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) Elderly and Disabled (E&D) 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 E&D Waiver are to:

    a. Update the Factor C to project unduplicated enrollment limits.
    b. Add language to allow reserved capacity for priority admission to the waiver for high acuity members.
    c. Updating auditing methodology to reflect new risk-based methodology.
    d. Update service rates and rate methodologies.
    e. Update quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
    f. Seek authority under the 1915(b)(4) fee-for-service selective contracting program and request a waiver of Section 1902(a)(23) Freedom of Choice for E&D case management services.
    g. Update language to streamline provider qualifications with appropriate references to the Mississippi Medicaid Administrative Code.
    h. Add language to allow for waiver capacity to be allocated regionally.
    i. Update Case Management services to allow for monthly contacts to be completed telephonically where appropriate.
    j. Update Case Management provider qualifications to allow for additional flexibilities in staff credentials.
    k. Add new Medication Management service.
    l. Add new Environmental Safety service.
    m. Update language related to the provision of services by family members/relatives and defining legally responsible persons.

2. The expected increase in annual aggregate expenditures is $22,268,054.98 in federal dollars and $4,282,624.61 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 reflect concurrent operation of a new 1915(b)(4) waiver.
• Updates to language to streamline provider qualifications.
• Addition of language to allow for waiver capacity to be allocated regionally.
• Update Case Management service specifications and provider qualifications to allow for additional flexibilities in staff credentials and service provision.
• Addition of a new Medication Management service.
• Addition of a new Environmental Safety service.
• Updates to the language related to the provision of services by family members/relatives and defining legally responsible persons.

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

1. Request Information (1 of 3)

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

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

Elderly and Disabled (E&D)

C. Type of Request: 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.0272
Draft ID: MS.005.07.00

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

Regular Waiver

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

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 aged and/or disabled. Individuals must be 21 and over.

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

§440.140

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **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 Elderly and Disabled (E&D) 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 E&D Waiver: case management, personal care services, adult day care, in-home respite, institutional respite, home delivered meals, community transition services, environmental safety services, medication management, physical therapy, speech therapy, and extended State Plan home health care services.

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 opportunities for flexibility related to the provision of services by relatives.
State's Response: DOM has reviewed and updated language related to the provision of services by relatives/legal guardians in this renewal.
Public Comments were received regarding opportunities for flexibility in provider credentialling requirements.
DOM Response: DOM has reviewed and updated language related to provider requirements in both the renewal and the accompanying Medicaid Administrative Code submission.
Public comments were received regarding the need to update reimbursement rates for several E&D Waiver services.
DOM 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. Providers are encouraged to participate. That data will be incorporated into ongoing rate updates/studies.
Public comments were received regarding the possible addition/removal of waiver services including Institutional Respite, Escorted Transportation, Pest Control, and Skilled Nursing.
State's Response: DOM has reviewed the requests and updated several services to address concerns/needs. Additionally, we will continue to evaluate the need for service updates in future amendments/renewals.
Public comments were received regarding the need for ongoing flexibility in the provision of case management.
State's Response: DOM has reviewed and updated language related to the provision of case management services.
Public comments were received regarding the need for updates to the waitlist management process including increased transparency for providers.
State's Response: DOM will continue to evaluate opportunities to streamline waitlist management processes.
Public comments were received regarding the implementation of electronic visit verification.
State's Response: DOM continues to work towards the implementation of an upgraded open hybrid EVV system in Summer 2023.

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:

The state is adding Environmental Safety Services and Medication Management as new services in this renewal. The state will work to operationalize those services and make them available to enrolled participants by January 1, 2024.

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:

Through contractual agreements, the Mississippi Planning and Development Districts (PDDs), who also act as the area agencies on aging, are responsible for some operational functions of the waiver on a day-to-day basis and are accountable to Division of Medicaid (DOM) which ensures that the waiver operates in accordance with federal waiver assurances. Functions are distributed as described below:

1) Waiver enrollment managed against approved waiver limits – PDDs notify DOM monthly of enrollment numbers; DOM verifies that enrollment limits are not exceeded
2) Waiver expenditures managed against approved waiver levels - DOM monitors that expenditure limits are not exceeded
3) Level of care evaluations are conducted by qualified staff, and DOM reviews/verifies that level of care has been determined prior to approving each case
4) Development, review and update of person's service plans – With the person's input PDD Case Managers develop and update the persons' service plans; DOM reviews and approves all services on the service plan
5) Qualified provider enrollment - DOM
6) Quality assurance and quality improvement activities - DOM
7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program – DOM
8) Provision of case management by qualified staff – PDD

Contractual agreements between the DOM and the PDDs are maintained and updated as needed. DOM monitors this agreement to assure that the provisions specified are met. In the agreement, DOM designates the assessment, evaluation, and reassessment of the person to be conducted by qualified individuals as specified in the current waiver. All such evaluations for certification or re-certification are subject to DOM's review and approval.

DOM is responsible for (1) performing monitoring of the PDDs to assess their operating performance and compliance with all rules and regulations; (2) reviewing each waiver persons' certifications, both initial and annual recertification; and (3) conducting quality assurance interviews to assess compliance with waiver requirements.

PDDs are responsible for (1) ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver and (2) initial and ongoing training of the case manager supervisors and individual case managers.

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 and the MS Planning and Development Districts.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
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:
PM 2: 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 3: 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 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%
☐ **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:
PM 4: Number and percent of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. N: Number of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. D: Total number of quarterly quality improvement strategy meetings.

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

Responsible Party for data collection/generation*(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 instances where reporting requirements of the case management agency were met in accordance to the Contractual Agreement. Number of instances where reporting requirements of the case management agency were met in accordance to the Contractual Agreement. D: Total number of instances where the case management agency was required to submit 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:

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)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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. If it is determined that a particular person's care costs are threatening the cost neutrality of the waiver, DOM reviews the PSS and evaluate ongoing enrollment.

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 the administrative staff at MDRS and 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 and the PDDs work 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	22200
Year 2	22200
Year 3	22200
Year 4	22200
Year 5	22200

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

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

Purpose(s) the state reserves capacity for:

Purposes
Transition of Persons from Other Mississippi 1915(c) HCBS Waivers
Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting
Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

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	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

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	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

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	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

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:

Waiver capacity is allocated to the ten (10) Planning and development districts who each have regional jurisdiction. Their combined coverage areas ensure statewide access to the waiver. Capacity is allocated based on an annual analysis of available funding, statewide utilization trends, county by county population fluctuations, and need as identified by regional waiting list numbers. DOM oversees the management of waiver capacity to ensure allocations are properly utilized, unused capacity is reallocated as needed, and that practices do not violate the requirement that individuals have comparable access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

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

○ **Other**

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

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

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

Specify:

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

- ○ **Other**

Specify:

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

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

Specify:

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

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

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

  Specify:

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

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **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: 2

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

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

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

The case managers performing the initial assessment are part of case management teams that consists of Mississippi licensed social workers (LSWs) and/or Mississippi registered nurses (RNs). 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 case management team composed of any mix of two appropriately licensed staff including Mississippi licensed social workers (LSWs) or Mississippi Registered Nurses (RNs). Case management teams may consist of two social workers, two nurses, or a social worker and nurse. On initial assessments, the case management agency must have an RN available for consultation in instances where the team is comprised of two LSWs.

Qualified assessors on the case management team perform the core standardized assessment at the time of evaluation and enter the person's pertinent data into the LTSS system. In LTSS, 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, the core standardized assessment tool is completed by the case management team 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 operating agency 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 case management agency offices. The core standardized assessment along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. The case management agency 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**

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 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 = 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:

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 claims 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**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **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 case management agency offices. The Informed Choice along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. The case management agency 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		
Statutory Service	**Adult Day Care**		
Statutory Service	**Case Management**		
Statutory Service	**In-Home Respite**		
Statutory Service	**Personal Care Service**		
Extended State Plan Service	**Extended Home Health Services**		
Other Service	**Community Transition Services**		
Other Service	**Environmental Safety Services**		
Other Service	**Home Delivered Meals**		
Other Service	**Institutional Respite Care**		
Other Service	**Medication Management**		
Other Service	**Physical Therapy Services**		
Other Service	**Speech Therapy Services**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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):*

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

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

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

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

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

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled E&D Waiver Adult Day Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled E&D Waiver Adult Day Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all 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:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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):*

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

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

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

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

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

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

A unit of service equals all case management activities provided in one month. Case management reimbursement is a flat rate which is billed monthly after the service is provided.

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 E&D Waiver Case Management Providers

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled E&D Waiver Case Management Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all case managers.

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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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

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):*

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled E&D Waiver In-Home Respite Providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled E&D Waiver In-Home Respite Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all direct care workers.

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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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

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):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled E&D Waiver Personal Care Attendant Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Service

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled E&D Waiver Personal Care Attendant Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all direct care workers.

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:

Extended State Plan Service

Service Title:

Extended Home Health Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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

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):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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 agency verifies the qualifications are met for all 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:

Community Transition Services

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):*

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

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

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

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

All items and services covered must be essential to:
1) Ensure that the person is able to transition from the current nursing facility or ICF/IID facility, and
2) Remove identified barriers and/or mitigates risks to the success of the transition to a more independent living situation.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	MS Medicaid Enrolled E&D Waiver Community Transition Services Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:

MS Medicaid Enrolled E&D Waiver Community Transition Services Providers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all 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:

Environmental Safety Services

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):*

Environmental safety services are services provided for the purpose of supporting members in maintaining a healthy and safe living environment through the performance of tasks in and around the individual's home that are beyond the individual's capability. This service includes minor home maintenance and repair, heavy household cleaning, non-routine disposal of garbage posing a threat to the individual's health and welfare, non-routine yard maintenance, pest control and related tasks to prevent, suppress, eradicate or remove pests posing a threat to the individual's health and welfare.

The service does not include tasks that are the legal or contractual responsibility of someone other than the individual, that can be accomplished through existing informal supports, formal supports, or do not provide a direct of remedial benefit to the individual. The services does not include tasks performed or interventions available through the personal care or in-home respite services.

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

Environmental safety services shall not exceed $500.00 per waiver year. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Medicaid Enrolled E&D Waiver Environmental Safety Service Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Safety Services

Provider Category:

Individual

Provider Type:

Medicaid Enrolled E&D Waiver Environmental Safety Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all vendors/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:

Home Delivered Meals

HCBS Taxonomy:

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

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

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):*

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

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

Minimum Program Requirements:
All service providers offering home delivered meals must adhere to the following requirements:
Service Activities:
(A) Safety: Home delivered meals providers are required to ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health regulations governing food service sanitation.

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

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

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

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

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

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

One unit of service is one meal delivered. One meal per day will be the maximum meal services allowed. Shelf-stable meals are provided to the homebound for designated holidays, weather or other emergencies, elections and various community events.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled E&D Waiver Home Delivered Meal Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled E&D Waiver Home Delivered Meal Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

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 agency verifies the qualifications are met for all vendors/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:

Institutional Respite Care

HCBS Taxonomy:

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

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):*

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Hospital, Nursing Facilities, Licensed Swing Bed Facilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Institutional Respite Care

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Hospital, Nursing Facilities, Licensed Swing Bed Facilities

Provider Qualifications

License *(specify):*

Providers must maintain a current and active Mississippi license to function as a Hospital, Nursing Facility, Licensed Swing Bed Facility.

Certificate *(specify):*

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 agency verifies the qualifications are met for all 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:

Medication Management

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):*

Medication Management services are services in which enrolled individual's with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications can receive consultations and follow up visits with a licensed pharmacist. As a core component of the service, the pharmacy provider will review all prescription and over-the-counter medications taken by the individual on at least a monthly basis in order to support the individual's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors. Reviews may occur more frequently, on an as needed basis, upon significant change in the individual's condition or immediately following discharge from an acute hospital stay. The service will include two components: a comprehensive initial/annual consultation and subsequent follow-up consultations.

The provider will be responsible for collecting a complete medical history and list of prescribed and over-the-counter medications in order to assess whether the individual's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented. If issues with the above are identified, the provider will take necessary steps to implement necessary interventions, including but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery/reminder services.

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

The service is limited to one initial/annual consultation and fifteen (15) follow-up visits per waiver year. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	MS Medicaid Enrolled Pharmacy Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Management

Provider Category:

Individual

Provider Type:

MS Medicaid Enrolled Pharmacy Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all 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:

Physical Therapy Services

HCBS Taxonomy:

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

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):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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 agency verifies the qualifications are met for all 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:

Speech Therapy Services

HCBS Taxonomy:

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

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):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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 agency verifies the qualifications are met for all 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:

In accordance with the concurrent 1915(b)(4) waiver, case management services are provided by the Mississippi Planning and Development Districts (PDDs).

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, personal care attendant services, in-home respite, adult day care, or community transition services 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 case management, personal care attendant services, in-home respite, adult day care, or community transition services 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:

The state does not make payments for furnishing waiver services to legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the participant's power of attorney or those designated as the participant's representative payee for Social Security benefits.

For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the participant. The state may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:
- There is documentation that there are no other willing/qualified providers available for selection.
- The selected relative is qualified to provide services as specified in Appendix C-1/C-3.
- The participant or another designated representative is available to sign verifying that services were rendered by the selected relative.
- The selected relative agrees to render services in accordance with the scope, limitations and professional requirements of the service during their designated hours.
- The service provided is not a function that a relative or housemate was providing for the participant without payment prior to waiver enrollment.

The state reserves the right to remove a selected relative from the provision of services at any time if there is the suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the participant will be asked to select an alternate qualified provider.

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:
PM 1: # 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** Specify:	☐ **Annually**
	☐ **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.

Performance Measure:
PM 2: Number and percent of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. N: # of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. D: Total number of enrolled non-licensed/non-certified providers reviewed. D: Total number of enrolled provider staff 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **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

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

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

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

Performance Measure:
PM 3: Number and percent of 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 *(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: 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** 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 agency/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. Provider claims 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: Every 24 months

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

Note instructions at Module 1, Attachment #2, 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.

E&D Waiver services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:
• Case management,
• Home-delivered meals,
• Personal care services,
• In-home respite,
• Community transition services,
• Environmental safety services,
• Medication management,
• Expanded home health visits.
• Speech Therapy, and
• Physical Therapy.

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

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

Part 208, Chapter 1 of the Medicaid Administrative Code requires persons enrolled in the E&D waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community and meet the requirements of the Home and Community-Based (HCB) settings. It further defines that the Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or on the grounds of or adjacent to institutions or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS). All ADC 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:

☐ **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:*

All Plans of Services and Supports (PSS), in conjunction with the LTSS assessment and the Emergency Preparedness Plan, are reviewed and approved by Division of Medicaid (DOM) Program Nurses prior to service implementation. This review allows DOM Program Nurses to ensure appropriateness and adequacy of services and to ensure that services furnished are consistent with the nature and severity of a person's disability. The PSS is a person-centered service plan. It is the fundamental tool by which DOM ensures the health and welfare of participants in the waiver. DOM's process for developing a person-centered plan requires the PSS to be based on a comprehensive LTSS assessment process. PSS development is conducted with the person's input to include what is important to the individual with regard to preferences for the delivery of services and supports. The participant's signature on the PSS indicates that they were provided all of their available service options under the chosen waiver in addition to freedom of choice of provider. The case manager engages the person and other interested parties as requested by the person in developing a PSS that meets their needs. The meeting is held at a time and location agreed upon with the person.

On the E&D Waiver, the case management agency develops the person-centered service plan and can only provide other waiver services to the person if there is no other willing providers in the geographic area and there are appropriate firewalls in place. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the Division of Medicaid, case management agencies cannot provide other services to waiver participants without the express permission of DOM. At no time are individual case managers authorized to provide direct care services. Oversight of waiver processes and periodic evaluations are completed by the DOM Office of Long Term Care and Office of Financial & Performance Audit.

At enrollment, the person is informed by the case management agency of the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing as outlined in Appendix F of this waiver. The person has the right to address any disputes regarding services with DOM at any time. The participant also signs a Bill of Rights outlining their rights and the appropriate contact information. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process.

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 process 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.

The case management agency is responsible for implementing the PSS. They, along with DOM, are jointly responsible for monitoring the PSS. The case management agency 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.

Participants are informed of the different waiver services, State plan services, settings and providers during the initial assessment and at each reassessment, or at the request of the individual.

The concurrent 1915(b)(4) waiver selectively limits providers of case management and home delivered meals to the MS Planning and Development Districts. The person is given a choice of all other qualified providers in their area and their selection is documented on the Freedom of Choice form. While the PDDs also act as the billing provider for environmental safety services, the member is allowed to select qualified vendors for services rendered who are then contracted by the PDD. The PDD is then responsible for billing those services to DOM as reimbursement for paid invoices.

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):

During the person-centered planning process, the person and/or their caregiver is given a list of qualified providers/vendors 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/vendors 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/vendor 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/vendor 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 (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, the case management agency contacts the service provider to engage in a problem-solving process to determine how to get the person the services needed in a consistent manner in accordance with the PSS.

b. Monitoring Safeguards. *Select one:*

- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and**

participant health and welfare may not provide other direct waiver services to the participant.

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

The case management agency monitors the person-centered service plan and can only provide other waiver services to the person if there is no other willing providers in the geographic area and there are appropriate firewalls in place. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the Division of Medicaid, case management agencies cannot provide other services to waiver participants without the express permission of DOM. At no time are individual case managers authorized to provide direct care services. Oversight of waiver processes and periodic evaluations are completed by the DOM Office of Long Term Care and Office of Financial & Performance Audit.

At enrollment, the person is informed by the case management agency of the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing as outlined in Appendix F of this waiver. The person has the right to address any disputes regarding services with DOM at any time. The participant also signs a Bill of Rights outlining their rights and the appropriate contact information. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
PM 1: Number and percent of persons reviewed whose PSS addresses all their needs (including health and safety risk factors and personal goals). N: Number of persons whose PSS is reviewed that addresses all their needs (including health and safety risk factors and personal goals). D: Total number of person whose PSS was reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(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**

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

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**	☒ **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: Every 24 months

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 6: Number and percent of persons' reviewed with documented presentation of available service options and freedom of choice of providers. N: Number of persons' reviewed with documented presentation of available service options and freedom of choice of providers. D: Total number of PSS reviewed.

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

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. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the case management agency 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 case management agency 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

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.

A case manager sends a Notice of Action (NOA) to the person by certified mail (Signature return requested). Fair Hearing Notices are maintained in person's file at the Case Management Agency.

Contents of Notice of Action include:
a. Description of the action the provider has taken or intends to take;
b. Explanation for the action;
c. Notification that the 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 management agency or DOM state office. If the written request is not received within the 30 day time period, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as identified in the Administrative Code.

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

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

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The person or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or person's case record.

2. The right to have legal representation at the hearing and to bring witnesses.

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

4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an

opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the person or service providers. Upon receipt of the request for a state hearing, the DOM Office of Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

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

At no time will the informal dispute resolution process conflict with the person's right to a State Fair Hearing in accordance with State Fair Hearing procedures and processes as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

State Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes.

Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

Critical incidents are identified as follows:
Abuse (A) - willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.
Neglect (N) - can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.
Exploitation (E) - Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

The Department of Human Services (DHS), Division of Aging and Adult Services, is the agency responsible for investigating allegations of A, N and E. There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver persons.

All reports of A, N and E are taken very seriously by DOM. DOM provides for the reporting and investigation of major and serious incidents of abuse, neglect and exploitation of a waiver persons. All reports of A, N and E are reported immediately verbally and in writing by the appropriate case manager to their supervisor and the Department of Human Services. The potential A, N and E are also to be reported in writing to DOM as it occurs. If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. In addition, reports are simultaneously made to DHS who is the investigative agency in Mississippi responsible for investigating allegations of A, N and E. DOM and the case management agency follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

Mississippi Vulnerable Persons Act, Section 43-47-9 (1). "Upon receipt of a report pursuant to Section 43-47-7 that a vulnerable person is in need of protective services, the department (The Mississippi Department of Human Services)shall initiate an investigation and/or evaluation within forty-eight (48) hours if immediate attention is needed, or within seventy-two (72) hours if the vulnerable person is not in immediate danger, to determine whether the vulnerable person is in need of protective services and what services are needed."

The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon entry into the waiver, case managers will provide the person and/or their caregiver education and information concerning the State's protection of the person against abuse, neglect and exploitation including how persons may notify appropriate authorities when the person may have experienced abuse, neglect or exploitation. When person are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains regular contact with each person by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities.

DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff.

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

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

First line entity to receive reports is the E&D Waiver case manager at the case management agency and/or DOM. The critical incident is reported as indicated and followed by DOM staff until the incident is resolved. The communication continues between the case management agency, DOM, Department of Human Services, and Attorney General's Office, if necessary, until resolution occurs.

The Department of Human Services (DHS), Division of Aging and Adult Services, as the lead agency responsible for investigation, is responsible for the notification of investigation results to parties as designated by state law. Time frames for notification of results vary based on investigation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The case management agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated §n 43-1-1, et seq. (1972, as amended), the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM works with DHS through the provision of a memorandum of understanding to ensure effective incident management of all home and community based waiver person under 42 CRFR § 441.302. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents. This is an ongoing process, and as these events occur, immediate action takes place and investigation begins. All of the above entities keep written records of suspected events of abuse, neglect, and exploitation. The LTSS system includes a module that will be implemented and will allow critical incident data to be reported and tracked between DOM, DHS, and the case management agency.

Appendix G: Participant Safeguards

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

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

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

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

The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver person. The case management team is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not permit the use of restrictive interventions. DOM and the case management agencies are jointly responsible for ensuring that restrictive interventions are not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not permit the use of seclusion. DOM and the case management agencies are jointly responsible for ensuring that seclusion is not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

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

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

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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**
☐ **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:

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 = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 3: Number and percent of persons who receive information on how to report suspected cases of abuse, neglect, or exploitation. N: Number of persons reviewed who received information on how to report suspected cases of abuse, neglect, or exploitation. D: Total number of person's records reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
LTC QA Home Visits/Telephone Interviews

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

collection/generation *(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 = 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**

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

DOM employs staff to assist in system design. Meetings are held routinely, or as needed, to review analyzed discovery and remediation data, to develop Computer System Request (CSRs), review progress, and test system changes. The CSRs are the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent. The meetings involve participation from DOM's Office of Information Technology Management, Long Term Care staff and others deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including nurses are held monthly or as needed for the purpose of addressing needs and resolving issues. When DOM identifies a system issue it is reported to the fiscal agent for review and research. System issues that affect services to persons or affect accurate payment to providers are considered a priority. DOM holds monthly meetings with the program staff and the systems staff to address issues that require system changes.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

b. System Design Changes

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

DOM meets on monthly or as needed basis with the Office of Information Technology Management, with daily communication whereby system errors and remedies are discussed and or reported. DOM staff and waiver providers/ direct users of the agency's electronic system have the ability to notify electronically, telephonically, or in writing concerns of the inability to process application packets or billing processes in a timely manner. The Office of Information Technology Management monitors all errors, omissions, and system downtimes in order for DOM to address either with the fiscal agent for a system change to remedy the problem and/or track the problem to propose a remedy. In addition, DOM and the case management agencies meet periodically to review and analyze the functionality of the LTSS process. Recommendations for improvement are reviewed and applied as appropriate.

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

DOM monitors the Quality Improvement Strategy on a quarterly basis. The Quality Improvement Strategy is reviewed annually. The review consists of 1) analyzing aggregated reports and progress toward meeting 100% of the sub assurances, 2) resolution of individual and systemic issues found during discovery, and 3) notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and the fiscal agent is made to meet waiver reporting requirements. The Quality Assurance nurses will utilize the Quality Improvement Strategy during all levels of QA activities.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**

- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

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 paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver. D: Total number of claims paid.

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

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

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.

DDOM contracted with an actuary firm to thoroughly evaluate the service rates in 2017. DOM reviews all waiver rates annually to ensure that they are sufficient to ensure a qualified pool of providers. This annual review was most recently completed in June 2022 and will be completed again in June 2023. If it is determined that rates are no longer sufficient, they are increased appropriately.

To set the context for developing service rates, the service descriptions for each waiver service were carefully considered. It was determined whether certain services had essentially the same provider education requirements, expectations and billable productivity levels. If so, these services were grouped together for purposes of rate development.

Rates for Home Delivered Meals will be aligned with the statewide meals contract rate is greater than the Consumer Price Index for the previous calendar year, DOM will pay the new contracted rate with no less than 20% above for accounting, billing and general management of the meal program. During the 2012 Milliman rate review, this add on was determined to be the comparative administrative fee for known vendor subcontracting terms to provide for the organization and coordination of meal deliveries.

For all services reviewed, we either compared current waiver rates to the same non-waiver Medicaid service rates, or we performed a thorough "ground up" provider rate development.

For the Adult Day Care, Personal Care, Case Management, In-Home Respite, and Community Transition services, we built rates from the ground up using the following rating variables:
- *Direct service provider salaries and benefits*
- *Direct service-related expense and overhead costs*
- *Annual number of hours practitioners are at work*
- *Percentage of time an at work practitioner is able to convert to billable units (productivity)*

A benefit load of 35% of salary was added for social workers and nurses, while direct care workers received a load of 25%. A blended load of 30%, was used for Adult Day Care Services which represents a blend of 25% for assistants and activity coordinators and 35% for program coordinator and clinical support. This load accounts for all mandatory Mississippi and Federal benefits, such as unemployment and Social Security, as well as employer costs for optional benefits, such as health and disability insurance.

The rating variable assumptions were developed using multiple data sources including the 2015 Bureau of Labor Statistics (BLS) data trended to 2017, a 2010 proprietary Milliman medical provider compensation survey, 2011 Mississippi Planning and Development District (PDD) and Adult Day Care (ADC) center surveys, and DOM and Milliman experience. Throughout the development process, DOM had multiple, extensive discussions with Milliman to confirm the appropriateness of each of the rate development assumptions regarding service specifications, overhead costs, staffing, average length of stay, etc. for use with the Mississippi HCBS environment. Milliman recommended rates in accordance with generally recognized and accepted actuarial principles and practices. DOM carefully reviewed the recommended rate changes and the resulting fiscal impact to providers prior to selecting the submitted rates. DOM knowledge of providers and the service delivery environment along with Milliman experience in rate development in other programs were considered in the development of certain assumptions, such as expected hours billed per day, as reflected in the rate development memos.

The rates for Physical Therapy, Speech Therapy, and Extended Home Health are set to match the State Plan reimbursement rate, which is based on an annual cost report, updated October 1st of each year.

The institutional respite rates were determined based on comparable rates for nursing facility services based on the average of daily rates in place for SFY 2023.

Once we calculated initial service rates, we compared them to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. After provider feedback, the ADC rate was adjusted up based on a change in the assumed units per day of services received.

The ADC must submit claims in 15 minute increments for the duration of time the services were provided and will be reimbursed by DOM the lessor of the maximum daily cap of &73.60 in Year 1 or the total amount of the 15 minute increment units billed. The duration of the service time should begin upon the person's entry in the facility and end upon their departure.

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 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:

There are ten (10) Planning and Development Districts (PDD's) in the State of Mississippi. Each PDD is an independent organization governed by a Board of Directors appointed by the local government officials. Each District represents a distinctly different region of the state, but each have common functions such as economic development, loan programs, community development, technical assistance, planning assistance, human resource development, job training, social services, transportation and gerontology. The state Area Agencies on Aging (AAAs) are housed within the PDDs. The PDD's provide case management services, community transition services, and home delivered meals.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***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:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	16869.81	3878.08	20747.89	56063.35	8350.25	64413.60	43665.71
2	16869.81	3986.67	20856.48	57633.13	8584.06	66217.19	45360.71
3	16869.81	4098.29	20968.10	59246.86	8824.41	68071.27	47103.17
4	16869.81	4213.05	21082.86	60905.77	9071.49	69977.26	48894.40
5	16869.81	4331.01	21200.82	62611.13	9325.50	71936.63	50735.81

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	*22200*	22200
Year 2	*22200*	22200

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	*22200*	*22200*
Year 4	*22200*	*22200*
Year 5	*22200*	*22200*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Based on the FY2022 CMS 372 Report data, the average length of stay for this waiver is 298 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 9.9 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 beneficiary in a nursing facility, including individuals who are elderly and disabled, 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, including individuals who are elderly and disabled, 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 Day Care	
Case Management	
In-Home Respite	
Personal Care Service	
Extended Home Health Services	
Community Transition Services	
Environmental Safety Services	
Home Delivered Meals	
Institutional Respite Care	
Medication Management	
Physical Therapy Services	
Speech Therapy Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**37682280.00**
Adult Day Care	☐	per 15 minutes	4440	1845.00	4.60	**37682280.00**	
Case Management Total:							**40341840.00**
Case Management	☐	monthly	22200	8.00	227.15	**40341840.00**	
In-Home Respite Total:							**27960171.84**
In-Home Respite	☐	per 15 minutes	3996	1174.00	5.96	**27960171.84**	
Personal Care Service Total:							**253152549.60**
Personal Care Service	☐	per 15 minutes	21090	2014.00	5.96	**253152549.60**	
Extended Home Health Services Total:							**14692.50**
Skilled Nursing	☐	per visit	11	10.00	110.19	**12120.90**	
Home Health Aide	☐	per visit	6	10.00	42.86	**2571.60**	
Community Transition Services Total:							**162558.00**
Community Transition Services	☐	per occurance	11	1.00	14778.00	**162558.00**	
Environmental Safety Services Total:							**1110000.00**
Environmental Safety Services	☐	per year	2220	1.00	500.00	**1110000.00**	
Home Delivered Meals Total:							**10574410.56**
Home Delivered Meals	☐	per meal	12432	142.00	5.99	**10574410.56**	
Institutional Respite Care Total:							**34541.10**
Institutional Respite Care	☐	per day	11	10.00	314.01	**34541.10**	
Medication Management Total:							**3468750.00**
Initial/Annual Consultation	☐	per visit	5550	1.00	85.00	**471750.00**	

GRAND TOTAL:	**374509735.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	374509735.20
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16869.81**
Services included in capitation:	
Services not included in capitation:	16869.81
Average Length of Stay on the Waiver:	298

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Follow-Up	☐	per visit	5550	12.00	45.00	2997000.00	
Physical Therapy Services Total:							3970.80
Physical Therapy Services	☐	per visit	6	10.00	66.18	3970.80	
Speech Therapy Services Total:							3970.80
Speech Therapy Services	☐	per visit	6	10.00	66.18	3970.80	

GRAND TOTAL:		374509735.20
Total: Services included in capitation:		
Total: Services not included in capitation:		374509735.20
Total Estimated Unduplicated Participants:		22200
Factor D (Divide total by number of participants):		16869.81
Services included in capitation:		
Services not included in capitation:		16869.81
Average Length of Stay on the Waiver:	298	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							37682280.00
Adult Day Care	☐	per 15 minutes	4440	1845.00	4.60	37682280.00	
Case Management Total:							40341840.00
Case Management	☐	monthly	22200	8.00	227.15	40341840.00	
In-Home Respite Total:							27960171.84
In-Home Respite	☐	per 15 minutes	3996	1174.00	5.96	27960171.84	

GRAND TOTAL:		374509735.20
Total: Services included in capitation:		
Total: Services not included in capitation:		374509735.20
Total Estimated Unduplicated Participants:		22200
Factor D (Divide total by number of participants):		16869.81
Services included in capitation:		
Services not included in capitation:		16869.81
Average Length of Stay on the Waiver:	298	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Service Total:							**253152549.60**
Personal Care Service	☐	per 15 minutes	21090	2014.00	5.96	**253152549.60**	
Extended Home Health Services Total:							**14692.50**
Skilled Nursing	☐	per visit	11	10.00	110.19	**12120.90**	
Home Health Aide	☐	per visit	6	10.00	42.86	**2571.60**	
Community Transition Services Total:							**162558.00**
Community Transition Services	☐	per occurance	11	1.00	14778.00	**162558.00**	
Environmental Safety Services Total:							**1110000.00**
Environmental Safety Services	☐	per year	2220	1.00	500.00	**1110000.00**	
Home Delivered Meals Total:							**10574410.56**
Home Delivered Meals	☐	per meal	12432	142.00	5.99	**10574410.56**	
Institutional Respite Care Total:							**34541.10**
Institutional Respite Care	☐	per day	11	10.00	314.01	**34541.10**	
Medication Management Total:							**3468750.00**
Initial/Annual Consultation	☐	per visit	5550	1.00	85.00	**471750.00**	
Follow-Up	☐	per visit	5550	12.00	45.00	**2997000.00**	
Physical Therapy Services Total:							**3970.80**
Physical Therapy Services	☐	per visit	6	10.00	66.18	**3970.80**	
Speech Therapy Services Total:							**3970.80**
Speech Therapy Services	☐	per visit	6	10.00	66.18	**3970.80**	

GRAND TOTAL:	**374509735.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	374509735.20
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16869.81**
Services included in capitation:	
Services not included in capitation:	16869.81
Average Length of Stay on the Waiver:	298

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**37682280.00**
Adult Day Care	☐	per 15 minutes	4440	1845.00	4.60	**37682280.00**	
Case Management Total:							**40341840.00**
Case Management	☐	monthly	22200	8.00	227.15	**40341840.00**	
In-Home Respite Total:							**27960171.84**
In-Home Respite	☐	per 15 minutes	3996	1174.00	5.96	**27960171.84**	
Personal Care Service Total:							**253152549.60**
Personal Care Service	☐	per 15 minutes	21090	2014.00	5.96	**253152549.60**	
Extended Home Health Services Total:							**14692.50**
Skilled Nursing	☐	per visit	11	10.00	110.19	**12120.90**	
Home Health Aide	☐	per visit	6	10.00	42.86	**2571.60**	
Community Transition Services Total:							**162558.00**
Community Transition Services	☐	per occurance	11	1.00	14778.00	**162558.00**	
Environmental Safety Services Total:							**1110000.00**
Environmental Safety Services	☐	per year	2220	1.00	500.00	**1110000.00**	

GRAND TOTAL:	**374509735.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	374509735.20
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16869.81**
Services included in capitation:	
Services not included in capitation:	16869.81
Average Length of Stay on the Waiver:	298

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**10574410.56**
Home Delivered Meals	☐	per meal	12432	142.00	5.99	**10574410.56**	
Institutional Respite Care Total:							**34541.10**
Institutional Respite Care	☐	per day	11	10.00	314.01	**34541.10**	
Medication Management Total:							**3468750.00**
Initial/Annual Consultation	☐	per visit	5550	1.00	85.00	**471750.00**	
Follow-Up	☐	per visit	5550	12.00	45.00	**2997000.00**	
Physical Therapy Services Total:							**3970.80**
Physical Therapy Services	☐	per visit	6	10.00	66.18	**3970.80**	
Speech Therapy Services Total:							**3970.80**
Speech Therapy Services	☐	per visit	6	10.00	66.18	**3970.80**	

GRAND TOTAL:		**374509735.20**
Total: Services included in capitation:		
Total: Services not included in capitation:		374509735.20
Total Estimated Unduplicated Participants:		**22200**
Factor D (Divide total by number of participants):		**16869.81**
Services included in capitation:		
Services not included in capitation:		16869.81
Average Length of Stay on the Waiver:	298	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**37682280.00**
Adult Day Care	☐	per 15 minutes	4440	1845.00	4.60	**37682280.00**	
Case Management Total:							**40341840.00**
Case Management	☐	monthly	22200	8.00	227.15	**40341840.00**	
In-Home Respite Total:							**27960171.84**
In-Home Respite	☐	per 15 minutes	3996	1174.00	5.96	**27960171.84**	
Personal Care Service Total:							**253152549.60**
Personal Care Service	☐	per 15 minutes	21090	2014.00	5.96	**253152549.60**	
Extended Home Health Services Total:							**14692.50**
Skilled Nursing	☐	per visit	11	10.00	110.19	**12120.90**	
Home Health Aide	☐	per visit	6	10.00	42.86	**2571.60**	
Community Transition Services Total:							**162558.00**
Community Transition Services	☐	per occurance	11	1.00	14778.00	**162558.00**	
Environmental Safety Services Total:							**1110000.00**
Environmental Safety Services	☐	per year	2220	1.00	500.00	**1110000.00**	
Home Delivered Meals Total:							**10574410.56**
Home Delivered Meals	☐	per meal	12432	142.00	5.99	**10574410.56**	
Institutional Respite Care Total:							**34541.10**
Institutional Respite Care	☐	per day	11	10.00	314.01	**34541.10**	
Medication Management Total:							**3468750.00**
Initial/Annual Consultation	☐	per visit	5550	1.00	85.00	**471750.00**	

GRAND TOTAL:	**374509735.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	374509735.20
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16869.81**
Services included in capitation:	
Services not included in capitation:	16869.81
Average Length of Stay on the Waiver:	298

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Follow-Up	☐	per visit	5550	12.00	45.00	2997000.00	
Physical Therapy Services Total:							3970.80
Physical Therapy Services	☐	per visit	6	10.00	66.18	3970.80	
Speech Therapy Services Total:							3970.80
Speech Therapy Services	☐	per visit	6	10.00	66.18	3970.80	

GRAND TOTAL:		374509735.20
Total: Services included in capitation:		
Total: Services not included in capitation:		374509735.20
Total Estimated Unduplicated Participants:		22200
Factor D (Divide total by number of participants):		16869.81
Services included in capitation:		
Services not included in capitation:		16869.81
Average Length of Stay on the Waiver:	298	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							37682280.00
Adult Day Care	☐	per 15 minutes	4440	1845.00	4.60	37682280.00	
Case Management Total:							40341840.00
Case Management	☐	monthly	22200	8.00	227.15	40341840.00	
In-Home Respite Total:							27960171.84
In-Home Respite	☐	per 15 minutes	3996	1174.00	5.96	27960171.84	

GRAND TOTAL:		374509735.20
Total: Services included in capitation:		
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Factor D (Divide total by number of participants):		16869.81
Services included in capitation:		
Services not included in capitation:		16869.81
Average Length of Stay on the Waiver:	298	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Service Total:							**253152549.60**
Personal Care Service	☐	per 15 minutes	21090	2014.00	5.96	**253152549.60**	
Extended Home Health Services Total:							**14692.50**
Skilled Nursing	☐	per visit	11	10.00	110.19	**12120.90**	
Home Health Aide	☐	per visit	6	10.00	42.86	**2571.60**	
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GRAND TOTAL:	**374509735.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	374509735.20
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16869.81**
Services included in capitation:	
Services not included in capitation:	16869.81
Average Length of Stay on the Waiver:	298

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 state is submitting a streamlined renewal therefore there are no significant changes to this renewal document. The State plans to submit another renewal in 2023 with the purpose of realigning 1915 (c) waivers on the same cycle to allow for administrative efficiencies, standardization of language and quality metrics across waivers, and utilizing information from a full HCBS workforce study that will be beneficial in projecting adjustments needed in service delivery.~~

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 reflect concurrent operation of a new 1915(b)(4) waiver.
• Updates to language to streamline provider qualifications.
• Addition of language to allow for waiver capacity to be allocated regionally.
• Update Case Management service specifications and provider qualifications to allow for additional flexibilities in staff credentials and service provision.
• Addition of a new Medication Management service.
• Addition of a new Environmental Safety service.
• Updates to the language related to the provision of services by family members/relatives and defining legally responsible persons.

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

1. Request Information (1 of 3)

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

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

Elderly and Disabled (E&D)

C. Type of Request: 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.0272
Waiver Number:MS.0272.R06.00
Draft ID: MS.005.06.00

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

Regular Waiver

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

~~07/01/22~~ 7/1/23

Approved Effective Date: 07/01/22

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 aged and/or disabled. Individuals must be 21 and over.

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

The Elderly and Disabled (E&D) 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 E&D Waiver: case management, personal care services, adult day care, in-home respite, institutional respite, home delivered meals, community transition services, environmental safety services, medication management, physical therapy, speech therapy, and extended State Plan home health care services.

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:

~~The renewal was posted for public notice on 4/28/22 for 30 days and the state received no comments. The notice was posted on the DOM webpage at https://medicaid.ms.gov/wp-content/uploads/2022/04/Updated-2022-ED-Waiver-Renewal-Combined-Public-Notice.pdf. In addition to being posted on the public webpage, a copy of the proposed waiver was made available in each county health department office and in the Department of Human Services office in Issaquena County for review.~~

~~Mississippi also obtains public input continuously throughout the waiver cycle via QIS Meetings and home visits/telephone interviews conducted by State staff. During these home visits/telephone interviews, direct feedback is received from the person and/or their representatives. Specific feedback is obtained regarding the person's satisfaction with their services, their satisfaction with their case manager, and any additional services that they believe could be of benefit to them. Public input is also obtained through calls received from applicants/participants, regarding inquiries, complaints, or appeals.~~

~~Another mechanism through which public input is obtained is from telephone correspondence with applicants/participants, and/or their representatives, regarding inquiries, complaints, or appeals.~~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 opportunities for flexibility related to the provision of services by relatives.
State's Response: DOM has reviewed and updated language related to the provision of services by relatives/legal guardians in this renewal.
Public Comments were received regarding opportunities for flexibility in provider credentialling requirements.
DOM Response: DOM has reviewed and updated language related to provider requirements in both the renewal and the accompanying Medicaid Administrative Code submission.
Public comments were received regarding the need to update reimbursement rates for several E&D Waiver services.
DOM 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. Providers are encouraged to participate. That data will be incorporated into ongoing rate updates/studies.
Public comments were received regarding the possible addition/removal of waiver services including Institutional Respite, Escorted Transportation, Pest Control, and Skilled Nursing.
State's Response: DOM has reviewed the requests and updated several services to address concerns/needs. Additionally, we will continue to evaluate the need for service updates in future amendments/renewals.
Public comments were received regarding the need for ongoing flexibility in the provision of case management.
State's Response: DOM has reviewed and updated language related to the provision of case management services.
Public comments were received regarding the need for updates to the waitlist management process including increased transparency for providers.
State's Response: DOM will continue to evaluate opportunities to streamline waitlist management processes.
Public comments were received regarding the implementation of electronic visit verification.
State's Response: DOM continues to work towards the implementation of an upgraded open hybrid EVV system in Summer 2023.

~~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.~~J. 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: Paulette Johnson

State Medicaid Director or Designee

Submission Date: ~~Jun 27, 2022~~

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

Agency: MS Division of Medicaid

Address: 550 High Street, Suite 1000

Address 2:

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:

~~DOM continues to work to implement processes to ensure that there is open enrollment of all willing and qualified providers for case management and home delivered meal services. The state has made significant progress in completing the systematic changes necessary to finish the planned implementation.~~

The state is adding Environmental Safety Services and Medication Management as new services in this renewal. The state will work to operationalize those services and make them available to enrolled participants by January 1, 2024.

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

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

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's

HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

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

Overview of Mississippi's 1915(c) HCBS Programs

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

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

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

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

Public notice was given on December 20, 2021, to the submission of the revised Mississippi Statewide Transition Plan for final approval. The draft was available for public comments for thirty (30) days.

The Division of Medicaid received comments from Beth Porter with Disability Rights Mississippi during the thirty (30) day comment period:

We would like to point out that first, there has been no real effort made to make Medicaid's State plan amendment changes available to the people who use this program. DRMS has consistently requested that the Mississippi Division of Medicaid make us and our consumers aware of any changes to the State plan. You responded that you would not only make us aware but also make your consumers aware. This has not happened over the past two years. During section k (Emergency) services, MDOM has placed amendment changes on the website and DRMS has not been given notice that there was a State Plan Amendment being changed. Consumers of Medicaid 1915i and 1915c HCB services were not made aware of any changes to the plan. Under the new rules, one should be given choice in all areas of life. Please advise DRMS of how how the Mississippi Division of Medicaid will come into compliance with this rule.

Response: The Division of Medicaid posts public notices of State Plan amendments in compliance with 42 C.F.R. § 447.205. All State Plan submittals and approvals are posted on the Division of Medicaid's website and emailed to everyone who has requested notifications through the Division of Medicaid's Office of Policy email. To request to be included in the list of recipients email DOMPolicy@medicaid.ms.gov. This information is also posted on the Division of Medicaid's website. During the public health emergency, the Division of Medicaid posted notifications as required by CMS for changes to waiver services and State Plan services. The Department of Mental Health notified all certified IDD providers through DMH Provider Bulletin(s) concerning Appendix K flexibilities. Participants were informed through both providers and Support Coordinators. Providers were informed of Final Rule requirements through a series of trainings and technical assistance through the assessment and remediation process. Participants and families were informed through a handout and through discussions with Support Coordinators and providers during the Plan of Services and Supports (PSS) person centered plan development. The Division of Medicaid's Office of Long

Term Care notified providers via email of COVID flexibilities related to their services. Public Notice requirements were waived during this time due to the emergency. The Division of Medicaid published public notices for non-emergency SPAs as required. The Division of Medicaid is in compliance with both state and federal public notice requirements.

Secondly, there do not seem to be many choices in providers. Please advise DRMS how the Mississippi Division of Medicaid will ensure that individuals are actually being given a choice for providers. DRMS receives calls from individuals who receive services who cannot get a Physical therapist, or an RN, or even an LPN, to do the services that have been granted to them through the 1915c and 1915i HCB services. All these specified services are lacking in choice, and have been lacking in choice since before the Pandemic, The Pandemic is now exploiting the holes in the Medicaid system.

Response: A Freedom of Choice of provider form must be completed by the person and/or representative and submitted prior to the Plan of Services and Supports being approved. If there is an issue with the chosen provider, the case manager is notified. The case manager will then provide a list of other provider agencies for the person to choose from.

Third, there is a lack of training for individuals who work for The Mississippi Division of Medicaid. There is a lack of training for the individuals whom Mississippi Division of Medicaid contracts with and there is a lack of compliance to any Person Centered plans. DRMS always refers people who call, back to their person centered plan and is always told, there is no Person Centered plan.

Response: The Division of Medicaid and the Department of Mental Health require all case managers for each program to receive person centered planning training. Each person must have a person centered plan of services and supports signed by the person and/or representative upon application and annually thereafter. The plan is reviewed at least quarterly and revised as needed with input from the person and/or representative.

DRMS has stood firmly and done what it could to explain how the transition plan should be open and available for any one, under that plan, to understand what types of services to see changing and how to understand them. This has not been done. And even further, DRMS did not receive notice of a plan amendment change. We thank you for your hard work on this plan. We know that there have been many people working very hard to make the changes meaningful and do more for our community. We ask you to please try and understand that by not defining it, gives too much room for error.

Response: There has been no change to services as part of the Statewide Transition Plan. Processes have been updated to ensure freedom of choice and person-centered planning for each person receiving services. During the development of the Statewide Transition Plan, changes were made to the Administrative Code. These changes are posted on the Secretary of State's website, The Division of Medicaid's website, and included in the published Statewide Transition Plan. The Division of Medicaid also emails notifications to everyone who requests to be notified.

DRMS gets calls all the time about there being no Physical therapists to help with their son or daughter and that that son or daughter has been without speech therapy since birth because there was not a speech therapist in their area. The schools in these urban areas should at least be staffed with a speech therapist. This is frequently a problem for our clients, and our disability community as a whole. Medicaid is given money to help with covering medical services for all those who cannot afford them.

Response: This does not appear to be applicable to the Statewide Transition Plan. Please contact the Division of Medicaid for assistance with specific beneficiaries.

The 1915c waivers have not been giving the services that are needed to our clients. We have met and spoken with many individuals who have not been able to find a Psychologist for mental health purposes or an RN to do services that just a month ago were being handled by LPN workers. Now, parents are doing everything they can just find a LPN to come into their home and help with their child's needs. We have also seen an influx in phone calls regarding the lack of speech therapy services and Physical therapists.

Response: This does not appear to be applicable to the Statewide Transition Plan. Please contact the Division of Medicaid or Department of Mental Health for assistance with specific beneficiaries and/or services.

In addition to calls regarding the ID/DD waiver and the 1915i Expanded EPSDT benefit programs, we have gotten many regarding the IL and the TBI/SCI waiver as well. We see that many people are not receiving the amount of services or even the correct services for their needs and there are no Person Centered plans and supports for any of the clients whom DRMS has worked with. These individuals are people who were just sent a letter stating they were losing services with no clear understanding as to why.

Response: Please see the above response regarding the requirement for a Plan of Services and Supports.

Under the new rule, Individual's on the 1915i and 1915c programs are supposed to have choice. There are several problems regarding being given choice. We were told that MDOM would provide choice and would train the individual on this service, of exactly what a choice was. This has not happened and beneficiaries have not had a choice. If MDOM will not employ the people needed to provide services that MDOM is supposed to provide, then MDOM has not followed its' own regulations.

Response: A Freedom of Choice of provider form must be completed by the person and/or representative and submitted prior to the Plan of Services and Supports being approved. If there is an issue with the chosen provider, the case manager is notified. The case manager will then provide a list of other provider agencies for the person to choose from.

The Commentor provided the following comment/responses from the published Statewide Transition Plan:

"DRMS has provided MDOM with the problems we have seen. See what was written below:

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 communitybased 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.
The next statement written in the plan to never come to fruition is as follows: 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. 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 September 1, 2021 transparency in regard to the plans of correction. The disability community has direct experience and knowledge of these settings and how they operate on a day-to-day basis, often from the perspective of the participants. DRMS asks 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.

Medicaid responded to these two very important and legitimate concerns as follows:

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."

Another Statement from DRMS that we have written, about this plan. See what it says below:

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 176 September 1, 2021 allowed to review information and provide comment. We think this would be helpful to the State and ease implementation.

MDOM response to the question is:

Response: A Statewide Transition Plan stakeholder committee was formed and met on June 23, 2015."
The meeting was held, however, no one listened to anything we tried to tell you regarding how important the decision making process is and how this will be difficult to implement when so many Agencies out there, believe they have every right to tell a consumer what he or she should and should not be able to do.

~~Response: Please see our response regarding freedom of choice forms and requirements. DRMS is not in agreement with our State plan regarding page 164 where Staff were able to do phone interviews to show they had come into compliance, we feel that this is not appropriate and we have told MDOM several times that Individuals who receive services from these organizations are very dependent on them and have problems speaking openly regarding their experiences. A phone interview means someone was holding the phone for that person which means you did not get a good sample because most will not speak about real experiences in front of the Staff they depend on each day.~~

~~Response: Initial assessments were conducted in person and included in person interviews with people receiving services. Settings completed remediation of issues discovered. A desk audit was conducted to validate strategies outlined in each setting's approved Plan of Compliance were completed. Types of evidence submitted for review were revised policies and procedures, training records of staff and participants, and photos of changes to physical settings if applicable. Validation visits to each setting were conducted virtually through platforms such as Zoom or FaceTime in 2020 and 2021 due to the pandemic. Although personal experience could not be validated fully due to decreased activities surrounding COVID, the settings demonstrated compliance through policies and procedures, training, and virtual validation tour of settings and interviews with staff and participants. Ongoing monitoring is vital for continued compliance with the Final Rule as outlined in the State Transition Plan. All forty-five (45) settings initially determined to be in Heightened Scrutiny will have an on-site visit by DMH which will include in-person interviews with participants in the setting by June 30, 2022.~~

~~The Statewide Transition Plan was submitted for final approval on February 25, 2022.~~

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~~Long Term Care, Division of Elderly and Disabled Waiver Program~~

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Through contractual agreements, the Mississippi Planning and Development Districts (PDDs), who also act as the area agencies on aging, are responsible for some operational functions of the waiver on a day-to-day basis and are accountable to Division of Medicaid (DOM) which ensures that the waiver operates in accordance with federal waiver assurances. Functions are distributed as described below:

1) Waiver enrollment managed against approved waiver limits – PDDs notify DOM monthly of enrollment numbers; DOM verifies that enrollment limits are not exceeded

2) Waiver expenditures managed against approved waiver levels - DOM monitors that expenditure limits are not exceeded

3) Level of care evaluations are conducted by qualified staff, and DOM reviews/verifies that level of care has been determined prior to approving each case

4) Development, review and update of person's service plans – With the person's input PDD Case Managers develop and update the persons' service plans; DOM reviews and approves all services on the service plan

5) Qualified provider enrollment - DOM

6) Quality assurance and quality improvement activities - DOM

7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program – DOM

8) Provision of case management by qualified staff – PDD

Contractual agreements between the DOM and the PDDs are maintained and updated as needed. DOM monitors this agreement to assure that the provisions specified are met. In the agreement, DOM designates the assessment, evaluation, and reassessment of the person to be conducted by qualified individuals as specified in the current waiver. All such evaluations for certification or re-certification are subject to DOM's review and approval.

DOM is responsible for (1) performing monitoring of the PDDs to assess their operating performance and compliance with all rules and regulations; (2) reviewing each waiver persons' certifications, both initial and annual recertification; and (3) conducting quality assurance interviews to assess compliance with waiver requirements.

PDDs are responsible for (1) ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver and (2) initial and ongoing training of the case manager supervisors and individual case managers.

Appendix A: Waiver Administration and Operation

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

~~DOM Health Services is responsible for contract monitoring of the services performed by the DOM UM/QIO.~~ DOM is responsible for contract monitoring of the services performed by the contracted UM/QIO and the MS Planning and Development Districts.

Appendix A: Waiver Administration and Operation

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

Monthly reports are ~~provided to DOM~~submitted by the contractors and reviewed by ~~Health Services~~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	Local Non-State Entity
Participant waiver enrollment	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☐	☒
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☐	☒
Prior authorization of waiver services	☒	☐	☐
Utilization management	☒	☐	☐
Qualified provider enrollment	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☐	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~LTSS~~ 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**
☐ **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 adult day care providers who met HCB setting requirements as defined by federal regulations. N: Number of adult day care providers who met HCB setting requirements as defined by federal regulations. D: Total number of adult day care providers reviewed.**~~

PM 2: 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:

~~**Compliance Review**~~ **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 = 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):*
☒ **X 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 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.**~~

PM 3: 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:
~~**QIS Tracking Spreadsheet**~~ **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**	☐ **X Representative Sample** 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:

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

Performance Measure:
PM 4: Number and percent of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. N: Number of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. D: Total number of quarterly quality improvement strategy meetings.

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

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
X State Medicaid Agency	X Annually	X 100% Review

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	X Annually

Performance Measure:
PM 5: Number and percent of instances where reporting requirements of the case management agency were met in accordance to the Contractual Agreement. Number of instances where reporting requirements of the case management agency were met in accordance to the Contractual Agreement. D: Total number of instances where the case management agency was required to submit 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):
X State Medicaid Agency	X Monthly	X 100% Review

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	X Annually

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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)**							
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**									
	☐	**Brain Injury**							☐
	☐	**HIV/AIDS**							☐
	☐	**Medically Fragile**							☐
	☐	**Technology Dependent**							☐
☐ **Intellectual Disability or Developmental Disability, or Both**									
	☐	**Autism**							☐
	☐	**Developmental Disability**							☐
	☐	**Intellectual Disability**							☐
☐ **Mental Illness**									
	☐	**Mental Illness**							☐
	☐	**Serious Emotional Disturbance**							

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

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

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

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

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

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

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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. If it is determined that a particular person's care costs are threatening the cost neutrality of the waiver, DOM reviews the PSS and evaluate ongoing enrollment.

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 the administrative staff at MDRS and 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 and the PDDs work 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	22200
Year 2	22200
Year 3	22200
Year 4	22200
Year 5	22200

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
~~Transition individuals who have been discharged from the Independent Living Waiver~~

Purposes
~~Transition of Participants from Nursing Home to Community~~

Purposes
Transition of Persons from Other Mississippi 1915(c) HCBS Waivers
Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting
Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

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~~Transition individuals who have been discharged from the Independent Living Waiver~~

Purpose *(describe):*

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

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:

~~The number was determined by analyzing the number of discharges received from the Independent Living Waiver over a period of two years.~~ 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	50~~25~~	
Year 2	50~~25~~	
Year 3	50~~25~~	
Year 4	50~~25~~	
Year 5	50~~25~~	

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~~Transition of Participants from Nursing Home to Community~~

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved		
Year 1		501~~00~~	
Year 2		501~~15~~	
Year 3		501~~30~~	
Year 4		501~~45~~	
Year 5		501~~60~~	

Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

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

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 wishing to transition out of institutional 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 priority admission.

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

Waiver Year	Capacity Reserved		
Year 1		50	
Year 2		50	
Year 3		50	
Year 4		50	
Year 5		50	

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:

Waiver capacity is allocated to the ten (10) Planning and development districts who each have regional jurisdiction. Their combined coverage areas ensure statewide access to the waiver. Capacity is allocated based on an annual analysis of available funding, statewide utilization trends, county by county population fluctuations, and need as identified by regional waiting list numbers. DOM oversees the management of waiver capacity to ensure allocations are properly utilized, unused capacity is reallocated as needed, and that practices do not violate the requirement that individuals have comparable access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

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

~~Mississippi Division of Medicaid Administrative Code, Title 23: Medicaid Part 208, Chapter 1: Home and Community-Based Services(HCBS)Elderly and Disabled Waiver, as well as the CMS approved Elderly and Disabled Waiver application, along with subsequently approved amendments.~~ 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 these criteria and 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

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

Specify dollar amount:

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage: [ ]

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

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

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

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

Specify:

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

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

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a

family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines

the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

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

    Specify:

- ○ **The following dollar amount**

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- ○ **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: 2

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

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

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

~~The case managers performing the initial assessment are part of a case management team that consists of a Mississippi licensed social worker (LSW) and a Mississippi registered nurse (RN). The case managers must meet all provider qualification requirements outlined in Appendix C. The case managers must have received training and certification as a qualified assessor on the assessment instrument as designated by the State.~~ The case managers performing the initial assessment are part of case management teams that consists of Mississippi licensed social workers (LSWs) and/or Mississippi registered nurses (RNs). 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 case management team composed of any mix of two appropriately licensed staff including Mississippi licensed social workers (LSWs) or Mississippi Registered Nurses (RNs). Case management teams may consist of two social workers, two nurses, or a social worker and nurse. On initial assessments, the case management agency must have an RN available for consultation in instances where the team is comprised of two LSWs.

Qualified assessors on the case management team perform the core standardized assessment at the time of evaluation

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

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

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

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

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

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

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

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

evaluation process, describe the differences:

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

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

~~In the LTSS system, a recertification packet is initiated and the case manager is sent an alert 90 days prior to the expiration of the current certification period. DOM provides the case management agencies with a monthly Eligibility Report, which includes person's names, the end date of the certification period, and the end date for Medicaid financial eligibility. These three processes ensure timely recertification.~~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 operating agency 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 case management agency offices. The core standardized assessment along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. The case management agency is required to maintain the entire document, either electronically or in paper, for the period of time specified under the current federal guidelines.~~The case management agencies are required to keep a copy of all paper documents generated, including those with original signatures, for the period of time specified under current federal laws. The LTSS system maintains an electronic record of all assessments and application packets, which is accessible by the DOM and the case management agency.~~

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable***

indication that services may be needed in the future.

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

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

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.

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 = 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.

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

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

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 claims 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):*
☐	☐
☒ **X State Medicaid Agency**	☐ ~~**Weekly**~~
☐	☒
☐	☐

Operating Agency	**X Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☒ **X 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.~~The application process requires the person or their legal representative to sign and attest to their choice of placement on an Informed Choice form. During this portion of the application process, long term care program options are explained by the case manager and the person indicates their choice of waiver services or institutional services by evidence of their signature and service choice indicated.~~

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

The person's original record is maintained at the case management agency offices. The Informed Choice along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS System. The case management agency is required to maintain the entire document, either electronically or in paper, for the period of time specified under the current federal guidelines.~~The Case Management providers maintain original paper copies of the Freedom of Choice (Informed Choice) forms, if generated at the case management agency. The LTSS system maintains copies of the Informed Choice forms within an electronic database which is available to DOM and~~

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

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):*

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

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

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

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

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

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	~~Qualified Adult Day Care Agency~~Medicaid Enrolled E&D Adult Day Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Medicaid Enrolled E&D Adult Day Care Providers~~Qualified Adult Day Care Agency~~

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

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

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

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

~~• The number of persons in the vehicle, including the driver, must not exceed the vehicle manufacturer's approved seating capacity.~~

~~• All vehicles must have adequately functioning heating and air-conditioning systems and must maintain a temperature at all times that is comfortable to the person.~~

~~• All vehicles must have functioning seat belts and restraints as required by federal, state, county, or local statute or ordinance. All such vehicles must have an easily visible interior sign that states: "ALL PASSENGERS MUST USE SEAT BELTS". Seat belts must be stored off the floor when not in use.~~

~~• Each ADC provider must have at least two (2) seat belt extensions available.~~

~~• For use in emergency situations, each vehicle must be equipped with at least one seat belt cutter that is kept within easy reach of the driver.~~

~~• All vehicles must have an accurate, operating speedometer and odometer.~~

~~• All vehicles must have two exterior rear view mirrors, one on each side of the vehicle.~~

~~• All vehicles must be equipped with an interior mirror for monitoring the passenger compartment.~~

~~• The exterior of all vehicles must be clean and free of broken mirrors or windows, excessive grime, major dents or paint damage that detracts from the overall appearance of the vehicles.~~

~~• The interior of all vehicles must be clean and free of torn upholstery, floor or ceiling covering;damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.~~

~~• All vehicles must have the ADC provider's business name and telephone number displayed on at least both sides of the exterior of the vehicle. The business name and phone number must appear in lettering that is a minimum of three (3) inches in height and of a color that contrasts with the surrounding background.~~

~~• To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that Medicaid waiver persons are being transported. The name of the ADC provider's business may not imply that Medicaid waiver persons are being transported.~~

~~• The vehicle license number and the ADC local phone number must be prominently displayed on the interior of each vehicle. This information and the complaint procedures must be clearly visible and available in written format in each vehicle for distribution to persons upon request.~~

~~• Smoking must be prohibited in all vehicles at all times. All vehicles must have an easily visible interior sign that states: "NO SMOKING".~~

~~• All vehicles must carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.~~

~~• All vehicles must be operated within the manufacturers safe operating standards at all times.~~

~~• All vehicles must be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash.~~

~~• Each vehicle must contain a current map of the applicable geographic area with sufficient detail to locate person's addresses.~~

~~• Each vehicle must be equipped with an appropriate working fire extinguisher that must be stored in a safe, secure location.~~

~~• Insurance coverage for all ADC vehicles must be in compliance with state law, and any county or city ordinance.~~

~~• Each vehicle must be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer.~~

~~• The ADC provider must require that all their vehicles have a real-time link, phone, or two-way radio. Pagers are not acceptable as a substitute.~~

~~• Vehicles must comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation. The ADC providers must maintain a current copy of the ADA vehicle requirements and inspect their vehicles for compliance during the scheduled bi-annual vehicle inspections. Vehicles used for transporting persons with disabilities must be in compliance with applicable ADA vehicle requirements in order to be approved for use under this program.~~

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

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

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

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

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.

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

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

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

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

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

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

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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):*

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

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

~~Case Management Service Requirements:~~
~~All providers offering case management services under the Medicaid Waiver Agreement must adhere to the following requirements:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Team

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Team

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:

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

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

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

Minimum Program Requirements/Service Activities
All in-home respite service providers must adhere to the following minimum program requirements and service activities:
A) Activities- The respite provider must provide one or more of the following primary activities: companionship, support or general supervision, feeding and personal care needs. The provision of these services does not entail hands- on nursing care. Any assistance with activities of daily living are incidental to the care of the individual and are not provided as discrete services.
B) Safety- The in-home respite provider should be aware of potential hazards in the person's home environment and should do everything possible to ensure a safe environment for the person.
C) Reporting- In-home respite staff shall report abusive behavior or situations to their supervisor immediately. Also, such behavior by a person should be documented in the case record.
D) Harassment- In-home respite staff shall not allow or be subjected to sexual harassment or advances by persons. This kind of behavior should not be tolerated. The staff must firmly state to the person or caregiver in the home that such behavior will be reported to the supervisor. The person and caregiver should be notified that such behavior could jeopardize the service being received in the future.
E) Documentation- The in-home respite provider shall note on the record of contact all factual observation, contacts, or visits with the person and actions or behavior displayed by the person. This documentation is essential in determining if changes should be made on the PSS. It is also essential to show that certain tasks were performed on certain dates and times. The in-home respite supervisor/provider agency must review copies of the in-home respite contact sheets for each visit indicating arrival and departure times, any services performed while in the home, any other pertinent information concerning the person, and signature of the caregiver to verify services were received. The documentation must be maintained in the provider files.
F) Coordination with case management- The in-home respite supervisor shall maintain regular and ongoing communication with the case management provider regarding case-managed respite persons. The case manager shall develop and direct the PSS for case managed persons that are referred for respite services. The respite provider must report to the case management agency any information pertinent to the person's status.
G) Termination of respite services- Persons receiving respite services shall be terminated based on the following criteria:
1) Death;
2) Relocation out of state or services area;
3) Increase of informal or formal support;
4) Improved health status or condition;
5) Person and/or caregiver become abusive and belligerent, including sexual harassment;
6) Person and/or caregiver refused services;
7) Caregiver/person reports that he/she no longer needs the service;
8) Caregiver does not return to relieve respite provider as scheduled. Exceptions may be made in extreme cases of emergency;
9) Person is placed in a long term care facility;
10) Person is not Medicaid eligible;
11) The person's home environment is not safe for services to be rendered

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

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

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	~~Qualified~~ MS Medicaid Enrolled E&D Waiver In-Home Respite Providers~~Agency~~

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Qualified In-Home Respite Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

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

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

A. All direct care workers, unless otherwise excluded in the approved Elderly and Disabled waiver, must successfully complete a 40 hour curriculum training course upon hire and prior to rendering services covering each of the following topics:
- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation

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

In addition to the above, providers must have the following training upon hire and prior to rendering services:
- CPR Certification
- First Aid

B. Additionally, all direct care workers must successfully complete an annual curriculum training course covering at a minimum each of the following topics:
- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation
- Participant Rights and Dignity
- Crisis Prevention and Intervention

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

In addition to the above, providers must have the following training annually:
- CPR Certification
- First Aid

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

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

E. All providers must maintain a current training plan as a component of their Policies/Procedures documenting their method of choice for the completion of required training. This training plan must be available to DOM upon request. 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 agency verifies the qualifications are met for all direct care workers.~~Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~Verification is done by the Division of Medicaid before initial enrollment as a waiver provider, and through periodic provider~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Service

HCBS Taxonomy:

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

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):*

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	~~Qualified~~ MS Medicaid Enrolled E&D Personal Care Service ~~Agency~~Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Service

Provider Category:

Agency

Provider Type:

~~Qualified~~ MS Medicaid Enrolled Personal Care Service ~~Agency~~Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

~~Training Requirements~~
~~Providers may use any training resources deemed appropriate to meet the following requirements set forth by DOM, including in-service trainings completed by supervisory staff or online training by a vendor of their choice. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three years as a nurse aide, orderly, nursing assistant or an equivalent position by one of~~

~~the above medical facilities shall be deemed to meet the training requirements.~~

~~A. All direct care workers, unless otherwise excluded in the approved Elderly and Disabled waiver, must successfully complete a 40 hour curriculum training course upon hire and prior to rendering services covering each of the following topics:~~
~~- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation~~
~~- Participant Rights and Dignity~~
~~- Crisis Prevention and Intervention~~
~~- Caring for Participants with Alzheimer's/Dementia~~
~~- Care of Participants with Mental Illness~~
~~- How to Deal with Difficult Participants~~
~~- Assisting with Activities of Daily Living~~
~~- Assisting with IADLs including Meal Preparation and Housekeeping~~
~~- HIPAA Compliance~~
~~- Recognition and Care of Individuals with Seizures~~
~~- Elopement Risks~~
~~- Safe Operation and Care of Individuals with Assistive Devices~~
~~- Caring for Individuals with Disabilities~~
~~- Safety including Preventing and Reporting of Accidents/Incidents~~
~~- Professional Documentation Practices~~
~~- Signs and Symptoms of Illness~~
~~- Emergency Preparedness~~
~~- Universal Precautions & Infection Control~~
~~- Person Centered Thinking~~

~~In addition to the above, providers must have the following training upon hire and prior to rendering services:~~
~~- CPR Certification~~
~~- First Aid~~

~~B. Additionally, all direct care workers must successfully complete an annual curriculum training course covering at a minimum each of the following topics:~~
~~- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation~~
~~- Participant Rights and Dignity~~
~~- Crisis Prevention and Intervention~~
~~- How to Deal with Difficult Participants~~
~~- HIPAA Compliance~~
~~- Safety including Preventing and Reporting of Accidents/Incidents~~
~~- Professional Documentation Practices~~
~~- Emergency Preparedness~~
~~- Universal Precautions & Infection Control~~
~~- Person Centered Thinking~~

~~In addition to the above, providers must have the following training annually:~~
~~- CPR Certification~~
~~- First Aid~~

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

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

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

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

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 agency verifies the qualifications are met for all direct care workers.~~Division of Medicaid~~

Frequency of Verification:

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

Extended State Plan Service

Service Title:

Extended Home Health Services

HCBS Taxonomy:

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

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):*

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

~~Qualified~~ MS Medicaid Enrolled Home Health Agencies~~y~~

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~At time of initial enrollment and at time of recertification.~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

HCBS Taxonomy:

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

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

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

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

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

All items and services covered must be essential to:
1) Ensure that the person is able to transition from the current nursing facility or ICF/IID facility, and
2) Remove identified barriers and/or mitigates risks to the success of the transition to a more independent living situation.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Navigator

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:

~~Community Navigator~~MS Medicaid Enrolled E&D Waiver Community Transition Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

b. The Community Navigator Supervisor must have at least two (2) years of supervisory experience in programs dealing with elderly and disabled persons and meet one of the following requirements:
i. A Bachelor's Degree in Social Work, Psychology, or related profession with one year of direct experience working with aged and disabled persons transitioning into the community.

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

~~iii.~~ 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 agency verifies the qualifications are met for all staff.~~Provider agencies and the Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~At least annually~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

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

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

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

Minimum Program Requirements:
All service providers offering home delivered meals must adhere to the following requirements:
Service Activities:
(A) Safety: Home delivered meals providers are required to ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health regulations governing food service sanitation.

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

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

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

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

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Qualified ~~Vendor~~MS Medicaid Enrolled Home Delivered Meal Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

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 agency verifies the qualifications are met for all vendors/staff.~~The Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~Verification is ongoing.~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Institutional Respite Care

HCBS Taxonomy:

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

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):*

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Certified

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Institutional Respite Care

Provider Category:

Agency

Provider Type:

~~Medicaid Certified~~ MS Medicaid Enrolled Hospital, Nursing Facilities, Licensed Swing Bed Facilities

Provider Qualifications

License *(specify):*

Providers must maintain a current and active Mississippi license to function as a Hospital, Nursing Facility, Licensed Swing Bed Facility.

Certificate *(specify):*

~~Medicaid certified Hospital, Nursing Facility, Licensed Swing Bed Facility~~

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 agency verifies the qualifications are met for all staff.~~Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~Upon initial enrollment and recertification set forth in the state or federal guidelines for the above stated facilities.~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy Services

HCBS Taxonomy:

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

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):*

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

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

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

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Home Health Agency~~Qualified Home Health Agency~~

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Home Health Agency~~Qualified Home Health Agency~~

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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.~~The Agency must perform national criminal background checks on all direct care employees. The agency must ensure direct care providers have current and active license and or certifications, and are not listed on~~

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider agency verifies the qualifications are met for all staff.~~Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~At time of initial enrollment and at time of recertification.~~

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech Therapy Services

HCBS Taxonomy:

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

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):*

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

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

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

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled Home Health Agency~~Qualified Home Health Agency~~

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Home Health Agency~~Qualified Home Health Agency~~

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The provider agency verifies the qualifications are met for all staff.~~Division of Medicaid~~

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.~~At time of initial enrollment and at time of recertification.~~

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:

Environmental Safety Services

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):*

Environmental safety services are services provided for the purpose of supporting members in maintaining a healthy and safe living environment through the performance of tasks in and around the individual's home that are beyond the individual's capability. This service includes minor home maintenance and repair, heavy household cleaning, non-routine disposal of garbage posing a threat to the individual's health and welfare, non-routine yard maintenance, pest control and related tasks to prevent, suppress, eradicate or remove pests posing a threat to the individual's health and welfare.

The service does not include tasks that are the legal or contractual responsibility of someone other than the individual, that can be accomplished through existing informal supports, formal supports, or do not provide a direct of remedial benefit to the individual. The services does not include tasks performed or interventions available through the personal care or in-home respite services.

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

Environmental safety services shall not exceed $500.00 per waiver year. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Enrolled E&D Waiver Environmental Safety Service Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy Services

Provider Category:

Agency

Provider Type:

Medicaid Enrolled E&D Waiver Environmental Safety Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all staff.

Frequency of Verification:

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

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:

Medication Management

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):*

Medication Management services are services in which enrolled individual's with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications can receive consultations and follow up visits with a licensed pharmacist. As a core component of the service, the pharmacy provider will review all prescription and over-the-counter medications taken by the individual on at least a monthly basis in order to support the individual's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors. Reviews may occur more frequently, on an as needed basis, upon significant change in the individual's condition or immediately following discharge from an acute hospital stay. The service will include two components: a comprehensive initial/annual consultation and subsequent follow-up consultations.

The provider will be responsible for collecting a complete medical history and list of prescribed and over-the-counter medications in order to assess whether the individual's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented. If issues with the above are identified, the provider will take necessary steps to implement necessary interventions, including but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery/reminder services.

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

The service is limited to one initial/annual consultation and fifteen (15) follow-up visits per waiver year. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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 Pharmacy Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Management

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled Pharmacy Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 agency verifies the qualifications are met for all 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:
In accordance with the concurrent 1915(b)(4) waiver, case management services are provided by the Mississippi Planning and Development Districts (PDDs).

Appendix C: Participant Services

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

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

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

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

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

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

~~Any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed to provide direct care to persons enrolled in the waiver.~~ A national criminal background check with fingerprints must be conducted on all individuals providing case management, personal care attendant services, in-home respite, adult day care, or community transition services 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):

~~All providers are responsible for verifying that all employees and volunteers are not on the Mississippi Nurse Aide Abuse Registry which is housed at the Mississippi State Department of Health within the Division of Licensure and Certification.~~
~~The DOM Office of Provider Enrollment performs mandatory screenings on owner's and operators of provider agencies, prior to enrollment and as required by federal regulations. Documentation of provider staff qualifications/screenings are reviewed by DOM's Office of Financial and Performance Review during post-utilization audits. Additionally, this Office checks the Nurse Abuse Registry during audits for direct care workers serving participants of the Elderly and Disabled Waiver.~~ Screenings of the Mississippi Nurse Aide Registry and the Office of Inspector General's Exclusion Database must be conducted on all individuals providing case management, personal care attendant services, in-home respite, adult day care, or community transition services 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:

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

The state does not make payments for furnishing waiver services to legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the participant's power of attorney or those designated as the participant's representative payee for Social Security benefits.

For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the participant. The state may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

- There is documentation that there are no other willing/qualified providers available for selection.
- The selected relative is qualified to provide services as specified in Appendix C-1/C-3.
- The participant or another designated representative is available to sign verifying that services were rendered by the selected relative.
- The selected relative agrees to render services in accordance with the scope, limitations and professional requirements of the service during their designated hours.
- The service provided is not a function that a relative or housemate was providing for the participant without payment prior to waiver enrollment.

The state reserves the right to remove a selected relative from the provision of services at any time if there is the suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the participant will be asked to select an alternate qualified provider.

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

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

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

PM 1: # 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.

Performance Measure:
~~**PM 2: Number and percent of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. N: Number of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet**~~

~~waiver provider qualifications. D: Total number of enrolled non-licensed/non-certified providers reviewed.~~

PM 2: Number and percent of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. N: # of reviewed enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. D: Total number of enrolled non-licensed/non-certified providers reviewed. D: Total number of enrolled provider 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**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ ~~**Representative Sample**~~ Confidence Interval = ~~95%~~
☐ **Other** Specify:	☒ **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

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**
	☒ **X Other** Specify: Every 24 Months

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

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

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

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

PM 3: 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 =~~ ~~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

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

b. Methods for Remediation/Fixing Individual Problems

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

~~For PM 1, DOM will (a) not issue provider numbers without verification of credentials (licensure/certification); (b) obtain verification of credentials (licensure/certification) prior to issuance of provider number; and (c) notify provider applicant of application denial within sixty (60) days of application to DOM.~~
~~For PM 2, DOM will (a) require a Corrective Action Plan from provider within 30 days of the request; (b) suspend referrals; (c) suspend and/or close provider number within 60 days of discovery if the provider continues to not meet the qualification; and (c) offer participants choice of other available providers, if provider number is closed or terminated.~~
~~For PM 3, DOM will (a) require a Corrective Action Plan from provider within 30 days of the request; (b) suspend referrals; (c) suspend and/or close provider number within 60 days of discovery if the provider continues to not meet the qualification; and (c) offer participants choice of other available providers, if provider number is closed or terminated.~~

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 agency/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. Provider claims 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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	X 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 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.

~~***Need updated STP.~~

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

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

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

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

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

- Institutional respite services.

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

Part 208, Chapter 1 of the Medicaid Administrative Code requires persons enrolled in the E&D waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community and meet the requirements of the Home and Community-Based (HCB) settings. It further defines that the Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or on the grounds of or adjacent to institutions or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS). All ADC 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.

~~Part 208, Chapter 1: 1915c Elderly and Disabled Waiver~~
~~Rule 1.1:General~~

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

~~B. The E & D Waiver is administered and operated by the Division of Medicaid. Current language is silent on the following verbiage from 42 CFR § 441.301(c)(4)(i) (iv) of the Final Rule which will be added as Rule 1.4.C.:~~

~~1. Persons enrolled in the E&D waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.~~

~~2. The Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or on the grounds of or adjacent to institutions or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).~~
~~Part 208, Chapter 1: 1915c Elderly and Disabled Waiver~~
~~Rule 1.3:Provider Enrollment~~

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

render services.

3. Qualifications for Adult Day Care Services:

a) Adult day care services must be provided by an established, qualified facility/agency.

b) Each adult day care service must meet the following requirements:

1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.

2) The facility must meet the requirements of the American Disabilities Act of 1990.

3) The facility must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.

Current language is in compliance with and supports the Final Rule 42 CFR § 441.301(c)(4)(i)-(iv).

Part 208, Chapter 1: 1915c Elderly and Disabled Waiver
Rule 1.4: Freedom of Choice

A. Medicaid waiver participants have the right to freedom of choice of Medicaid providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Each individual found eligible for the Elderly and Disabled (E&D) waiver must be given free choice of all qualified providers. Persons enrolled in a Medicaid waiver have the right to freedom of choice of providers for Medicaid covered services.
Each individual found eligible for the E&D waiver must be given free choice of qualified providers. Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 1.4.C.:

C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).
Part 208, Chapter 1: 1915c Elderly and Disabled Waiver
Rule 1.6:
Covered Services

2. Adult Day Care Services

a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled participants through an individualized care plan that includes the following:

1) Personal care and supervision,
2) Provision of meals as long as meals do not constitute a full nutritional regimen,
3) Provision of limited health care,
4) Transportation to and from the site, with cost being included in the rate paid to providers, and
5) Social, health, and recreational activities.

b. Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the participant's assigned case manager.

c. To receive Medicaid reimbursement the participant must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the participant to and from the facility.

4. Institutional or In-Home Respite Services

a. Respite Care provides non-medical care and supervision/assistance to participants unable to care for themselves in the absence of the participant's primary full-time, live-in caregiver(s) on a short-term basis.

b. Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the participant.

c. Institutional Respite Services

1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities.
2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service.
3) Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

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

Rule 1.6.A.2.a)2) is revised to comply with 42 CFR § 441.301(c)(4)(iv):

2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs in addition to the following:

(a) A mid-morning snack,
(b) A noon meal, and

~~(c) An afternoon snack.~~

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

~~The following verbiage from 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5) will be added as Rule 1.6.A.2.d. and 1.6.A.2.e.:~~

~~d. Adult Day Care settings must be physically accessible to the person and must:~~

~~1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community , to the same degree of access as individuals not receiving Medicaid HCBS.~~

~~2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.~~

~~3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.~~

~~4) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.~~

~~5) Facilitate individual choice regarding services and supports, and who provides them.~~

~~e. Adult Day Care settings do not include the following :~~

~~1)A nursing facility,~~
~~2)An institution for mental diseases,~~
~~3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),~~
~~4)A hospital, or~~
~~5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.~~

~~Part 208, Chapter 1: 1915c Elderly and Disabled Waiver~~
~~Rule 1.12:~~
~~Hearing and Appeals~~

~~A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.~~

~~B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(v) of the Final Rule.~~

~~1915(c) HCBS Waiver: MS.0272.R04.01~~
~~Elderly and Disabled Waiver Rule Content Determination~~
~~Appendix C: Participant Services~~
~~C-1/C-3: Service Specification~~
~~1915c Elderly and Disabled Waiver A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant. Current language is in conflict with 42 CFR § 441.301(c)(4)(iv) of the Final Rule. The following verbiage will be deleted with the July 2017 waiver renewal: "A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant".~~

Appendix F: Participant – Rights
F-2: Additional Dispute Resolution
1915c Elderly and Disabled Waiver

b. The informal dispute resolution process is initiated with the case management agencies at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants address disputes by first reporting to their case management team, which is composed of a registered nurse and a licensed social worker. The case management team responds to the participant within 24 hours. If a resolution is not reached within 72 hours the case management team reports the issue to the case management supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the client's satisfaction with the new case management team within the following month and notifies DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the case management agency at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.
At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process – Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(ii) of the Final Rule

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

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

Administrative Code, Title 23: Medicaid Part 100, Chapter 5: The Hearing Process. – Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.
Safeguards

G-1: Response to Critical Events or Incidents
1915c Elderly and Disabled Waiver – Upon entry into the waiver, case managers will provide the waiver participant/and/or caregiver education and information concerning the State's protection of the waiver participant against abuse, neglect and exploitation including how participants may notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation.
When participants are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains monthly contact with each participant by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or participant representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible. – Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

~~Appendix G:~~
~~Participant Safeguards~~
~~G-2: Safeguards Concerning Restraints and Restrictive Interventions~~
~~1915c Elderly and Disabled Waiver The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to ensure safety and the quality of waiver services provided. Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.~~

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

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

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

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

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

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

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

☐ **Social Worker**
Specify qualifications:

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

~~Must be credentialed to perform assessments.~~

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

~~The registered nurse in addition to possessing a current and active nursing license to practice in Mississippi, or a privilege to practice on a compact license, must have at least 2 years of nursing experience with aged and/or disabled individuals. If less than two years of experience, the registered nurse must complete ninety (90) days of orientation/training of direct waiver services under the supervision of an established waiver case manager who has two years of waiver experience.~~

~~Must be credentialed to perform assessments.~~

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

~~The case management agency develops the person-centered service plan & can only provide other waiver services to the person if there is no other willing provider in the geographic area, as defined by DOM. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the Division of Medicaid, case management agencies cannot provide other services to waiver participants without the express permission of DOM. Oversight of waiver processes & periodic evaluations are completed by DOM Office of Long Term Care and Office of Financial & Performance Review.~~

~~Service plan development is a component of the Case Management service. Once completed, each service plan is submitted for review & is the fundamental tool by which the State ensures the health/welfare of waiver persons participating in the E&D Waiver. The process for developing a waiver person's PSS requires the plan to be based on a comprehensive assessment process. A registered nurse & a licensed social worker along with the waiver person, and interested parties as requested by the person, are jointly responsible for determining the waiver person's needs, preferences, and goals through a person-centered planning process. The PSS includes a comprehensive emergency preparedness plan specific to meet the person's needs.~~

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

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

~~DOM maintains administrative oversight of the waiver to ensure persons receive freedom of choice of providers and to monitor potential conflicts of interest. 100% of Plans of Services and Supports are signed by participants/legal representatives attesting that they were presented with a list of available providers and offered Freedom of Choice. Each time a participant selects a provider, they sign a Freedom of Choice of Provider form that lists all of the available service providers in their area to ensure the process is conflict free. Oversight is accomplished through audits and reviews by DOM staff conducting home visits/telephone interviews. Also, documentation of a signed freedom of choice form is reviewed during DOM compliance audits.~~

~~The person is informed by the case management agency, at the time of enrollment in the waiver, the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing. The person is given their bill of rights which addresses disputes, complaints/grievances and State Fair Hearings. The person has the right to address any disputes regarding services with DOM at any time.~~

~~The informal dispute resolution process may be initiated by the person with the case management agency at the agency local level and is understood as not being a pre-requisite or substitute for a state fair hearing. The types of disputes that can be addressed include issues concerning service providers, waiver services, and anything that directly affects the person's waiver services. Waiver persons may address disputes by first reporting the issue to their case management team, which includes a registered nurse and licensed social worker. The case management team will respond to the person within 24 hours. If a person believes that a resolution has not been reached within 72 hours, the case management team will report the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If the person believes a resolution has not been reached within this time frame, the issue is reported to DOM. DOM will consult with the case management agency to investigate the issue and work towards a resolution within seven days. In the event the dispute involves the case management~~

~~team, the case management agency and DOM will work with the person to identify and select a new case management team. Once a new case management team is selected, the case management supervisor will evaluate the person's satisfaction with the new case management team within the following month and will notify DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute process. DOM has the final authority over any dispute.~~

All Plans of Services and Supports (PSS), in conjunction with the LTSS assessment and the Emergency Preparedness Plan, are reviewed and approved by Division of Medicaid (DOM) Program Nurses prior to service implementation. This review allows DOM Program Nurses to ensure appropriateness and adequacy of services and to ensure that services furnished are consistent with the nature and severity of a person's disability. The PSS is a person-centered service plan. It is the fundamental tool by which DOM ensures the health and welfare of participants in the waiver. DOM's process for developing a person-centered plan requires the PSS to be based on a comprehensive LTSS assessment process. PSS development is conducted with the person's input to include what is important to the individual with regard to preferences for the delivery of services and supports. The participant's signature on the PSS indicates that they were provided all of their available service options under the chosen waiver in addition to freedom of choice of provider. The case manager engages the person and other interested parties as requested by the person in developing a PSS that meets their needs. The meeting is held at a time and location agreed upon with the person.

On the E&D Waiver, the case management agency develops the person-centered service plan and can only provide other waiver services to the person if there is no other willing providers in the geographic area and there are appropriate firewalls in place. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the Division of Medicaid, case management agencies cannot provide other services to waiver participants without the express permission of DOM. At no time are individual case managers authorized to provide direct care services. Oversight of waiver processes and periodic evaluations are completed by the DOM Office of Long Term Care and Office of Financial & Performance Audit.

At enrollment, the person is informed by the case management agency of the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing as outlined in Appendix F of this waiver. The person has the right to address any disputes regarding services with DOM at any time. The participant also signs a Bill of Rights outlining their rights and the appropriate contact information. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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 process 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):

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

~~A case manager(s), the person, caregivers and/or interested parties work together to develop the PSS, especially in identifying personal goals, health care needs and preferences. These planning meetings are scheduled at the place and time of the participants choosing.~~
~~The case manager is responsible for informing the person and others as requested by the person about State Plan services and services furnished through other State and Federal programs. The case manager will coordinate waiver services and non-waiver services to meet the needs of the person.~~

~~The case management team is responsible for continued and ongoing monitoring of the person's needs and effectiveness of the PSS. The PSS is reassessed on a regular basis with monthly face-to-face visits. However, a quarterly review of the PSS is required. If a change in the PSS is warranted or desired by the person, the person will confer with the case management team to identify potential changes. The PSS is updated annually or more frequently based on the individual needs, desires and goals of the person and/or responsible party.~~

~~Informed Choice is ensured by the case manager informing the person and/or the legal representative of the available Medicaid-covered long term care options including alternatives to nursing facility placement. The person acknowledges their participation in the application process by signature attesting long term care program options were explained to him/her. Fair Hearing Notices are maintained in person's file at the Case Management Agency.~~

~~As part of the person centered planning process, service provider signatures are captured on the PSS.~~
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.

The case management agency is responsible for implementing the PSS. They, along with DOM, are jointly responsible for monitoring the PSS. The case management agency 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.

~~Person involvement and choice, in all aspects of the waiver program and in service planning, is an integral part of identifying and mitigating risks. The case management team must assist the person and provide them with sufficient information and assistance in order to make an informed choice regarding choice of services and supports, always taking into account risks that may be involved for that person. The person and informal caregivers/supports assist in developing strategies and complying with strategies to help mitigate risk and ensure health and safety. This is ensured by ongoing monitoring by the case management agency and DOM. The PSS is monitored by the case management agency and the Medicaid agency. Monthly and quarterly actions are required to review/assess the person's service needs, with a new plan developed every twelve months. The Medicaid agency utilizes an assessment and application process for annual eligibility, admission, and recertification for persons. Beginning at the initial assessment and person-centered planning process, the presence and effect of risk factors must be determined. The assessment is specifically designed to assess and document risks a person may encounter. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. All risk factors identified must be addressed in the PSS. Risk factors considered are documented abuse/neglect/exploitation, socially inappropriate behavior, communication, nutrition concerns, environmental security and safety, falls, orientation, emotional/mental functioning, and lack of informal support. The case management team must also determine whether a medical condition is present that requires specific intervention to prevent a decline in health and safety.~~

~~The types of backup arrangements that are used include the person designating alternate care providers in the event that their caregiver is unable to provide care. The person and caregiver identify family members who are able to provide services in the event of an emergency. The case management agency and the person also maintain a list of qualified local community providers from which the person can choose if the caregiver is not available. During a community disaster or emergency the case management agency notifies the local first response team (i.e. the American Red Cross) of persons with special needs who may require special attention. Back up plans are developed by the case management agency in partnership with the person and their family/caregiver upon admission. The case managers evaluate the appropriateness and adequacy of both waiver and non-waiver services at least monthly during monthly face-to-face home visits with the person. As situations warrant, more frequent face-to-face visits may be made. At each visit, the case manager is required to document and monitor the delivery of services, as well as, document the person's health and welfare.~~

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

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 provider would best meet the needs, preferences, and goals of the person. The person and/or representative is given an opportunity in some instances to meet the provider prior to the selection in order to make a more informed choice. Once all options are taken into consideration, the person and/or caregiver selects the provider they feel best meets their needs.~~

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

Participants are informed of the different waiver services, State plan services, settings and providers during the initial assessment and at each reassessment, or at the request of the individual.

The concurrent 1915(b)(4) waiver selectively limits providers of case management and home delivered meals to the MS Planning and Development Districts. The person is given a choice of all other qualified providers in their area and their selection is documented on the Freedom of Choice form. While the PDDs also act as the billing provider for environmental safety services, the member is allowed to select qualified vendors for services rendered who are then contracted by the PDD. The PDD is then responsible for billing those services to DOM as reimbursement for paid invoices.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

~~For initial application packets, DOM utilizes a LOC algorithm to determine if the person meets the LOC criteria. A DOM nurse reviews the application packet and will notify the case manager in a timely manner of the approval/disapproval of services requested. If additional information is needed by DOM prior to making a determination, a clarification request is sent to the Case Management Agency. Waiver services may be provided from the date the person is determined eligible for waiver services. If the LOC criteria is not met, the DOM nurse will review documentation and establish LOC. If the DOM nurse cannot establish LOC, if will be reviewed by a physician.~~

~~For recertification application packets, DOM utilize a LOC algorithm to determine if the person meets the LOC criteria. DOM also utilizes within its electronic Long Term Services and Supports system a formula to determine if the amount of services listed on the PSS and the cost for those services are appropriate for the needs identified in the assessment as indicated by the assessment scoring algorithm. Recertification applications that meet specific algorithm criteria will be auto approved in LTSS,, and the case manager is notified of the approval. Recertification application packets that do not meet the established criteria for auto approval will be reviewed by a DOM nurse in the same process as initials.~~

~~During the auto approval process, a random number of applications will be selected for Quality Assurance review by DOM staff. Upon review of these applications, if it is found that a particular case management agency is often out of compliance with submission of applications, this agency will be removed from the auto approval process. Each application submitted by that agency will then be reviewed by DOM staff for compliance.~~

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

During the person-centered planning process, the person and/or their caregiver is given a list of qualified providers/vendors 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/vendors 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/vendor 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/vendor 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 (8 of 8)

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

- ◉ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☒ **Medicaid agency**
- ☐
- ☒
- ☐

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

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

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

~~The Case Management Agency is responsible for monitoring service provision and the person's health and welfare on a monthly and quarterly basis. In rural areas where provider agencies also provide direct services, administrative firewalls must exist to ensure the separation between case management and other services provided. For services which include an administrative fee, the fees have been evaluated and determined to be an appropriate administrative fee by an outside actuary. DOM maintains a list of providers and can verify when a case management agency is the only willing and qualified provider in an area.~~

~~DOM, as part of its Continuous Quality Improvement process, monitors service provision and referrals to service providers by reports generated from the LTSS system to identify Case Management Agencies that have disproportionately referred to services within their own agency. DOM staff sample cases of people enrolled in the waiver to conduct in-home visits to discuss services they receive, informed choice in the selection of service providers, and whether the services are sufficient to meet the health and welfare of the person in a home and community based setting.~~

The case management agency monitors the person-centered service plan and can only provide other waiver services to the person if there is no other willing providers in the geographic area and there are appropriate firewalls in place. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the Division of Medicaid, case management agencies cannot provide other services to waiver participants without the express permission of DOM. At no time are individual case managers authorized to provide direct care services. Oversight of waiver processes and periodic evaluations are completed by the DOM Office of Long Term Care and Office of Financial & Performance Audit.

At enrollment, the person is informed by the case management agency of the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing as outlined in Appendix F of this waiver. The person has the right to address any disputes regarding services with DOM at any time. The participant also signs a Bill of Rights outlining their rights and the appropriate contact information. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
PM 1: Number and percent of persons reviewed whose PSS addresses all their needs (including health and safety risk factors and personal goals). N: Number of persons whose PSS is reviewed that addresses all their needs (including health and safety risk factors and personal goals). D: Total number of person whose PSS was reviewed.

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

Responsible Party for data collection/generation *(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**	☒ **X Monthly**	☒ **X Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **X 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):*
☒ **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 State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

~~**PM 3: 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 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:
~~**Compliance Review**~~**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**	☐ **X 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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	☐ **Continuously and Ongoing**
	☒ ~~**Other**~~ ~~Specify:~~ ~~Every 24 months~~

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 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:
~~**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):*
☒ **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

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~~**	☐ **~~100% Review~~**
☐ **Operating Agency**	☒ **X Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **X 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):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	☒ **X 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**	☒ **X Representative Sample** 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**

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' reviewed with documented presentation of available service options and freedom of choice of providers. N: Number of persons' reviewed with documented presentation of available service options and freedom of choice of providers. D: Total number of PSS reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
~~LTSS~~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 = 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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

~~For PM 1, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) provide one-on-one Case Manager training by phone or letter as needed; and (d) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted that did not document all needs.~~
~~For PM 2, DOM (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) conduct Case Manager training quarterly and annually; and (d) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted that did not have the persons signature.~~
~~For PM 3, DOM will (a) require Case Management Agency to complete quarterly update; (b) require Case Management Agency to submit a corrective action plan within thirty days; (c) recoup payment for case management services from provider; and (d) provide Case Manager training annually to educate providers on DOM waiver requirements for case management.~~
~~For PM 4, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency and include reason for the lapse of the PSS within seven business days; (c) prevent payments from being made to providers if a PSS expires (exceeds 365 days); and (d) conduct provider training on waiver requirements.~~
~~For PM 5, DOM will (a) notify Case Management Agency of identified PSS where services were provided outside of the type, scope, amount, duration, and frequency (b) require Case Management Agency to identify the cause of deficiency and intervene within seven business days to assure participants receive services according to the type, scope, amount, duration, and frequency of the (c) require Case Management Agency to submit a revised PSS within fourteen (14) days; (d) require provider to submit an adjust/void within thirty days, if warranted; and (e) provide Case Manager training on waiver requirements.~~
~~For PM 6, DOM will (a) require the Case Management Agency to document presentation of service options and freedom of choice within seven business days; and (b) provide Case Manager training annually on waiver requirements; and (c) investigate the cause of the system failure within LTSS that allowed a PSS to be submitted without documentation of presentation of service options and freedom of choice of provider.~~

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. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the case management agency 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 case management agency will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions.

i.

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 Specify:	**Annually**
	☒ **X 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 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.

A case manager sends a Notice of Action (NOA) to the person by certified mail (Signature return requested). Fair Hearing Notices are maintained in person's file at the Case Management Agency.

Contents of Notice of Action include:
a. Description of the action the provider has taken or intends to take;
b. Explanation for the action;
c. Notification that the ~~consumer~~ participant has the right to file an appeal;
d. Procedures for filing an appeal;
e. Notification of ~~consumer's~~ participant's right to request a Fair Hearing;
f. Notice that the ~~consumer~~ 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 management agency or DOM state office. If the written request is not received within the 30 day time period, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as identified in the Administrative Code.

At the local hearing level, the case management agency will issue a written determination within 30 days of the date of the initial request for a hearing. Although the waiver allows 30 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The person has the right to appeal a local hearing decision by requesting a State hearing; however, the State hearing request must be made within 15 days of the mailing date of the local hearing decision.

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The person or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or person's case record.

2. The right to have legal representation at the hearing and to bring witnesses.

3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an

opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the person or service providers. Upon receipt of the request for a state hearing, the DOM Office of Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The informal dispute resolution process is initiated with the case management agencies at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. A person may address disputes to DOM at any time. The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Persons address disputes by first reporting to their case management team~~, which is composed of a registered nurse and a licensed social worker~~. The case management team responds to the person within 24 hours. If a resolution is not reached within 72 hours the case management team reports the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case management team then the case management agency and DOM works with the person to assign a new case management agency or team. Once a new case management agency/team is assigned the case management supervisor evaluates the person's satisfaction with the new case management agency/team within the following month and notifies DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by the case management agency at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and fair hearing. The person is given their bill of rights which addresses disputes, complaints/grievances and hearings. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

At no time will the informal dispute resolution process conflict with the person's right to a State Fair Hearing in accordance with State Fair Hearing procedures and processes as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DOM and the case management agency are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints/grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Persons should first address any complaints/grievance by reporting it to their case management team, but may address any complaint/grievance to DOM at any time. The case management team begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case management team reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the participant's satisfaction with the new case management team within the following month and notifies DOM of the final resolution. Upon admission to the waiver, the participant receives a written copy of their bill of rights which addresses disputes, complaints/grievances and hearings. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

State Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes.

Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents are identified as follows:
Abuse (A) - willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.
Neglect (N) - can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.
Exploitation (E) - Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

The Department of Human Services (DHS), Division of Aging and Adult Services, is the agency responsible for investigating allegations of A, N and E. There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver persons.

All reports of A, N and E are taken very seriously by DOM. DOM provides for the reporting and investigation of major and serious incidents of abuse, neglect and exploitation of a waiver persons. All reports of A, N and E are reported immediately verbally and in writing by the appropriate case manager to their supervisor and the Department of Human Services. The potential A, N and E are also to be reported in writing to ~~the~~ DOM~~/Office of LTC/E&D Waiver Program Division~~ as it occurs. ~~DOM staff review the documentation and report findings to the DOM E&D waiver director.~~ If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. In addition, reports are simultaneously made to DHS who is the investigative agency in Mississippi responsible for investigating allegations of A, N and E. DOM and the case management agency follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

Mississippi Vulnerable Persons Act, Section 43-47-9 (1). "Upon receipt of a report pursuant to Section 43-47-7 that a vulnerable person is in need of protective services, the department (The Mississippi Department of Human Services)shall initiate an investigation and/or evaluation within forty-eight (48) hours if immediate attention is needed, or within seventy-two (72) hours if the vulnerable person is not in immediate danger, to determine whether the vulnerable person is in need of protective services and what services are needed."

The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon entry into the waiver, case managers will provide the person and/or their caregiver education and information concerning the State's protection of the person against abuse, neglect and exploitation including how persons may notify appropriate authorities when the person may have experienced abuse, neglect or exploitation. When person are initially assessed for the E&D Waiver, they are given the names and phone numbers of their case managers. The case manager maintains regular contact with each person by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities.

DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

First line entity to receive reports is the E&D Waiver case manager at the case management agency and/or ~~the~~ DOM-~~Office of LTC E&D Waiver Program Division~~. ~~When DOM receives a critical incident report, DOM staff review the documentation and report findings to the DOM E&D waiver director.~~ The critical incident is reported as indicated and followed by DOM staff until the incident is resolved. The communication continues between the case management agency, DOM, Department of Human Services, and Attorney General's Office, if necessary, until resolution occurs.

The Department of Human Services (DHS), Division of Aging and Adult Services, as the lead agency responsible for investigation, is responsible for the notification of investigation results to parties as designated by state law. Time frames for notification of results vary based on investigation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The case management agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated §n 43-1-1, et seq. (1972, as amended), the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM works with DHS through the provision of a memorandum of understanding to ensure effective incident management of all home and community based waiver person under 42 CRFR § 441.302. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents. This is an ongoing process, and as these events occur, immediate action takes place and investigation begins. All of the above entities keep written records of suspected events of abuse, neglect, and exploitation. The LTSS system includes a module that will be implemented and will allow critical incident data to be reported and tracked between DOM, DHS, and the case management agency.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver person. The case management team is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State does not permit the use of restrictive interventions. DOM and the case management agencies are jointly responsible for ensuring that restrictive interventions are not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State does not permit the use of seclusion. DOM and the case management agencies are jointly responsible for ensuring that seclusion is not used for waiver persons. The case management team is responsible for monthly contact with waiver persons to ensure safety and to ensure quality of services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

All providers are required to receive training in methods to detect abuse, neglect and exploitation which includes unauthorized use of seclusion. The person and their environment is monitored to detect unauthorized use of seclusions during provider scheduled visits, unannounced home visits by the provider's supervisor, monthly home visits by the case management agency and randomly selected annual visits/telephone interviews by DOM staff. Incidents of seclusion are immediately reported verbally and in writing by the case manager to their supervisor and the Department of Human Services (DHS). The report is also sent to DOM. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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**
☐ **Operating Agency**	☒ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **X Annually**
	☒ **X 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.**~~

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):
~~**On-site observations, interviews, monitoring**~~**Other**
If 'Other' is selected, specify:
~~**LTC QA Home Visits/Telephone Interviews**~~ **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**	☒ **X Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **X Representative Sample** 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**	☐ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	☒ **X 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 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**~~ **On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

~~**LTSS**~~ **LTC QA Home Visits/Telephone Interviews**

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 = 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):*
	☒ **X 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**	☐ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	☐ **X 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/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**
	☒ **X 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**	☒ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X Annually**
	☒ **X 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 Case Management Agency to address alleged instances of abuse, neglect, exploitation, and unexplained/suspicious deaths within the required timeframe as specified in the approved waiver; (b) provide additional training to providers on reporting requirements; (c) request immediate follow up of the reported critical incident for those with no follow-up by MS Department of Human Services; (d) request documentation from DHS within 30 days, for those reported critical incidents with late follow up.~~
~~For PM 2, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; (b) require Case Management Agency to respond to deficiency within seven business days; (c) provide one on one training with case manager supervisor upon discovery.~~
~~For PM 3, DOM will (a) require Case Management Agency to provide participant with information as part of the corrective action plan within thirty (30) days; and (b) provide training annually.~~
~~For PM 4, DOM will (a) require unresolved complaints to be sent to DOM within seven business days of report to Case Manager Supervisor; and (b) provide additional training on complaint resolution requirements.~~
~~For PM 5, DOM will (a) hold annual complaint review meeting; and (b)will provide training to prevent similar complaints, to the extent possible.~~
~~For PM 6, DOM will (a) require the policies surrounding the prohibition of the use use restrictive interventions be followed immediately; (b)require Case Management Agency to report unauthorized use of restrictive interventions via email notification within 24 hours of knowledge of the incident; (c) require Case Management Agency to submit a Monthly Activity Report that will include all critical incidents including unauthorized us of restrictive interventions; (d) will require Case Managers to make unscheduled monthly home visits to monitor for the unauthorized use of restrictive interventions with substantiated cases of critical incidents.~~
~~For PM 7, DOM will (a) immediately notify Case Management Agency of deficiency via clarification request; and (b) have the Case Management Agency conduct a core standardized assessment which assesses a 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:	☒ **X Annually**
	X 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.

~~DOM employs staff to assist in system design. Meetings are held routinely, or as needed, to review analyzed discovery and remediation data, to develop Computer System Request (CSRs), review progress, and test system changes. The CSRs are the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent. The meetings involve participation from DOM's Office of Information Technology Management, Long Term Care staff and others deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including nurses are held monthly or as needed for the purpose of addressing needs and resolving issues. When DOM identifies a system issue it is reported to the fiscal agent for review and research. System issues that affect services to persons or affect accurate payment to providers are considered a priority. DOM holds monthly meetings with the program staff and the systems staff to address issues that require system changes.~~

DOM employs staff to assist in system design. Meetings are held routinely, or as needed, to review analyzed discovery and remediation data, to develop Computer System Request (CSRs), review progress, and test system changes. The CSRs are the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent. The meetings involve participation from DOM's Office of Information Technology Management, Long Term Care staff and others deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including nurses are held monthly or as needed for the purpose of addressing needs and resolving issues. When DOM identifies a system issue it is reported to the fiscal agent for review and research. System issues that affect services to persons or affect accurate payment to providers are considered a priority. DOM holds monthly meetings with the program staff and the systems staff to address issues that require system changes.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Ongoing and as needed

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DOM meets on monthly or as needed basis with the Office of Information Technology Management, with daily communication whereby system errors and remedies are discussed and or reported. DOM staff and waiver providers/ direct users of the agency's electronic system have the ability to notify electronically, telephonically, or in writing concerns of the inability to process application packets or billing processes in a timely manner. The Office of Information Technology Management monitors all errors, omissions, and system downtimes in order for DOM to address either with the fiscal agent for a system change to remedy the problem and/or track the problem to propose a remedy. In addition, DOM and the case management agencies meet periodically to review and analyze the functionality of the LTSS process. Recommendations for improvement are reviewed and applied as appropriate.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DOM monitors the Quality Improvement Strategy on a quarterly basis. The Quality Improvement Strategy is reviewed annually. The review consists of 1) analyzing aggregated reports and progress toward meeting 100% of the sub assurances, 2) resolution of individual and systemic issues found during discovery, and 3) notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and the fiscal agent is made to meet waiver reporting requirements. The Quality Assurance nurses will utilize the Quality Improvement Strategy during all levels of QA activities.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

~~*DOM maintains responsibility for ensuring that financial audits of E&D Waiver providers are conducted. DOM will also generate all required financial reporting for each E&D Waiver service provided. The audit will verify the maintenance of appropriate financial records and review claims to verify coding and accuracy of the payments made. The audits are also a mean of identifying if services are delivered according to the approved plan of care. Immediate action will be taken when necessary to address any financial irregularities identified in the review, or if services are billed and not delivered according to the person's plan of services and supports.*~~

~~*Mississippi DOM staff also monitors waiver providers for fiscal accountability through post payment audits of paid claims. Audits are conducted as part of the overall monitoring of the waiver during the annual compliance review. In instances where claims have been paid erroneously, the provider is notified of any necessary recoupment. The LTC staff also closely review the CMS 372 report for accuracy prior to submittal.*~~

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.

02/24/2023

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver. D: Total number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS/Cognos

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***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***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***X 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:
~~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 =* *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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***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***	☒ ***X 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:*	☒ ***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.

~~*PM 1 & 2): 1.DOM will recoup money paid erroneously to providers within 30 days of notification; 2. Submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; 3. Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.*~~

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***	☒ ***X Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

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.

DOM contracted with an actuary firm to thoroughly evaluate the service rates in 2017. ~~A new rate study will be completed subsequent to an ongoing in depth workforce study and prior to a 2023 renewal.~~ DOM reviews all waiver rates annually to ensure that they are sufficient to ensure a qualified pool of providers. This annual review was most recently completed in June 2022~~1~~ and will be completed again in June 2023~~2~~. If it is determined that rates are no longer sufficient, they are increased appropriately.

To set the context for developing service rates, the service descriptions for each waiver service were carefully considered. It was determined whether certain services had essentially the same provider education requirements, expectations and billable productivity levels. If so, these services were grouped together for purposes of rate development.

Rates for Home Delivered Meals will be aligned with the statewide meals contract rate is greater than the Consumer Price Index for the previous calendar year, DOM will pay the new contracted rate with no less than 20% above for accounting, billing and general management of the meal program. During the 2012 Milliman rate review, this add on was determined to be the comparative administrative fee for known vendor subcontracting terms to provide for the organization and coordination of meal deliveries. ~~Rates for Home Delivered Meals will be increased by either 1.6% annually or in accordance with, but not to exceed, the rate change in the United States Department of Labor's Consumer Price Index, All Urban Consumers, South Region, Food Away from Home, based upon the preceding calendar year. If the increase in the statewide meals contract rate is greater than the Consumer Price Index for the previous calendar year, DOM will pay the new contracted rate with no less than 20% above for accounting, billing and general management of the meal program. During the 2012 Milliman rate review, this add on was determined to be the comparative administrative fee for known vendor subcontracting terms to provide for the organization and coordination of meal deliveries. Rates for meals will be increased by either 1.6% annually or in accordance with, but not to exceed, the rate change of the average CPI Core throughout years 1 through 5.~~

For all services reviewed, we either compared current waiver rates to the same non-waiver Medicaid service rates, or we performed a thorough “ground up” provider rate development.

For the Adult Day Care, Personal Care, Case Management, In-Home Respite, and Community Transition services, we built rates from the ground up using the following rating variables:
- Direct service provider salaries and benefits
- Direct service-related expense and overhead costs
- Annual number of hours practitioners are at work
- Percentage of time an at work practitioner is able to convert to billable units (productivity)

A benefit load of 35% of salary was added for social workers and nurses, while direct care workers received a load of 25%. A blended load of 30%, was used for Adult Day Care Services which represents a blend of 25% for assistants and activity coordinators and 35% for program coordinator and clinical support. This load accounts for all mandatory Mississippi and Federal benefits, such as unemployment and Social Security, as well as employer costs for optional benefits, such as health and disability insurance.

The rating variable assumptions were developed using multiple data sources including the 2015 Bureau of Labor Statistics (BLS) data trended to 2017, a 2010 proprietary Milliman medical provider compensation survey, 2011 Mississippi Planning and Development District (PDD) and Adult Day Care (ADC) center surveys, and DOM and Milliman experience. Throughout the development process, DOM had multiple, extensive discussions with Milliman to confirm the appropriateness of each of the rate development assumptions regarding service specifications, overhead costs, staffing, average length of stay, etc. for use with the Mississippi HCBS environment. Milliman recommended rates

in accordance with generally recognized and accepted actuarial principles and practices. DOM carefully reviewed the recommended rate changes and the resulting fiscal impact to providers prior to selecting the submitted rates. DOM knowledge of providers and the service delivery environment along with Milliman experience in rate development in other programs were considered in the development of certain assumptions, such as expected hours billed per day, as reflected in the rate development memos.

The rates for Physical Therapy, Speech Therapy, and Extended Home Health are set to match the State Plan reimbursement rate, which is based on an annual cost report, updated October 1st of each year.

The institutional respite rates were determined based on comparable rates for nursing facility services based on the average of daily rates in place for SFY 2023.

~~Once we calculated initial service rates, we compared them to the current service rates and made adjustments considering a projected increase in costs of service delivery. Where necessary, we adjusted the initial rates. After~~

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.

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.

~~*provider feedback, the ADC rate was adjusted up based on a change in the assumed units per day of services received.*~~

~~*The ADC must submit claims in 15 minute increments for the duration of time the services were provided and will be reimbursed by DOM the lessor of the maximum daily cap of $62.08 in Year 1 or the total amount of the 15 minute increment units billed. The duration of the service time should begin upon the person's entry in the facility and end upon their departure.*~~

~~*Projected rates for waiver years following the initial year were based on an expected one point six (1.6) percent increase in accordance with the average projected Consumer Price Index Core based on the prior 12 months as identified in the US Congress Joint Economic Committee report for Mississippi in June 2022.*~~

~~*Rates do not vary geographically and are assumed to be adequate to solicit a qualified pool of providers as the variable assumptions are based on regional BLS wage data.*~~

~~*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 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 that can be produced upon request. The MMIS has audit functions to deny payment for services when an individual is not Medicaid eligible on the date of service. The MMIS also has an audit function to deny any individual who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS requires an individual to be an approved, eligible Medicaid waiver person, documented in the MMIS, in order for the claim to pay. The lock-in function is housed in the MMIS under the recipient file and is performed/completed by Medicaid staff or the Medicaid Fiscal Agent staff.*~~

~~*DOM conducts post utilization reviews to ensure the services provided were on the person's approved service plan.*~~

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:

There are ten (10) Planning and Development Districts (PDD's) in the State of Mississippi. Each PDD is an independent organization governed by a Board of Directors appointed by the local government officials. Each District represents a distinctly different region of the state, but each have common functions such as economic development, loan programs, community development, technical assistance, planning assistance, human resource development, job training, social services, transportation and gerontology. The state Area Agencies on Aging (AAAs) are housed within the PDDs. The PDD's provide case management services, ~~transition assistance~~community transition services,, ~~adult day care~~ and home delivered meals.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***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:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

****** Appendix J Financial Data is not updated in the track changes version. New financial data can be found in the "clean" copy.***

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	16493.36	4351.36	20844.72	63254.59	8849.54	72104.13	51259.41
2	16754.28	4420.98	21175.26	64266.66	8991.13	73257.79	52082.53
3	17020.52	4491.71	21512.23	65294.93	9134.99	74429.92	52917.69
4	17312.11	4563.58	21875.69	66339.65	9281.15	75620.80	53745.11
5	17575.84	4636.60	22212.44	67401.08	9429.65	76830.73	54618.29

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	22200	22200
Year 2	22200	22200
Year 3	22200	22200
Year 4	22200	22200
Year 5	22200	22200

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 298 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 9.9 months.~~The average length of stay is 322 days. This number is based upon information captured in the state fiscal year 2020 CMS 372 Annual Report.~~

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis 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 projected number of persons who will be served on the Elderly and Disabled waiver were based upon the sum of the current unduplicated count. The number of users, average units per user, and average cost per unit are based on the SFY 2020 CMS 372 report. Estimates for number of users and average units per user were not trended, as when validated against unfinalized current year data, utilization is consistent. These numbers were then projected as stable for each waiver year forward. DOM identified the average costs/unit for year one (1) of the waiver by utilizing rates expected to be in effect as of July 1, 2022 and trended the cost per unit incrementally over the following four (4) years based on a 1.6% average projected CPI Core based on the prior 12 months as identified in the US Congress Joint Economic Committee report for Mississippi in June 2022.~~

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:*

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these*

~~The estimates for Factor D' are based on the SFY 2020 CMS 372 report and is trended forward to FY2023 based on 1.6% CPI Core. The estimate was applied for year one and every year after was adjusted based on a 1.6% average projected CPI Core based on the prior 12 months as identified in the US Congress Joint Economic Committee report for Mississippi in June 2022.~~

~~Factor G' is projected higher than Factor D' as utilization of some state plan services including hospital benefits and therapy codes may be more higher for members in nursing facility settings who have more chronic health conditions that cannot be managed at home on the waiver.~~

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.

estimates is as follows:

~~The Factor G is based upon DOM's analysis of nursing home expenditures for FY2020 based on 372 reporting and is trended forward to FY2023 based on 1.6% CPI Core. The specific nursing home expenditures analyzed were actual paid claims per Medicaid beneficiary in a nursing facility, including elderly and disabled individuals with a similar average length of stay. Every year after was adjusted based on a 1.6% average projected CPI Core based on the prior 12 months as identified in the US Congress Joint Economic Committee report for Mississippi in June 2022.~~\ 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 beneficiary in a nursing facility, including individuals who are elderly and disabled, 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 2020 based on 372 reporting and is trended forward to FY2023 based on 1.6% CPI Core. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility, including elderly and disabled individuals with a similar average length of stay. Every year after was adjusted based on a 1.6% average projected CPI Core based on the prior 12 months as identified in the US Congress Joint Economic Committee report for Mississippi in June 2022.*~~

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, including individuals who are elderly and disabled, 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 Day Care	
Case Management	
In-Home Respite	
Personal Care Service	
Extended Home Health Services	
Community Transition Services	
Home Delivered Meals	
Institutional Respite Care	
Physical Therapy Services	
Speech Therapy Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Care Total:						***29372376.00***
Adult Day Care	*per 15 minutes*	*3441*	*2200.00*	*3.88*	***29372376.00***	
Case Management Total:						***44448840.00***
Case Management	*monthly*	*22200*	*10.00*	*200.22*	~~***44448840.00***~~	

In-Home Respite Total:						*32035342.50*

GRAND TOTAL:	*366152608.90*
Total Estimated Unduplicated Participants:	*22200*
Factor D (Divide total by number of participants):	*16493.36*
Average Length of Stay on the Waiver:	*322*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite	per 15 minutes	4151	1750.00	4.41	32035342.50	
Personal Care Service Total:						244755000.00
Personal Care Service	per 15 minutes	22200	2500.00	4.41	244755000.00	
Extended Home Health Services Total:						28270.00
Skilled Nursing	per visit	22	10.00	116.50	25630.00	
Home Health Aide	per visit	6	10.00	44.00	2640.00	
Community Transition Services Total:						162558.00
Community Transition Services	per occurance	11	1.00	14778.00	162558.00	
Home Delivered Meals Total:						15324660.00
Home Delivered Meals	per meal	14430	200.00	5.31	15324660.00	
Institutional Respite Care Total:						14342.40
Institutional Respite Care	per day	6	10.00	239.04	14342.40	
Physical Therapy Services Total:						7260.00
Physical Therapy Services	per visit	11	10.00	66.00	7260.00	
Speech Therapy Services Total:						3960.00
Speech Therapy Services	per visit	6	10.00	66.00	3960.00	

GRAND TOTAL:	366152608.90
Total Estimated Unduplicated Participants:	22200
Factor D (Divide total by number of participants):	16493.36
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**29826588.00**
Adult Day Care	per 15 minutes	3441	2200.00	3.94	**29826588.00**	
Case Management Total:						**45159240.00**
Case Management	monthly	22200	10.00	203.42	**45159240.00**	
In-Home Respite Total:						**32543840.00**
In-Home Respite	per 15 minutes	4151	1750.00	4.48	**32543840.00**	
Personal Care Service Total:						**248640000.00**
Personal Care Service	per 15 minutes	22200	2500.00	4.48	**248640000.00**	
Extended Home Health Services Total:						**28721.20**
Skilled Nursing	per visit	22	10.00	118.36	**26039.20**	
Home Health Aide	per visit	6	10.00	44.70	**2682.00**	
Community Transition Services Total:						**165158.95**
Community Transition Services	per occurance	11	1.00	15014.45	**165158.95**	
Home Delivered Meals Total:						**15555540.00**
Home Delivered Meals	per meal	14430	200.00	5.39	**15555540.00**	
Institutional Respite Care Total:						**14571.60**
Institutional Respite Care	per day	6	10.00	242.86	**14571.60**	
Physical Therapy Services Total:						**7376.60**
Physical Therapy Services	per visit	11	10.00	67.06	**7376.60**	
Speech Therapy Services Total:						**4023.60**
Speech Therapy Services	per visit	6	10.00	67.06	**4023.60**	

GRAND TOTAL:	**371945059.95**
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**16754.28**
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**30356502.00**
Adult Day Care	per 15 minutes	3441	2200.00	4.01	**30356502.00**	
Case Management Total:						**45882960.00**
Case Management	monthly	22200	10.00	206.68	**45882960.00**	
In-Home Respite Total:						**33052337.50**
In-Home Respite	per 15 minutes	4151	1750.00	4.55	**33052337.50**	
Personal Care Service Total:						**252525000.00**
Personal Care Service	per 15 minutes	22200	2500.00	4.55	**252525000.00**	
Extended Home Health Services Total:						**29182.40**
Skilled Nursing	per visit	22	10.00	120.26	**26457.20**	
Home Health Aide	per visit	6	10.00	45.42	**2725.20**	
Community Transition Services Total:						**167801.48**
Community Transition Services	per occurance	11	1.00	15254.68	**167801.48**	
Home Delivered Meals Total:						**15815280.00**
Home Delivered Meals	per meal	14430	200.00	5.48	**15815280.00**	
Institutional Respite Care Total:						**14805.00**
Institutional Respite Care	per day	6	10.00	246.75	**14805.00**	
Physical Therapy Services Total:						**7494.30**
Physical Therapy Services	per visit	11	10.00	68.13	**7494.30**	
Speech Therapy Services Total:						**4087.80**
Speech Therapy Services					**4087.80**	

GRAND TOTAL:	**377855450.48**
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**17020.52**
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per visit	6	10.00	68.13		
			GRAND TOTAL:			377855450.48
			Total Estimated Unduplicated Participants:			22200
			Factor D (Divide total by number of participants):			17020.52
			Average Length of Stay on the Waiver:			322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						30810714.00
Adult Day Care	per 15 minutes	3441	2200.00	4.07	30810714.00	
Case Management Total:						46617780.00
Case Management	monthly	22200	10.00	209.99	46617780.00	
In-Home Respite Total:						33633477.50
In-Home Respite	per 15 minutes	4151	1750.00	4.63	33633477.50	
Personal Care Service Total:						256965000.00
Personal Care Service	per 15 minutes	22200	2500.00	4.63	256965000.00	
Extended Home Health Services Total:						29648.60
Skilled Nursing	per visit	22	10.00	122.18	26879.60	
Home Health Aide	per visit	6	10.00	46.15	2769.00	
Community Transition Services Total:						170486.25
Community Transition Services	per occurance	11	1.00	15498.75	170486.25	
Home Delivered						16075020.00
			GRAND TOTAL:			384328935.75
			Total Estimated Unduplicated Participants:			22200
			Factor D (Divide total by number of participants):			17312.11
			Average Length of Stay on the Waiver:			322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals Total:						
Home Delivered Meals	per meal	14430	200.00	5.57	16075020.00	
Institutional Respite Care Total:						15042.00
Institutional Respite Care	per day	6	10.00	250.70	15042.00	
Physical Therapy Services Total:						7614.20
Physical Therapy Services	per visit	11	10.00	69.22	7614.20	
Speech Therapy Services Total:						4153.20
Speech Therapy Services	per visit	6	10.00	69.22	4153.20	

GRAND TOTAL:	384328935.75
Total Estimated Unduplicated Participants:	22200
Factor D (Divide total by number of participants):	17312.11
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						31264926.00
Adult Day Care	per 15 minutes	3441	2200.00	4.13	31264926.00	
Case Management Total:						47361480.00
Case Management	monthly	22200	10.00	213.34	47361480.00	
In-Home Respite Total:						34141975.00
In-Home Respite	per 15 minutes	4151	1750.00	4.70	34141975.00	
Personal Care Service Total:						260850000.00
Personal Care Service	per 15 minutes				260850000.00	

GRAND TOTAL:	390183717.33
Total Estimated Unduplicated Participants:	22200
Factor D (Divide total by number of participants):	17575.84
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		22200	2500.00	4.70		
Extended Home Health Services Total:						**30123.60**
Skilled Nursing	per visit	22	10.00	124.14	**27310.80**	
Home Health Aide	per visit	6	10.00	46.88	**2812.80**	
Community Transition Services Total:						**173214.03**
Community Transition Services	per occurance	11	1.00	15746.73	**173214.03**	
Home Delivered Meals Total:						**16334760.00**
Home Delivered Meals	per meal	14430	200.00	5.66	**16334760.00**	
Institutional Respite Care Total:						**15282.60**
Institutional Respite Care	per day	6	10.00	254.71	**15282.60**	
Physical Therapy Services Total:						**7736.30**
Physical Therapy Services	per visit	11	10.00	70.33	**7736.30**	
Speech Therapy Services Total:						**4219.80**
Speech Therapy Services	per visit	6	10.00	70.33	**4219.80**	

GRAND TOTAL:	**390183717.33**
Total Estimated Unduplicated Participants:	**22200**
Factor D (Divide total by number of participants):	**17575.84**
Average Length of Stay on the Waiver:	322