are not eligible on the date of service are denied. All waiver services included in the participant's service plan must be prior approved by DOM. Approved Plans of Services and Supports (PSSs) are electronically tracked in the DOM electronic Long Term Services and Supports System (eLTSS).

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with*

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any***

supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***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.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:*

This waiver is for participants residing in residential, home and community based care facilities. The Assisted Living waiver services rendered in this waiver do not include coverage for room and board. Waiver participant records, to demonstrate the facility is not charging for room and board, are required to be maintained within Assisted living waiver providers and are available to representatives of the Medicaid agency at all times. Such records include admission agreements which must contain provisions specifically setting forth services and accommodations to be provided by the Assisted Living provider. The admission agreements must include the following items:
1) Basic charges agreed upon, separating costs for room and board and personal care services
2) Period of time to be covered in charges
3) List of itemized charges,
4) Agreement regarding refunds for payments.

Participant admission agreements are subject to review to ensure that no Medicaid payment is made for room and board charges.

The costs for room and board may not fluctuate based on the amount of Medicaid reimbursement each month. Admission agreements must be reviewed and approved by the Division of Medicaid prior to admission into the waiver and subsequently every time there is a change or update to the agreement. Regardless of any agreement between the participant or the participant's family or guardian, the provider must not charge for services over and above what Medicaid has agreed to pay.

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

****** Appendix J Financial Data is not updated in this version. Updated data and projections are included in the "clean" version of the document.***

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	16735.61	6273.00	23008.61	55257.00	7861.00	63118.00	40109.39
2	16705.37	6436.10	23141.47	56693.68	8065.39	64759.07	41617.60

3	16678.15	6603.44	23281.59	58167.72	8275.09	66442.81	43161.22
4	16653.52	6775.13	23428.65	59680.08	8490.24	68170.32	44741.67

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)
5	16631.13	6951.28	23582.41	61231.76	8710.98	69942.74	46360.33

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	900	900
Year 2	950	950
Year 3	1000	1000
Year 4	1050	1050
Year 5	1100	1100

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 estimated average length of stay is 299 days. This number is based upon information captured in the federal fiscal year 2016 CMS 372 Annual Report.*~~

Based on the FY2022 CMS 372 Report data, the average length of stay for this waiver is 240 days. Based on this information, it is estimated that average length of stay for waiver participants during the course of the waiver renewal period is approximately 8 months.

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. The FY2016 372 report was used to project the components of Factor D including percentage of users utilizing each service out of the overall unduplicated count and average units per user for each service. Estimates of the number of persons who will be served on the Assisted Living waiver were based upon the sum of the current unduplicated count and 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.*~~

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 waiver were based upon the sum of the current unduplicated count and the estimated need for Year 1. The estimates for number of users, average units per user, and average cost per unit are based on the SFY 2022 CMS 372 report data. The numbers were then projected as stable for each waiver year.

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 FY 2016 CMS 372 report. The estimate was applied for year one and every year after was adjusted based on a 2.6% average projected CPI.*~~

~~*Both Factor D' and Factor G' were obtained based on actual State Plan expenditures. Historically, state plan expenditures are higher for nursing facility residents than for 1915(c) waiver participants in Mississippi.*~~

The estimates for Factor D' are based on the SFY 2022 CMS 372 report data and is trended forward to FY2024 using a 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q3 2023. The estimate was applied for year one and every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028. Factor G' is projected higher than Factor D' as utilization of some state plan services including hospital benefits and therapy codes may be higher for members in nursing facility settings who have more chronic health conditions that cannot be managed at home on the waiver.

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 FY2016. The specific nursing home expenditures analyzed were actual paid claims per Medicaid beneficiary in a nursing facility, including individuals with a similar average length of stay. Every year after was adjusted based on a 2.6% average projected CPI.*~~

The Factor G is based upon DOM's analysis of nursing home expenditures for FY2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The specific nursing home expenditures analyzed were actual paid claims per Medicaid beneficiaries with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

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 FY 2016. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility, including individuals with a similar average length of stay. Every year after was adjusted based on a 2.6% average projected CPI.*~~

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 2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

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 Residential for Care for Acquired Traumatic Brain Injury Participants	
Assisted Living	

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						*598000.00*

GRAND TOTAL:	*15062050.25*
Total Estimated Unduplicated Participants:	*900*
Factor D (Divide total by number of participants):	*16735.61*
Average Length of Stay on the Waiver:	*299*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	299.00	400.00	598000.00	
Assisted Living Total:						14464050.25
Assisted Living	per day	895	299.00	54.05	14464050.25	
				GRAND TOTAL:		15062050.25
				Total Estimated Unduplicated Participants:		900
				Factor D (Divide total by number of participants):		16735.61
				Average Length of Stay on the Waiver:		299

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						598000.00
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	299.00	400.00	598000.00	
Assisted Living Total:						15272097.75
Assisted Living	per day	945	299.00	54.05	15272097.75	
				GRAND TOTAL:		15870097.75
				Total Estimated Unduplicated Participants:		950
				Factor D (Divide total by number of participants):		16705.37
				Average Length of Stay on the Waiver:		299

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**598000.00**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	299.00	400.00	**598000.00**	
Assisted Living Total:						**16080145.25**
Assisted Living	per day	995	299.00	54.05	**16080145.25**	
				GRAND TOTAL:		**16678145.25**
				Total Estimated Unduplicated Participants:		**1000**
				Factor D (Divide total by number of participants):		**16678.15**
				Average Length of Stay on the Waiver:		299

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						**598000.00**
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	per day	5	299.00	400.00	**598000.00**	
Assisted Living Total:						**16888192.75**
Assisted Living	per day	1045	299.00	54.05	**16888192.75**	
				GRAND TOTAL:		**17486192.75**
				Total Estimated Unduplicated Participants:		**1050**
				Factor D (Divide total by number of participants):		**16653.52**
				Average Length of Stay on the Waiver:		299

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 Residential for Care for Acquired Traumatic Brain Injury Participants Total:						***598000.00***
Adult Residential for Care for Acquired Traumatic Brain Injury Participants	*per day*	*5*	*299.00*	*400.00*	***598000.00***	
Assisted Living Total:						***17696240.25***
Assisted Living	*per day*	*1095*	*299.00*	*54.05*	***17696240.25***	

GRAND TOTAL:	***18294240.25***
Total Estimated Unduplicated Participants:	***1100***
Factor D (Divide total by number of participants):	***16631.13***
Average Length of Stay on the Waiver:	*299*