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) Independent Living (IL) 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 IL Waiver are to:

    a. Updates to Factor C to project unduplicated enrollment limits.
    b. Additional language to allow reserved capacity for priority admission to the waiver for high acuity members.
    c. Updates to the auditing methodology to reflect new risk-based methodology.
    d. Updates to the service rates and rate methodologies.
    e. Updates to the quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
    f. Updates to language to streamline provider qualifications.
    g. Updates to the Case Management service specifications and provider qualifications to allow for additional flexibilities in staff credentials and the provision of services.
    h. Updates to the 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 $3,498,696.51 in federal dollars and $672,874.38 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.
• Additional language to allow reserved capacity for priority admission to the waiver for high acuity members.
• Updates to the auditing methodology to reflect new risk-based methodology.
• Updates to the service rates and rate methodologies.
• Updates to the quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
• Updates to language to streamline provider qualifications.
• Updates to the Case Management service specifications and provider qualifications to allow for additional flexibilities in staff credentials and the provision of services.
• 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*):

Independent Living Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MS.0255
Draft ID: MS.002.07.00

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 meeting the criteria below. Individuals must be 16 and over.
The participant must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living.
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care.
3) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) an active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) intravenous infusions to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

○ **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 Independent Living (IL) 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 by the Division of Medicaid (otherwise known as the State or DOM) and operated statewide by Mississippi Department Rehabilitation Services (otherwise known as the Department or MDRS) through an interagency agreement. The following are services provided under the IL Waiver: case management, personal care attendant service, environmental accessibility adaptation, specialized medical equipment and supplies, and transition assistance.

Upon entry into the waiver, the person will direct their own services through a co-participant service model.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and

welfare of waiver participants in specified areas.

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met

for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for

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

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

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

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

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

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

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

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

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

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

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

Summary of Public Comments and Responses:
Public comments were received regarding the wait time to receive services after participant's have been approved to receive home modifications.
State's Response: The commenter was given information on how to report his specific situation to DOM for follow up.

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

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: Naik

First Name: Anita

Title: Office Director

Agency: Mississippi Department of Rehabilitation Services

Address: 1281 Highway 51 North

Address 2:

City: Madison

State: **Mississippi**

Zip: 39110

Phone: (601) 853-5230 **Ext:** ☐ **TTY**

Fax: (601) 853-5301

E-mail: anaik@mdrs.ms.gov

8. Authorizing Signature

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

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

in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Mississippi**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

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

Specify the transition plan for the waiver:

No transition plan is required.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (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:

Mississippi Department of Rehabilitation Services (MDRS)

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:

Through an interagency agreement, Mississippi Department of Rehabilitation Services (MDRS) is responsible for the operational management of the waiver on a day-to-day basis and is 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 – MDRS notifies DOM monthly of enrollment numbers; DOM verifies that enrollment limits are not exceeded
2) Waiver expenditures managed against approved waiver levels - MDRS notifies DOM monthly of expenditures; DOM verifies 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 MDRS develops and updates the person's service plans; DOM reviews and approves all services on the service plan
5) Qualified provider enrollment - MDRS and DOM
6) Quality assurance and quality improvement activities - MDRS and DOM
7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program – MDRS and DOM (with DOM having the final authority)
8) Provision of case management by qualified staff – MDRS

An interagency agreement between the DOM and MDRS is 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 MDRS 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.

MDRS is responsible for (1) ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver; (2) initial and ongoing training of the case manager supervisors, individual case manager, registered nurses, and personal care attendants (PCAs); (3) verifying that the qualifications for all PCAs and newly hired employees are met; and (4) obtaining criminal background checks on all personnel who provide direct care to persons on the waiver.

MDRS must notify DOM of the following types of denials of waiver services: equipment, home modifications, and waiver admissions.

Appendix A: Waiver Administration and Operation

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

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

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

The DOM Utilization Management/Quality Improvement Organization (UM/QIO) is contracted to make licensed physicians available for secondary review of Level of Care determinations and service requests that cannot be approved by the automated algorithm or the DOM nurses. The UM/QIO physicians provide clinical recommendations to DOM who is responsible for final determinations.

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

   Monthly reports are submitted by the contractor and reviewed by DOM staff.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
   In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts*

the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

PM 1: Number and percent of monthly enrollment reports indicating that current census

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

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

Responsible Party for data aggregation and analysis *(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:

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 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**

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

Performance Measure:
PM 4: 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):
On-site observations, interviews, monitoring
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**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 5: Number and percent of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. Number of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. D: Total number of instances where the operating 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**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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 with the toperating agency 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 operating agency and/or 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 operating agency and/or 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)**	16	64	
	☒	**Disabled (Other)**	16	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Eligibility is limited to individuals meeting the following criteria:
The person must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living; and
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care; and
3) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) An active, life-threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) IV drip to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

There is no maximum age limit for this waiver. The minimum age limit is 16 years of age.

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Prior to admission to this waiver, the case manager(s) 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. 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. 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. Please see Appendix F-1 for more information on the client's appeal rights.

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 and MDRS ensure the waiver remains cost neutral.

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

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

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

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

Upon a change in the participant's condition, the case manager(s) assesses the person to determine if their health and welfare can continue to be assured through the provision of waiver services in the community. If so, a change request PSS is submitted for review. Each additional service request is thoroughly reviewed by 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 and/or MDRS 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 MDRS 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	5800
Year 2	5800
Year 3	5800
Year 4	5800
Year 5	5800

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

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	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (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	25
Year 2	25
Year 3	25
Year 4	25

Waiver Year	Capacity Reserved
Year 5	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 Other Mississippi 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	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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:

42 CFR § 435.110 - Parents and other caretaker relatives
42 CFR § 435.118 - Children under 19
42 CFR § 435.222 – CWS Foster Children
42 CFR § 435.226 – Independent Foster Care Adolescents (up to age 21)
42 CFR § 435.227 – Adoptive Assist Foster Children (non-IVE adoption assistance)
42 CFR § 435.145 - IVE foster children and adoption assistance
42 CFR § 435.150 – Former Foster Care Children
1634(c) of the Act - Disabled adult children (ages 19 and over)

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

(*select one*):

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

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

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

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

  Specify:

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

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

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

○ **Other**

Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

  Specify the entity:

- ○ **Other**
  Specify:

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

The comprehensive preadmission screening process is conducted by a case manager and a registered nurse. The case manager must have, at a minimum, a Bachelor's Degree in Rehabilitation counseling, or other related field and one year of experience working with individuals with disabilities. In addition, the registered nurse must have a current and active unencumbered registered nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a compact valid RN license, and at least one year of experience with the aged and/or individuals with disabilities.

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.

During the recertification process, the Case Manager may perform the core standardized assessment tool for reevaluation without a Registered Nurse.

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 operating 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 operating 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 & percent of initial and recert assessments completed by qualified assessors who were certified to accurately apply the criteria described in the approved waiver. N: Number of initial and 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 with the operating agency within 30 days to examine if any changes need to be implemented systemically. The operating agency will be required to 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. 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 operating 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 operating 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	**Personal Care Attendant (PCA)**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Transition Assistance 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:

Personal Care

Alternate Service Title (if any):

Personal Care Attendant (PCA)

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 are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Personal Care Service may include:

a) support for activities of daily living such as, but not limited to, bathing (sponge/tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.

b) assistance with housekeeping that is directly related to the person's disability, and which is necessary for the health and well-being of the person such as, but not limited to, changing bed linens, straightening area used by the person, doing the personal laundry of the person, preparation of meals for the person, cleaning the person's equipment such as wheelchairs or walkers.

c) food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;

d) support for community participation by accompanying and assisting the person, as necessary, to access community resources and participate in community activities, including: appointments, shopping, and community recreation/leisure resources, and socialization opportunities. This does not include the price of the activities themselves, nor the cost of transportation.

Personal Care Services are non-medical, hands-on care of both a supportive and health related nature. Personal Care Attendants (PCAs) are instructed to report noted changes in condition and new needs to the case manager as soon as possible. The provision of Personal Care Services is recorded on the PSS, and is not purely diversional in nature.

There must be adequate justification for the relative to function as the PCA, e.g., lack of other qualified PCAs in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.

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

The Mississippi State Plan includes personal care services as a 1905(a) service available to EPSDT recipients under the age of 21, if medically necessary, and not addressed elsewhere in the State Plan. However, the state ensures that personal care services are not duplicated by this waiver for persons under the age of 21. The case manager identifies all comparable benefits for persons of all services. If a needed service is available through the Medicaid State Plan, Medicare, or private insurance, it is provided as a non-waivered service. DOM reviews 100% all PSSs at initial application, and each annual recertification. MDRS conducts quarterly reviews of all PSSs, secondary reviews of all PSS by in-house medical staff, and annual programmatic audits by Program Evaluation. DOM conducts annual compliance reviews and on-site visits to ensure appropriate billing. Additionally, service restrictions are imposed with the use of the Lock-in. A review of claims history can be conducted to determine if personal care services are being provided and covered through the State Plan.

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 IL 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 Attendant (PCA)

Provider Category:

Individual

Provider Type:

MS Medicaid Enrolled IL Waiver Personal Care Attendant Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency 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:

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 Accessibility Adaptations

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):*

Those physical adaptations to the home, required by the person's PSS, which are necessary to ensure the health, welfare, and safety of the person, or which enable the person to function with greater independence in the home, and without which, the person would require institutionalization. Such adaptations may include: the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the person. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the person.

Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

The services under the Independent Living Waiver 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 IL Waiver Environmental Accessibility Adaptation Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

MS Medicaid Enrolled IL Waiver Environmental Accessibility Adaptation Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

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:

Specialized Medical Equipment and Supplies

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):*

Specialized medical equipment and supplies include devices, controls, or appliances which enable the person to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or provide a direct medical or remedial benefit to the person. These items must be specified on the PSS.

Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payers (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.

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

Each request for specialized medical equipment is evaluated by the case manager or DOM staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation. The case manager will update the person and monitor the progress of each specialized medical equipment request on a monthly basis. If the case manager determines there is a need to make adjustments to the request, he/she will notify the appropriate personnel (i.e. Assistive Technology) as soon as possible. The case manager will discuss and document the person's choice of vendor on the PSS prior to authorizing for services.

If it is determined through the person-centered planning process that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

The services under the Independent Living Waiver 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 IL Waiver Specialized Medical Equipment and Supply Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled IL Waiver Specialized Medical Equipment and Supply Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

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:

Transition Assistance 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):*

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

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

Transition assistance services are capped at $800.00 one-time initial expense per lifetime.

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

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

Need for this service: All items and services covered must be essential to:
1) Ensure that the person is able to transition from the current nursing facility; and
2) Remove an identified barrier or risk to the success of the transition to a more independent living situation.

To be eligible, the individual must:
1) Be a current nursing facility (NF) resident whose NF services are being paid by Medicaid;
2) Not have another source to fund or attain the items or support;
3) Be transitioning from a living arrangement where these items were provided; and
4) Be transitioning to a residence where these items are not normally furnished.

The transition service must occur within 90 days of the discharge, but must also be completed by the day the person relocates from the institution. Persons whose nursing facility 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
Agency	MS Medicaid Enrolled IL Waiver Transition Assistance Service Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled IL Waiver Transition Assistance Service Providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

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:

Case Management is provided as an administrative activity by the operating agency, the Mississippi Department of Rehabilitation Services.

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, or 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, or 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 enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. N: Number of enrolled non-licensed/non-certified providers, by provider type, who meet waiver provider qualifications. 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 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**

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

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 with the operating agency within thirty (30) days to examine if any changes need to be implemented systematically. 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 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:

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.

The average cost for a person receiving IL waiver services must not be above the average estimated cost for nursing home level of care approved by The Centers of Medicaid and Medicare Services for the current waiver year. DOM and MDRS must assure the waiver remains cost neutral. If the total projected annual cost of all services requested exceeds the most recent annual nursing home bed cost, then the request is denied and returned for reconsideration. Cost neutrality provisions are explained to the person. At that point, some negotiation may occur regarding the amount of services requested under this waiver, whether or not another waiver may have a package of services which can more efficiently meet the needs of the person, or whether nursing home is the most appropriate setting based on the amount and complexity of services required. If the annual cost to serve a person in this waiver exceeds the annual nursing home costs, the cost neutrality requirement is jeopardized.

There is reference in Appendix B of this waiver renewal application as to provisions for a participant's safeguards. Following these safeguard procedures, it is possible for an individual to exceed the cost neutrality limit, but the possibility of such occurrences is mitigated by active case management. These requests are considered on an individual basis considering each on its own merits. Related decisions are appealable and covered as addressed in Appendix F of this waiver renewal application.

If a waiver applicant is denied services, the person is given a Notice of action, and the opportunity for a Fair Hearing.

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.

Based upon the DOMs assessment of the HCBS settings in the IL waiver, the DOM confirms that services in this waiver are rendered in a HCB setting. Waiver participants reside in private homes located in the community. The IL waiver does not provide services to persons in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for 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 (PSS)

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:

The Case Manager must possess, at minimum, a Bachelor's degree in Rehabilitation Counseling or other related field, and one year of experience working with individuals with disabilities.

☐ **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.

Case management is provided by MDRS case managers as an administrative activity as structured through an interagency agreement between DOM and MDRS. MDRS case managers initiate and complete the process of assessment and reassessment of the person and are responsible for ongoing monitoring of services and supports the person is receiving in their home and community.

The person chooses their personal care attendants, environmental accessibility adaptations, specialized medical supplies and equipment providers. If requested, the person is also offered the choice of an alternate MDRS case manager. Case Management services are provided by qualified staff employed by MDRS. Personal care services are provided by individuals chosen by the participants as potential PCAs who are then certified by the Case Managers at MDRS prior to the provision of services. At no time are personal care services provided by Case Managers.

Oversight of waiver processes and periodic evaluations are completed by DOM Office of Long Term Care and Office of Financial and 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 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.ing.

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

During the person-centered planning process, the person and/or their representative is given a choice of personal care attendants, SMS/DME companies, and contractors for adaptations/modifications. If requested, individuals are also offered the choice of an alternate case manager based on geographical availability. The person selects their personal care attendant. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements to become a personal care attendant, as set forth in the IL Waiver, that individual is allowed to provide the direct care for that person. If a person does not have a specific personal care attendant, the Case manager will assist the person with locating potential PCA candidates for them to interview.

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 (7 of 8)

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- [x] **Medicaid agency**
- [x] **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 operating 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 operating 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 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 =
☐ **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 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 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: Total Number of PSSs reviewed.

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

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

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

Data Aggregation and Analysis:

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

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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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**

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

c. Timelines

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

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take

advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver engages the person to make choices in regards to their needs, preferences and desires with all aspects of the services provided. Once a person has been determined eligible for waiver services they are allowed to self-direct their personal care services. The person recruits, hires and may terminate employment of the PCAs with assistance from their case manager. The person does not exercise budgetary authority (including salary negotiations, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance). Those functions are completed as an administrative activity by the operating agency. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case manager(s).

The person also continually evaluates their medical equipment/supply needs and informs their case manager(s) if their needs change. The person and their case manager(s) work together to meet these needs as quickly, safely and efficiently as possible. Medical equipment and environmental accessibility adaptation needs are evaluated by MDRS' Assistive Technology Division.

Each person is involved in the formation of their PSS, including input into the number of hours of PCA services they need per day/week.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

  The individual may live with several other persons in a private residence/apartment.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- (●) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Applicants and other interested parties expressing an interest in this waiver are provided information on participant-directed personal care services. MDRS and DOM waiver staff are trained to provide this information upon referral, at initial application intake, and ongoing while the participant is enrolled in the waiver. Information is provided to each applicant to assure informed decision making is based on an understanding of the participant directed service delivery method. The case manager also outlines the roles and responsibilities for the person or the legal representative, the case manager, and the providers. It is explained to the person that PCA services will not begin prior to the PCA being certified as competent in accordance with the Part 208 of the Medicaid Administrative Code.

This waiver affords each person the opportunity to select the PCA of their choice. The benefit of participant-direction allows the person to choose a PCA that is proven competent. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements as set forth in the approved wavier application and the Administrative Code, that individual is allowed to provide direct care for the person on the waiver. The case manager will assist the person with locating potential PCA candidates for them to interview.

In the event that the case manager determines that the PCA poses potential safety concerns or threats of harm to the person or other service providers, or poses a threat for potentially fraudulent activities, the case manager may immediately terminate the PCA. The person may then choose a replacement PCA, provided they meet minimum requirements, and are certified by the case manager to be competent. All reports of abuse, neglect, exploitation or fraud are to be reported in accordance with the process outlined in Appendix G of this waiver.

If the person been without a PCA for six consecutive months, the person will be reevaluated and the operating agency in consultation with DOM will determine alternatives available to better meet the participant’s needs. Those alternatives will be presented to the participant and, if appropriate, the case manager will assist the participant with referral/transition to the selected alternative.

Each person also chooses State approved vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care Attendant (PCA)	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Once a waiver applicant has been determined eligible for waiver services, the case manager provides information to each applicant on the participant directed service delivery method.

The person recruits, hires, and may terminate employment of their PCAs with assistance from the case manager. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case manager.

The case manager confers with the person to determine who they would desire to provide their personal care services. After the person has determined who they would desire, the case manager goes through the specified steps to determine if the requested PCA meets the minimum requirements. Once it has been determined that the person meets the minimal requirements, completes training, and is certified, the PCA begins working for the person. Ongoing evaluation of the care provided and the satisfaction of the person is done and alterations, if needed, are made to the PSS.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☐
Transition Assistance Services	☐
Personal Care Attendant (PCA)	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

MDRS provides case management as an administrative activity. As component of this case management, MDRS staff provide information and assistance in support of participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a person decides to terminate participant direction at any time, they may choose to transfer to an alternate home and community-based waiver for which they qualify. There is coordination amongst DOM, MDRS and other waiver providers to which the person will be transitioning.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Immediate termination of the Participant-Directed personal care service option can occur if the following circumstances arise including, but not limited to:

- The participant’s and/or service provider’s health, safety, or welfare is immediately jeopardized or there is potential for threat of harm.
- Fraudulent activity by the participant/their representative or the provider is detected.
- There is non-compliance related to implementing the approved PSS.

When it is decided that a person can no longer direct their personal care services, there is coordination by the case manager to provide continuity of services and ensure the person's health and welfare while transitioning the participant to an alternate service/setting options.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	5800	
Year 2	5800	
Year 3	5800	
Year 4	5800	
Year 5	5800	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The operating Agency, MDRS, completes the necessary payroll and human resource functions, as an administrative activity, to support the person as the co-employer of their PCAs.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☐ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such**

qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a.

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

With DOM approval, a person may be terminated from waiver services for any of the following reasons: (1) The person or his/her legal representative request termination; (2) The person no longer meets program eligibility requirements; (3) The person refuses to accept services; (4) The person is not available for services after thirty days; (5) The person is in an environment that is hazardous to self or service providers; (6) The person and/or individuals in the person's home become abusive and belligerent including, but not limited to, sexual harassment, racial discrimination, threats.

State Fair Hearing procedures are based on the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Applicant is informed of Fair Hearing process during entrance to waiver by the Case Manager.

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

Contents of Notice of Action include:
a. Description of the action the operating agency 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 (AL Waiver should note waiver case manager or DOM state office, IL and TBI/SCI Waivers should note MDRS 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 operating 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. Case management staff will notify person if services will remain in place during the appeal process. Upon receipt of the request for a state hearing, the DOM Office of Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

The informal dispute resolution process is initiated with the case manager(s) at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. A person may address disputes to DOM at any time. The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Persons are encouraged to report disputes to their case manager(s). However, dispute resolution can start at any level in the process. If a resolution is not reached by the person and the case manager within seventy-two (72) hours of the initial report by the person, the case manager(s) reports the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the operating agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case manager(s) then the operating agency and DOM work with the person to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the person's satisfaction with the new case management staff within the following month and notifies DOM of the final resolution. DOM and the operating agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by the operating 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 operating 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 manager(s), but may address any complaint/grievance to DOM at any time. The case manager(s) begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case manager(s) reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the operating agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case manager then the operating agency and DOM work with the participant to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the participant's satisfaction with the new case management staff within the following month and 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 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 in accordance with Mississippi Code § 43-47-9. All reports of A, N and E must be reported immediately by the appropriate case manager to their supervisor and the Department of Human Services. The potential incidents are also to be reported in writing to the DOM as it occurs. If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager calls 911 to request immediate assistance.

There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver participants. DOM and the operating agency follow up with DHS to ensure that reports are investigated, and action is taken. In cases of Vulnerable Adult Abuser, reports may also be submitted to the Mississippi Attorney General's Office.

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.

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff. Upon initial entry into the waiver, case manager(s) will provide the person and/or their caregiver education and information concerning the State's protection of the person against abuse, neglect and exploitation including how persons may notify appropriate authorities when the person may have experienced abuse, neglect or exploitation. At that time, they are provided the names and phone numbers of their case manager(s). The person is contacted by the case manager(s) on a monthly basis (by phone or face-to face visit). If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the case manager of their concern by phone, a 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 is notified of any suspected abuse, neglect, exploitation cases as they occur, and is available to provider support in ensuring a prompt resolution, if feasible.

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

The 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 the participant and other parties as designated by State law. Time frames for notification of results vary based on investigation. Each case will be analyzed on an individual basis to determine the appropriate plan of action. By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM works with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302. 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 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." Communication continues between the operating agency, Division of Medicaid, Department of Human Services, and Attorney General's office, if necessary, until resolution occurs. Additionally, DHS provides information on critical incidences involving alleged A, N and E of waiver participants. 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.

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 operating agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended), 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.

Appendix G: Participant Safeguards

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

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

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

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

The State prohibits the use of restraints during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that restraints are not used for waiver participant. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State prohibits the use of restrictive interventions during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

restraints.)

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

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

The State prohibits the use of seclusion during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that seclusion is not used for waiver participants. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

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

b. Medication Management and Follow-Up

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

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 Incident 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**

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

Performance Measure:
PM 2: Number and percent of persons reviewed whose emergency preparedness plan (EPP) and Plan of Services and Supports (PSS) address prevention strategies for identified risks (including critical incidents). N: Number of persons reviewed whose EPP and PSS address prevention strategies for identified risks (including critical incidents). D: Number of persons reviewed.

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with a =/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
PM 4: Number and percent of complaints that were addressed/resolved as approved in the waiver. N: Number of complaints that were addressed/resolved as approved in the waiver. D: Total number of complaints.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 5: Number and percent of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. N: Number of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. D: Total number of annual complaint reviews.

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

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

Data Aggregation and Analysis:

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

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:

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

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 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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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 Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

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

ii. System Improvement Activities

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

b. System Design Changes

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

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

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

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

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

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

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

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

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
PM 1: Number and percent of claims 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:* *(Fiscal Agent)*	☒ ***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	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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.

DOM 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. If it is determined that rates are no longer sufficient, they are increased appropriately.

To set the context for developing service rates, careful consideration was given for service descriptions and provider handbook information for each waiver service. Educational requirements, expectations, and billable productivity levels were also considered. Current waiver rates were compared to the same non-waiver Medicaid service rates or a ground up analysis was conducted.

For the Personal Care Attendant service, initial rates were updated using the following rating variables:
> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hours practitioners are at work
> Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including 2015 Bureau of Labor Statistics (BLS) data trended to 2017, a 2010 proprietary Milliman medical provider compensation survey, and Division of Medicaid 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.

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.

Transitional Assistance rate of $800.00 per lifetime usage was based upon past utilization practices across all waivers. Transition assistance is reimbursed based on actual costs; however, the rate outlined in the waiver is the maximum allowable reimbursement. The Specialized Medical Equipment and Supplies and Environmental Accessibility Adaptations rates were determined based on previous utilization patterns and current costs. Specialized Medical Equipment and Supplies are reimbursed based on actual costs identified by invoice and MSRP; however, the estimated rate outlined in the waiver an average based on utilization per the SFY 2022 372 report.
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 all waiver services flow directly from providers to the State's claims payment system (MMIS).

Appendix I: Financial Accountability

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

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

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

Select at least one:

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

The Mississippi Department of Rehabilitation Services (MDRS), the operating State agency, is the provider of case management. Participants choose a vendor of their choice for specialized medical equipment and supplies, environmental accessibility adaptations, personal care attendant services, respite services and transition assistance services.

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:

The Mississippi Department of Rehabilitation Services (MDRS) is appropriated the state funds for this waiver. MDRS pays the state match in advance to the Division of Medicaid (DOM) via an intergovernmental transfer (IGT) based on the prior quarter's claims payments.

☐ ***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	17037.20	6364.88	23402.08	61266.41	9159.90	70426.31	47024.23
2	17037.20	6543.09	23580.29	62981.87	9416.37	72398.24	48817.95
3	17037.20	6726.30	23763.50	64745.37	9680.03	74425.40	50661.90
4	17037.20	6914.64	23951.84	66558.24	9951.07	76509.31	52557.47
5	17037.20	7108.25	24145.45	68421.87	10229.70	78651.57	54506.12

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	5800	5800
Year 2	5800	5800
Year 3	5800	5800
Year 4	5800	5800
Year 5	5800	5800

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 unofficial FY2022 CMS 372 Report data, the average length of stay for this waiver is 315 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 10.5 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 with severe orthopedic and/or neurological impairments, 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 with severe orthopedic and/or neurological impairments, 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	
Personal Care Attendant (PCA)	
Environmental Accessibility Adaptations	
Specialized Medical Equipment and Supplies	
Transition Assistance 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*
Personal Care Attendant (PCA) Total:						***97300043.10***
Personal Care Attendant (PCA)	*per 15 min*	*5510*	*4563.00*	*3.87*	***97300043.10***	
Environmental Accessibility Adaptations Total:						***1160000.00***
Environmental Accessibility Adaptations	*per modification*	*58*	*2.00*	*10000.00*	***1160000.00***	
Specialized Medical Equipment and Supplies Total:						***350900.00***
Specialized Medical Equipment and Supplies	*per item*	*319*	*2.00*	*550.00*	***350900.00***	
Transition Assistance Services Total:						***4800.00***
Transition Assistance Services	*per service*	*6*	*1.00*	*800.00*	***4800.00***	
				GRAND TOTAL:		***98815743.10***
				Total Estimated Unduplicated Participants:		***5800***
				Factor D (Divide total by number of participants):		***17037.20***
				Average Length of Stay on the Waiver:		*315*

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
Personal Care Attendant (PCA) Total:						**97300043.10**
Personal Care Attendant (PCA)	per 15 min	5510	4563.00	3.87	**97300043.10**	
Environmental Accessibility Adaptations Total:						**1160000.00**
Environmental Accessibility Adaptations	per modification	58	2.00	10000.00	**1160000.00**	
Specialized Medical Equipment and Supplies Total:						**350900.00**
Specialized Medical Equipment and Supplies	per item	319	2.00	550.00	**350900.00**	
Transition Assistance Services Total:						**4800.00**
Transition Assistance Services	per service	6	1.00	800.00	**4800.00**	
				GRAND TOTAL:		**98815743.10**
				Total Estimated Unduplicated Participants:		**5800**
				Factor D (Divide total by number of participants):		**17037.20**
				Average Length of Stay on the Waiver:		315

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
Personal Care Attendant (PCA) Total:						**97300043.10**
Personal Care Attendant (PCA)	per 15 min	5510	4563.00	3.87	**97300043.10**	
Environmental Accessibility Adaptations Total:						**1160000.00**
Environmental Accessibility Adaptations	per modification	58	2.00	10000.00	**1160000.00**	
Specialized Medical Equipment and						**350900.00**
				GRAND TOTAL:		**98815743.10**
				Total Estimated Unduplicated Participants:		**5800**
				Factor D (Divide total by number of participants):		**17037.20**
				Average Length of Stay on the Waiver:		315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplies Total:						
Specialized Medical Equipment and Supplies	per item	319	2.00	550.00	350900.00	
Transition Assistance Services Total:						4800.00
Transition Assistance Services	per service	6	1.00	800.00	4800.00	

GRAND TOTAL:	98815743.10
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	17037.20
Average Length of Stay on the Waiver:	315

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
Personal Care Attendant (PCA) Total:						97300043.10
Personal Care Attendant (PCA)	per 15 min	5510	4563.00	3.87	97300043.10	
Environmental Accessibility Adaptations Total:						1160000.00
Environmental Accessibility Adaptations	per modification	58	2.00	10000.00	1160000.00	
Specialized Medical Equipment and Supplies Total:						350900.00
Specialized Medical Equipment and Supplies	per item	319	2.00	550.00	350900.00	
Transition Assistance Services Total:						4800.00
Transition Assistance Services	per service	6	1.00	800.00	4800.00	

GRAND TOTAL:	98815743.10
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	17037.20
Average Length of Stay on the Waiver:	315

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*
Personal Care Attendant (PCA) Total:						***97300043.10***
Personal Care Attendant (PCA)	*per 15 min*	*5510*	*4563.00*	*3.87*	***97300043.10***	
Environmental Accessibility Adaptations Total:						***1160000.00***
Environmental Accessibility Adaptations	*per modification*	*58*	*2.00*	*10000.00*	***1160000.00***	
Specialized Medical Equipment and Supplies Total:						***350900.00***
Specialized Medical Equipment and Supplies	*per item*	*319*	*2.00*	*550.00*	***350900.00***	
Transition Assistance Services Total:						***4800.00***
Transition Assistance Services	*per service*	*6*	*1.00*	*800.00*	***4800.00***	

GRAND TOTAL:	***98815743.10***
Total Estimated Unduplicated Participants:	***5800***
Factor D (Divide total by number of participants):	***17037.20***
Average Length of Stay on the Waiver:	*315*

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 significant changes to this waiver are to: 1. Remove Case Management as a service and convert it to an administrative activity completed by the operating agency, the Mississippi Department of Rehabilitation Services. 2. Remove the concurrent 1915(b)(4) 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.
• Additional language to allow reserved capacity for priority admission to the waiver for high acuity members.
• Updates to the auditing methodology to reflect new risk-based methodology.
• Updates to the service rates and rate methodologies.
• Updates to the quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
• Updates to language to streamline provider qualifications.
• Updates to the Case Management service specifications and provider qualifications to allow for additional flexibilities in staff credentials and the provision of services.
• Updates to the language related to the provision of services by family members/relatives and defining legally responsible persons.

~~The significant changes to this waiver are to:
1. Remove Case Management as a service and convert it to an administrative activity completed by the operating agency, the Mississippi Department of Rehabilitation Services.
2. Remove the concurrent 1915(b)(4)

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.~~

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*):

Independent Living Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MS.0255
Waiver Number:MS.0255.R06.00
Draft ID: MS.002.06.00

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

Regular Waiver

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

07/01/232 07/01/23

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 meeting the criteria below. Individuals must be 16 and over. The participant must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living.
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care.
3) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) an active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) intravenous infusions to control or support blood pressure; (c)

○ **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 Independent Living waiver provides individuals, seeking Long Term Care assistance, meaningful choices to allow 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 assessment process that provides a single point of entry for individuals seeking long term care services, and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.~~

~~This waiver is administered by the Division of Medicaid (otherwise known as the State or DOM), and operated statewide by the Mississippi Department of Rehabilitation Services (otherwise known as the Department or MDRS) through an interagency agreement. The following are services that are provided under the IL Waiver: case management, personal care attendant service, environmental accessibility adaptations, specialized medical equipment and supplies, and transition assistance.~~

~~Upon entry into the waiver, the person will direct their own services through a co-participant service model.~~

The Independent Living (IL) 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 by the Division of Medicaid (otherwise known as the State or DOM) and operated statewide by Mississippi Department Rehabilitation Services (otherwise known as the Department or MDRS) through an interagency agreement. The following are services provided under the IL Waiver: case management, personal care attendant service, environmental accessibility adaptation, specialized medical equipment and supplies, and transition assistance.

Upon entry into the waiver, the person will direct their own services through a co-participant service model.

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-IL-Waiver-Renewal-Combined-Public-Notice-4.28.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 the wait time to receive services after participant's have been approved to receive home modifications. State's Response: The commenter was given information on how to report his specific situation to DOM for follow up.

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

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: Naik

First Name: Anita

Title: Office Director

Agency: Mississippi Department of Rehabilitation Services

Address: 1281 Highway 51 North

Address 2:

City:	Madison
State:	**Mississippi**
Zip:	39110
Phone:	(601) 853-5230 **Ext:** ☐ **TTY**
Fax:	(601) 853-5301
E-mail:	anaik@mdrs.ms.gov

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 24, 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:

~~The state is converting Case Management from a service to an administrative activity completed by the operating agency, the Mississippi Department of Rehabilitation Services. Individuals enrolled in this waiver will not be negatively impacted by this change.~~

No transition plan is required.

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

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

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

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

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

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

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. The Statewide Transition Plan can be located at https://medicaid.ms.gov/submitted-ms-statewide-transition-plan/.~~

~~Based upon the State's assessment of the HCBS settings in the Independent Living waiver, the State confirms that services in this waiver are rendered in a home and community setting. Persons on the waiver reside in private homes located in the community. This waiver does not provide services in either congregate living facilities, institutional settings or adjacent to or on the grounds of institutions. No further transition plan is required.~~

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:

(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:

Mississippi Department of Rehabilitation Services (MDRS)

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:

~~Through an interagency agreement, Mississippi Department of Rehabilitation Services (MDRS) is responsible for the operational management of the waiver on a day-to-day basis, and is accountable to Division of Medicaid (DOM) which ensures that the waiver operates in accordance with federal waiver assurances.~~
~~1) Waiver enrollment managed against approved waiver limits – MDRS notifies DOM monthly of enrollment numbers~~
~~2) Waiver expenditures managed against approved waiver levels – MDRS notifies DOM monthly of expenditures; DOM verifies 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 a person's service plans – With the person's input, MDRS develops and updates the person's service plan; DOM reviews and approves all services on the service plan.~~
~~5) Qualified provider enrollment, – MDRS and DOM~~
~~6) Quality assurance and quality improvement activities and, – MDRS and DOM~~
~~7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program. – MDRS and DOM (with DOM having the final authority)~~

~~An interagency agreement between the DOM and MDRS is maintained and updated as needed. DOM monitors this agreement to ensure that the provisions specified are met. In the agreement, DOM designates the assessment, evaluation, and reassessment of the person to be conducted by qualified professionals as specified in the current waiver. All such evaluations for certification or recertification are subject to DOM's review and approval.~~

~~DOM performs monitoring of the multi-site offices of MDRS on an annual basis to assess their operating performance and compliance with all rules and regulations. DOM reviews each waiver persons' certifications, both initial and annual recertification. Home visits/telephone interviews are also conducted to assess compliance with waiver requirements.~~

~~MDRS is responsible for ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver. In addition, MDRS State Office Management Staff are responsible for initial and ongoing training of the case manager supervisors, individual case managers, registered nurses, and personal care attendants (PCA).~~

~~MDRS is also responsible for verifying the qualifications for all PCAs and newly hired employees are met. MDRS is responsible for obtaining criminal background checks on all personnel who provide direct care to persons on the waiver.~~

Through an interagency agreement, Mississippi Department of Rehabilitation Services (MDRS) is responsible for the operational management of the waiver on a day-to-day basis and is 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 – MDRS notifies DOM monthly of enrollment numbers; DOM verifies that enrollment limits are not exceeded
2) Waiver expenditures managed against approved waiver levels - MDRS notifies DOM monthly of expenditures; DOM verifies 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 MDRS develops and updates the person's service plans; DOM reviews and approves all services on the service plan
5) Qualified provider enrollment - MDRS and DOM
6) Quality assurance and quality improvement activities - MDRS and DOM
7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program – MDRS and DOM (with DOM having the final authority)
8) Provision of case management by qualified staff – MDRS

An interagency agreement between the DOM and MDRS is 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 MDRS 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.

MDRS is responsible for (1) ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver; (2) initial and ongoing training of the case manager supervisors, individual case manager, registered nurses, and personal care attendants (PCAs); (3) verifying that the qualifications for all PCAs and newly hired employees are met; and (4) obtaining criminal background checks on all personnel who provide direct care to persons on the waiver.

MDRS must notify DOM of the following types of denials of waiver services: equipment, home modifications, and waiver admissions.

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 DOM Utilization Management/Quality Improvement Organization (UM/QIO) is contracted to make licensed physicians available for secondary review of Level of Care determinations and service requests that cannot be approved by the automated algorithm or the DOM nurses. The UM/QIO physicians provide clinical recommendations to DOM who is responsible for final determinations.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

~~DOM 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.

Appendix A: Waiver Administration and Operation

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

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

Monthly reports are submitted by the contractor and reviewed by DOM staff.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

~~**PM 5: Number and percent of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. N: Number of instances where reporting requirements of the operating agency were met in accordance to the**~~

~~Interagency Agreement. D: Total number of instances where the operating agency was require to submit 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:
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	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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
~~**PM 4: 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.**~~

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):
~~**On-site observations, interviews, monitoring**~~ **Other**
If 'Other' is selected, specify:
~~**QA Home Visits/Telephone Interviews**~~ **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**	☐ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X 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.**~~

PM 3: 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):*
☒	☐	☒

XState Medicaid	Weekly	X 100% Review

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

Data Aggregation and Analysis:

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

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

Performance Measure:

~~**PM 3: 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 4: 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**~~ **On-site observations, interviews, monitoring**

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

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 5: Number and percent of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. Number of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. D: Total number of instances where the operating 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**	☐ ~~**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:	☒ **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) require MDRS to provide report monthly; and (b) DOM and MDRS will cease enrollment immediately if current census and unduplicated count exceed estimates of the waiver.~~
~~For PM 2, DOM will (a) require MDRS to provide report monthly; and (b) DOM and MDRS will cease enrollment immediately if expenditures exceed estimates of the waiver.~~
~~For PM 3, DOM will (a) hold a quality improvement strategy meeting within 30 days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically, as needed.~~
~~For PM 4, DOM will (a) require MDRS to assist the person with relocating to a HCB setting within 30 days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically as needed.~~
~~For PM 5, DOM will (a) require MDRS to submit the missing/corrected reports within seven business days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically as needed.~~

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 with the toperating agency 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 operating agency and/or 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 operating agency and/or 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**
☒ **X Operating Agency**	☐ ~~**Monthly**~~
☐ **Sub-State Entity**	☒ **X 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 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)	16	64	
	☒	Disabled (Other)	16	64	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Eligibility is limited to individuals meeting the following criteria: The person must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living; and
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care; and
3) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) An active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) IV drip to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

There is no maximum age limit for this waiver. The minimum age limit is 16 years of age.

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

    - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

~~Prior to the admission to this waiver, the case management team completes a thorough comprehensive Long Term Support Services (LTSS) assessment to determine how the person could be best served. The overall assessment of the person provides an estimated projection of the total cost for services to determine whether their needs are able to be met in a manner that ensures the person's health and welfare. Along with the core standardized assessment, the case management team submits documentation including a person centered plan of services and supports (PSS) to DOM which includes specific service needs of the individual. An oversight review and approval by a registered nurse at DOM is conducted to ensure the person's needs are able to be met by the specified services and service amounts. 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 care 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 and MDRS must ensure the waiver is cost neutral. If MDRS determines a particular person's care costs are threatening the cost neutrality of the waiver, MDRS must collaborate with DOM as soon as possible to review the PSS.~~

Prior to admission to this waiver, 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. 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. 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. Please see Appendix F-1 for more information on the client's appeal rights. 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 and MDRS ensure the waiver remains cost neutral.

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

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

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

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

~~Each additional service requested is thoroughly reviewed by the administrative staff at MDRS, and additionally by a Medicaid program nurse. If the service is deemed appropriate, the Medicaid program nurse will approve the request and will notify the staff at MDRS of the approval. If the additional services requested are determined to exceed the average estimated cost, then the request may be denied per MDRS, and the applicant or person will be notified of their right to a State Fair Hearing (Appendix F). MDRS must notify DOM of the following types of denials of waiver services: equipment, home modifications, and waiver admissions. The denial must not compromise the quality of care of the individual in any way; if so, an approval may be granted by overriding the denial via management of DOM and/or MDRS. If an increase in services is denied, the person will be informed, and given the opportunity to request a Fair Hearing.~~

~~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 may also provide physicians for secondary review of PSS requests that cannot be approved by the DOM Nurse or DOM Administrator.~~

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 and/or MDRS 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 MDRS work collectively 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.~~

DOM and MDRS 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	5800
Year 2	5800
Year 3	5800
Year 4	5800

	5800

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
Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers

Purposes
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
Transition of Persons from Other Mississippi HCBS Waivers

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):*

~~Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers~~

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

Purpose *(describe):*

~~MDRS agrees to reserve capacity for each waiver year for individuals transitioning from nursing facilities and other home and community based services (HCBS) waivers.~~

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

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 referrals received for transition from nursing facilities to a community setting for FY15 and FY16. It was determined that maintaining the reserve capacity of 25 IL waiver slots, in addition to capacity reserved in other waivers, would be sufficient to meet the needs of individuals wishing to transition out of nursing facilities into a Home and Community setting.~~

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

Transition of Persons from Other Mississippi 1915(c) HCBS Waivers

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.

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.

Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

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.

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		25	
Year 2		25	
Year 3		25	
Year 4		25	
Year 5		25	

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

~~MDRS maintains a statewide referral database of individuals who request waiver services through the IL Waiver. The statewide database is maintained on date of referral.~~

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:

42 CFR § 435.110 - Parents and other caretaker relatives
42 CFR § 435.118 - Children under 19
42 CFR § 435.222 – CWS Foster Children
42 CFR § 435.226 – Independent Foster Care Adolescents (up to age 21)
42 CFR § 435.227 – Adoptive Assist Foster Children (non-IVE adoption assistance)
42 CFR § 435.145 - IVE foster children and adoption assistance
42 CFR § 435.150 – Former Foster Care Children
1634(c) of the Act - Disabled adult children (ages 19 and over)

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

applies only to the 42 CFR §435.217 group.

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

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

    Specify:

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

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

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

- ○ **Other**

  Specify:

ii. 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:

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

~~The comprehensive preadmission screening process is conducted by a case manager and a registered nurse. The case manager must have, at a minimum, a Bachelor's Degree in Rehabilitation counseling, or other related field and one year of experience working with individuals with disabilities. In addition, the registered nurse must have a current and active unencumbered registered nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a compact valid RN license, and at least one year of experience with the aged and/or individuals with disabilities.~~

~~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 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.

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.~~

~~During the recertification process, the Case Manager may perform the core standardized assessment tool for reevaluation without a Registered Nurse.~~

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 newly implemented 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. Also, DOM provides MDRS 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 MDRS is aware of any person that is about to lose eligibility or waiver services. By reviewing this monthly eligibility report, DOM and MDRS identify certification end dates, and prevent deficiencies in timely submission of certifications. These processes ensure timely recertification.~~

~~In addition, MDRS has district offices throughout the state. Each of these district offices has manual and automated monitoring systems to ensure that re-certifications are completed timely. These procedures are inclusive of:~~
~~1. Tickler file;~~
~~2. Edits in the computer system; and~~
~~3. Component part of case management.~~

~~The goal of each office is to renew these in a timely manner so that there will not be a lapse in service for the person. A statewide tickler file and computer edits are also maintained in the state office of MDRS to further ensure timely reevaluations.~~

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 housed at MDRS and in the LTSS system. The core standardized assessment along with other required documentation is submitted electronically which produces a copy that is housed in the LTSS System. MDRS is required to keep the entire document for the period of time specified under the current federal guidelines.~~

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

PM 1: Number and percent of waiver applicants, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. N: Number of waiver applicants, for whom there is reasonable indication that services may be needed in the future, that received a comprehensive LTSS assessment. D: Total number of waiver applicants.

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

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

	Continuously and Ongoing	**Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **X State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X 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 & percent of initial and recert assessments completed by qualified assessors who were certified to accurately apply the criteria described in the approved waiver. N: Number of initial and 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**	☒ **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:

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 have (a) MDRS obtain correct documentation prior to DOM completing determination letter; and (b) MDRS will conduct comprehensive LTSS assessment within fifteen days.~~
~~For PM 2, DOM will(a) immediately indicate deficiency in LTSS System for data collection; (b) require MDRS to conduct a new LOC evaluation by a qualified staff person within seven business days, if indicated; and (c) approve LOC evaluation within seven business days of receipt.~~

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 with the operating agency within 30 days to examine if any changes need to be implemented systemically. The operating agency will be required to 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. 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**
☒ **X Operating Agency**	☒ **X 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 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 placement on an Informed Choice form. Long term care options are explained by the case manager prior to enrollment, and the person indicates their choice of waiver services or institutional services by evidence of their signature and initials placed by service choice.~~

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 housed at MDRS and in the LTSS system. MDRS is required to keep the entire document 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	**Personal Care Attendant (PCA)**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Transition Assistance 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:

Personal Care

Alternate Service Title (if any):

Personal Care Attendant (PCA)

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 are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Personal Care Service may include:

a) support for activities of daily living such as, but not limited to, bathing (sponge/tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.

b) assistance with housekeeping that is directly related to the person's disability, and which is necessary for the health and well-being of the person such as, but not limited to, changing bed linens, straightening area used by the person, doing the personal laundry of the person, preparation of meals for the person, cleaning the person's equipment such as wheelchairs or walkers.

c) food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;

d) support for community participation by accompanying and assisting the person, as necessary, to access community resources and participate in community activities, including: appointments, shopping, and community recreation/leisure resources, and socialization opportunities. This does not include the price of the activities themselves, nor the cost of transportation.

Personal Care Services are non-medical, hands-on care of both a supportive and health related nature. Personal Care Attendants (PCAs) are instructed to report noted changes in condition and new needs to the case manager as soon as possible. The provision of Personal Care Services is recorded on the PSS, and is not purely diversional in nature.

There must be adequate justification for the relative to function as the PCA, e.g., lack of other qualified PCAs in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.

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

The Mississippi State Plan includes personal care services as a 1905(a) service available to EPSDT recipients under the age of 21, if medically necessary, and not addressed elsewhere in the State Plan. However, the state ensures that personal care services are not duplicated by this waiver for persons under the age of 21. The case manager identifies all comparable benefits for persons of all services. If a needed service is available through the Medicaid State Plan, Medicare, or private insurance, it is provided as a non-waivered service. DOM reviews 100% all PSSs at initial application, and each annual recertification. MDRS conducts quarterly reviews of all PSSs, secondary reviews of all PSS by in-house medical staff, and annual programmatic audits by Program Evaluation. DOM conducts annual compliance reviews and on-site visits to ensure appropriate billing. Additionally, service restrictions are imposed with the use of the Lock-in. A review of claims history can be conducted to determine if personal care services are being provided and covered through the State Plan.

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	Personal Care Attendant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Attendant (PCA)

Provider Category:

Individual

Provider Type:

Personal Care Attendant

MS Medicaid Enrolled IL Waiver Personal Care Attendant Providers

Provider Qualifications

License *(specify)*:

N/A

Certificate *(specify)*:

N/A

Other Standard *(specify):*

~~DOM and MDRS have implemented a personal care curriculum which is required for all non- licensed personal care attendants prior to providing services to person on the waiver. Changes to the PCA training curriculum must be approved by DOM. Documentation of completion of this course work must be maintained at the operating agency, and be made available to DOM upon request. A personal care attendant must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The training, to be conducted by the person and the case manager/registered nurse, or an agency permitted by law to train nurse aides, shall include the purpose and philosophy of self-directed services by persons with disabilities, disability awareness, employee-employer relationships and the need for respect for the person's s privacy and property. Upon hire and annually thereafter, training must also include the Vulnerable Person's Act, caregiver boundaries, and managing challenging situations. Instructions and training will cover the basic elements of body functions, infection control procedures, universal precautions, maintaining a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet. The educational program will be personalized with participation of the person to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants will not be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the person and the case manager/registered nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care attendant must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the person and case manager/registered nurse to be adequate in fulfilling the responsibilities of personal care.~~

~~There must be adequate justification for the relative to function as the PCA attendant, e.g., lack of other qualified PCAs attendants in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and they must be certified competent to perform the required tasks by the person and the case manager/registered nurse.~~

~~Minimum Requirements:~~

~~- 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 be able to follow verbal and written instructions;~~

~~- Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;~~

~~- Must be certified as meeting the training and competence requirement by the person and the Case Manager/Registered Nurse;~~

~~- Must be able to communicate effectively and carry out directions.~~

~~- 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.~~

~~- Must receive training in the areas of the Vulnerable Person's Act, caregiver boundaries, and dealing with difficult patients upon hire and annually thereafter.~~

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 Department of Rehabilitation Services verifies the competency for all personal care providers.~~

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all direct care workers.

Frequency of Verification:

~~As Needed~~

~~National criminal background checks with fingerprints must be completed prior to employment and every two (2) years thereafter, and the record must be maintained by MDRS.~~

~~Mississippi Nurse Aide Abuse Registry and Office of the Inspector General's (OIG) exclusion list checks must be completed prior to employment and monthly thereafter, and the record must be maintained by MDRS.~~

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 Accessibility Adaptations

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):*

Those physical adaptations to the home, required by the person's PSS, which are necessary to ensure the health, welfare, and safety of the person, or which enable the person to function with greater independence in the home, and without which, the person would require institutionalization. Such adaptations may include: the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the person. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the person.

Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

The services under the Independent Living Waiver 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	Environmental Accessibility Adaptations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:

Environmental Accessibility Adaptations

MS Medicaid Enrolled IL Waiver Environmental Accessibility Adaptation Providers

Provider Qualifications

License *(specify):*

~~N/A~~

N/A

Certificate *(specify):*

N/A

~~N/A~~

Other Standard *(specify):*

~~General Service Standards:~~
~~1. All providers must meet any state or local requirements for licensure or certification, where applicable (such as building contractors, plumbers, electricians or engineers).~~
~~2. All modifications, improvements, or repairs must be made in accordance with local and state housing and building codes.~~
~~3. Quality of work~~
~~a. All work should be done in a fashion that exhibits good craftsmanship.~~
~~b. All materials, equipment, and supplies should be installed clean, and in accordance with manufacturer's instructions.~~
~~c. Contractor is responsible for all permits that are required by local government bodies.~~
~~d. All non-salvaged supplies and/or materials should be new and of best quality, without defects.~~
~~e. At completion of the project, contractor will be responsible for removal of all excess materials and trash, leaving the site clear of debris.~~
~~f. All work should be accomplished in compliance with applicable codes, ordinances, regulations and laws.~~
~~g. The specifications and drawings shall not be modified without a written change order from the case manager.~~
~~h.~~a. ~~No barriers shall be created by the modification and/or construction process.~~

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

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

Entity Responsible for Verification:

~~Mississippi Department of Rehabilitation Services~~

Frequency of Verification:

~~As Needed~~

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:

~~Specialized Medical Equipment and Supplies~~

Specialized Medical Equipment and Supplies

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):*

Specialized medical equipment and supplies include devices, controls, or appliances which enable the person to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or provide a direct medical or remedial benefit to the person. These items must be specified on the PSS.

Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payers (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.

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

Each request for specialized medical equipment is evaluated by the case manager or DOM staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation. The case manager will update the person and monitor the progress of each specialized medical equipment request on a monthly basis. If the case manager determines there is a need to make adjustments to the request, he/she will notify the appropriate personnel (i.e. Assistive Technology) as soon as possible. The case manager will discuss and document the person's choice of vendor on the PSS prior to authorizing for services.

If it is determined through the person-centered planning process that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

The services under the Independent Living Waiver 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	~~Specialty Medical~~

MS Medicaid Enrolled IL Waiver Specialized Medical Equipment and Supply Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Specialty Medical

MS Medicaid Enrolled IL Waiver Specialized Medical Equipment and Supply Providers

Provider Qualifications

License *(specify):*

~~N/A~~

Certificate *(specify):*

~~N/A~~

Other Standard *(specify):*

~~Providers of specialized medical equipment and supplies under this home and community based services waiver shall meet the following minimum qualifications:~~

~~A) General Business Standards:~~
~~- A permanent local address and phone number,~~
~~- State of MS sales tax number,~~
~~- Federal I.D. number or social security number,~~
~~- Liability insurance~~

~~B) General Service Standards:~~
~~- Manufacturer's guarantee or warranty must be honored as published,~~
~~- Provide repair capability for products~~

~~Providers should meet the following additional standards for custom in-house seating systems, powered mobility, three wheel scooters, and high-tech systems:~~
~~- Must provide documented proof of attendance of training with seating & positioning,~~
~~- Maintain a current list of power chair manufacturers represented,~~
~~- Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer,~~
~~- Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above,~~
~~- Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting,~~
~~- Must have and present at purchase all necessary manuals and written warranties,~~
~~- Must be able to provide instruction in proper use and care of equipment,~~
~~- Must be capable to provide training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price, and~~
~~- Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.~~

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 Department of Rehabilitation Services~~

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

Frequency of Verification:

~~Upon hire and as needed~~

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:

Transition Assistance 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):*

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

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

Transition assistance services are capped at $800.00 one-time initial expense per lifetime.

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

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

Need for this service: All items and services covered must be essential to:
1) Ensure that the person is able to transition from the current nursing facility; and
2) Remove an identified barrier or risk to the success of the transition to a more independent living situation.

To be eligible, the individual must:
1) Be a current nursing facility (NF) resident whose NF services are being paid by Medicaid;
2) Not have another source to fund or attain the items or support;
3) Be transitioning from a living arrangement where these items were provided; and
4) Be transitioning to a residence where these items are not normally furnished.

The transition service must occur within 90 days of the discharge, but must also be completed by the day the person relocates from the institution. Persons whose nursing facility 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
Agency	~~Case Management~~

MS Medicaid Enrolled IL Waiver Transition Assistance Service Providers

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:

Agency

Provider Type:

~~Case Management~~

MS Medicaid Enrolled IL Waiver Transition Assistance Service Providers

Provider Qualifications

License *(specify):*

The Registered Nurse must have a current, active, and unencumbered registered nurse license to practice in the state of Mississippi, or be working in Mississippi on a privilege with a valid compact RN license, and at least one year of experience with the aged and/or individuals with disabilities. The nurse must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The RN's name must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's (OIG) exclusion list.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The Case Manager must possess, at minimum, a Bachelor's degree in Rehabilitation Counseling or other related field, and one year of experience working with individuals with disabilities. The Case Manager must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The Case Manager's name must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) 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 Department of Rehabilitation Services

Mississippi Division of Medicaid is responsible for the credentialing of all providers. The Mississippi Department of Rehabilitation Services verifies the competency for all vendors.

Frequency of Verification:

At least annually

National criminal background checks with fingerprints must be completed prior to employment and every two (2) years thereafter, and the record must be maintained by MDRS.

Mississippi Nurse Aide Abuse Registry and Office of the Inspector General's (OIG) exclusion list checks must be completed prior to employment and monthly thereafter, and the record must be maintained by MDRS.

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:

Case Management is provided as an administrative activity by the operating agency, the Mississippi Department of Rehabilitation Services

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 employees prior to employment and every two (2) years thereafter, and the record must be maintained by MDRS.~~

~~Providers must not have been, or employ individuals who have been, convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f) , 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.~~

~~Pursuant to Section 37-33-157 of the Mississippi Code of 1972, annotated, as amended, MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants. MDRS is authorized to use the results of the investigations for the purpose of employment decisions and/or actions, and service provision to consumers of the department's services.~~

~~This background check allows the agency to check things such as credit history, criminal records, work history, and driving record.~~
~~Documentation of provider staff qualifications are reviewed annually by DOM's Office of Financial and Performance Review.~~

A national criminal background check with fingerprints must be conducted on all individuals providing case management, personal care attendant services, or 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):

~~MDRS must conduct registry checks, prior to employment and monthly thereafter, to ensure employees are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record.~~

~~DOM Office of Provider Enrollment performs mandatory screenings on owners 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 Independent Living 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, or 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:

~~There must be adequate justification for the relative to function as the PCA, e.g., lack of other qualified PCAs in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.~~

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: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:
~~**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

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

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) have MDRS remove individual immediately; and (b) require MDRS to review hiring practices and modify if necessary in thirty days.~~
~~For PM 2, DOM will require MDRS to immediately remove the non-licensed/non-certified provider from providing care to the person until the non-licensed/non-certified provider qualification standards are met.~~
~~For PM 3, DOM will (a) require MDRS to remove the provider from providing care to the person immediately; (b) ask MDRS to apply applicable measures to ensure the provider is trained prior to resuming care; and (c) require MDRS to apply applicable disciplinary action if warranted in accordance with their policies and procedures.~~

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 with the operating agency within thirty (30) days to examine if any changes need to be implemented systematically. 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 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**
☒ **X 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 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.

~~The average cost for a person receiving IL waiver services must not be above the average estimated cost for nursing home level of care approved by The Centers of Medicaid and Medicare Services for the current waiver year. DOM and MDRS must assure the waiver remains cost neutral. If the total projected annual cost of all services requested exceeds the most recent annual nursing home bed cost, then the request is denied and returned for reconsideration. Cost neutrality provisions are explained to the person. At that point, some negotiation may occur regarding the amount of services requested under this waiver, whether or not another waiver may have a package of services which can more efficiently meet the needs of the person, or whether nursing home is the most appropriate setting based on the amount and complexity of services required. If the annual cost to serve a person in this waiver exceeds the annual nursing home costs, the cost neutrality requirement is jeopardized.~~

~~There is reference in Appendix B of this waiver renewal application as to provisions for a participant's safeguards. Following these safeguard procedures, it is possible for an individual to exceed the cost neutrality limit, but the possibility of such occurrences is mitigated by active case management. These requests are considered on an individual basis considering each on its own merits. Related decisions are appealable and covered as addressed in Appendix F of this waiver renewal application.~~

~~If a waiver applicant is denied services, the person is given a Notice of action, and the opportunity for a Fair Hearing.~~

The average cost for a person receiving IL waiver services must not be above the average estimated cost for nursing home level of care approved by The Centers of Medicaid and Medicare Services for the current waiver year. DOM and MDRS must assure the waiver remains cost neutral. If the total projected annual cost of all services requested exceeds the most recent annual nursing home bed cost, then the request is denied and returned for reconsideration. Cost neutrality provisions are explained to the person. At that point, some negotiation may occur regarding the amount of services requested under this waiver, whether or not another waiver may have a package of services which can more efficiently meet the needs of the person, or whether nursing home is the most appropriate setting based on the amount and complexity of services required. If the annual cost to serve a person in this waiver exceeds the annual nursing home costs, the cost neutrality requirement is jeopardized. There is reference in Appendix B of this waiver renewal application as to provisions for a participant's safeguards. Following these safeguard procedures, it is possible for an individual to exceed the cost neutrality limit, but the possibility of such occurrences is mitigated by active case management. These requests are considered on an individual basis considering each on its own merits. Related decisions are appealable and covered as addressed in Appendix F of this waiver renewal application. If a waiver applicant is denied services, the person is given a Notice of action, and the opportunity for a Fair Hearing.

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.

Based upon the DOMs assessment of the HCBS settings in the IL waiver, the DOM confirms that services in this waiver are rendered in a HCB setting. Waiver participants reside in private home located in the community. The IL waiver does not provide services to persons in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

~~Part 208, Chapter 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.1: General~~

~~A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.~~

~~The following verbiage is being added to Rule 2.1.A. to comply with 42 CFR § 441.301(c)(4)(i)-(iv) Final Rule with the Admin. Code filing effective January 1, 2017:~~

~~1. Waiver persons must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.~~

~~2. The Division of Medicaid does not cover IL waiver services to persons in congregate living facilities, institutional settings, 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 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.3: Covered Services~~

~~The Division of Medicaid covers the following Independent Living Waiver services:~~

~~A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities:~~

~~1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs, preferences, and goals.~~
~~2. Must assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.~~
~~3. Are responsible for ongoing monitoring of the provision of services included in the participant's plan of care.~~
~~4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.~~

~~C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.~~

~~D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.~~

~~E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the Independent Living Waiver program.~~

~~F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.~~

~~Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule.~~

~~Part 208, Chapter 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.5: Freedom of Choice~~

~~A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.~~

~~B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.~~

~~C. Beneficiaries must be:~~
~~1. Informed of any feasible alternatives under the waiver, and~~
~~2. Given the choice of either institutional or home and community based services.~~

~~Current language is in compliance with and supports the Final Rule but silent on the following verbiage which is being added to Rule 2.5.C.3 with the Admin. Code filing effective January 1, 2017 to comply with 42 CFR § 441.301(c)(4)(ii):~~

~~3. Provided a choice among providers or settings in which to receive HCBS including non disability specific setting options.~~

~~Part 208, Chapter 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.7: Participant Direction of Services~~

~~A. Participants are encouraged to make choices in regards to participant needs, goals, preferences and desires with all aspects of the services provided.~~

~~Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(v) of the Final Rule.~~

~~Part 208, Chapter 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.8: Monitoring Safeguards~~

~~A. MDRS case managers are required to provide each waiver participant with written information regarding their rights as a waiver participant at the initial assessment.~~

~~Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i) (iv) of the Final Rule.~~

~~Part 208, Chapter 2: HCBS Independent Living (IL) Waiver~~
~~Rule 2.9: Additional Dispute Resolution Process~~

~~A. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.~~

~~B. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services.~~

~~C. MDRS must inform the participant at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes.~~

~~D. MDRS must inform the participant of their rights which address disputes, complaints/ grievances and hearings.~~

~~Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) of the 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 (PSS)

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:

~~The Case Manager must possess, at minimum, a Bachelor's degree in Rehabilitation Counseling or other related field, and one year of experience working with individuals with disabilities. The Case Manager must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The Case Manager's name must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.~~

☐ **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 plan of services and supports, known as 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 IL 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 participants' 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 Mississippi Department of Rehabilitation Services (MDRS) case manager engages the person and other interested parties as requested by the person in developing a PSS that meets their needs.~~

~~MDRS Case Managers are required, at minimum, to make phone contact monthly and to conduct a face-to-face visit with the person every three months or more frequently, based on the their needs, level of involvement the person wishes the case manager to have, and in the event of alleged abuse, neglect or exploitation of the person.~~

~~Case management is provided by MDRS case managers as an administrative activity as structured through an interagency agreement between DOM and MDRS.~~

~~MDRS case managers initiate and complete the process of assessment and reassessment of the person, and are responsible for ongoing monitoring of services and supports the person is receiving in their home and community.~~

~~The person chooses their personal care attendants, environmental accessibility adaptations, specialized medical supplies and equipment providers. If requested, the person is also offered the choice of an alternate MDRS case manager. Case Management services are provided by qualified staff employed by MDRS. Personal care services are provided by individuals chosen by the participants as potential PCAs who are then certified by the Case Managers at MDRS prior to the provision of services. At no time are personal care services provided by Case Managers.~~

~~Oversight of waiver processes and periodic evaluations are completed by DOM Office of Long Term Care and Office of Financial and Performance Review.~~

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. Case management is provided by MDRS case managers as an administrative activity as structured through an interagency agreement between DOM and MDRS. MDRS case managers initiate and complete the process of assessment and reassessment of the person and are responsible for ongoing monitoring of services and supports the person is receiving in their home and community. The person chooses their personal care attendants, environmental accessibility adaptations, specialized medical supplies and equipment

providers. If requested, the person is also offered the choice of an alternate MDRS case manager. Case Management services are provided by qualified staff employed by MDRS. Personal care services are provided by individuals chosen by the participants as potential PCAs who are then certified by the Case Managers at MDRS prior to the provision of services. At no time are personal care services provided by Case Managers. Oversight of waiver processes and periodic evaluations are completed by DOM Office of Long Term Care and Office of Financial and 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 IL Waiver, has made an Informed Choice, and meets clinical eligibility criteria, as determined by the LTSS assessment process, the development of the PSS is initiated. The MDRS case manager engages the person, caregivers and other interested parties, as requested by the person, in the development of their the 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.~~

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the

services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

~~Persons found clinically eligible for long-term care are provided information about available services and supports. The participant 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.~~

~~MDRS is responsible for implementing the PSS. DOM and MDRS are jointly responsible for monitoring the PSS. MDRS is responsible for coordination of waiver services, State Plan services, services provided through other funding sources and service agencies.~~

~~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, without the RN component, if appropriate. The PSS is signed by all of the individuals who participated in its development. Each applicant/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 to the Mississippi Department of Rehabilitation Services office in their district, and a contact name of the MDRS case manager and their supervisor, if 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 individual's circumstances and needs are identified.~~

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 operating agency is responsible for implementing the PSS. They, along with DOM, are jointly responsible for monitoring the PSS. The operating 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 are 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 MDRS and DOM. Monthly and quarterly actions are required to review/assess the person's service needs, with a new PSS developed every twelve months. The case management team must also determine whether a condition or situation is present that requires specific intervention to prevent a decline in health and safety.~~

~~Back up plans are developed by the MDRS case manager in partnership with the individual and their family/caregiver upon admission. The PSS may 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. The case manager will assist the person with locating potential PCA candidates for them to interview. During a community disaster or emergency, the MDRS case manager notifies MDRS State Office, 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 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.

~~Each person is provided information about providers in accordance with their identified needs, desires and goals noted on the PSS. The MDRS case manager informs the person of trained, competent and willing providers so the person may request their provider of choice.~~

~~Case management is provided as administrative activity through an interagency agreement between DOM and MDRS. The person is given a choice of personal care attendants, SMS/DME companies, and contractors for adaptations/modifications. If requested, individuals are also offered the choice of an alternate case manager based on geographical availability.~~

~~The person selects their personal care attendant. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements to become a personal care attendant, as set forth in the IL Waiver, that individual is allowed to provide the direct care for that person.~~

~~If a person does not have a specific personal care attendant, the Case manager will assist the person with locating potential PCA candidates for them to interview.~~

~~There must be adequate justification for the relative to function as the PCA, e.g., lack of other qualified PCAs in remote areas. PCA services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.~~

During the person-centered planning process, the person and/or their representative is given a choice of personal care attendants, SMS/DME companies, and contractors for adaptations/modifications. If requested, individuals are also offered the choice of an alternate case manager based on geographical availability. The person selects their personal care attendant. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements to become a personal care attendant, as set forth in the IL Waiver, that individual is allowed to provide the direct care for that person. If a person does not have a specific personal care attendant, the Case manager will assist the person with locating potential PCA candidates for them to interview. 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 (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the

service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- [x] **Medicaid agency**
- [x] **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.

~~MDRS is responsible for the implementation of the PSS which includes coordination of waiver services, State Plan services, and services provided through other funding sources and service agencies. DOM and MDRS are jointly responsible for monitoring the PSS, and the health and welfare of each person on the waiver. DOM, as the administrative agency of the waiver, has the responsibility of overseeing that MDRS has appropriate processes in place to implement each person's PSS.~~

~~MDRS monitors the PSS through monthly contacts and quarterly face-to-face reviews. These contacts and reviews enable the MDRS case manager to determine the utilization and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's needs preferences and goals.~~

~~The MDRS case manager documents personal contact with the person on a monthly basis to receive feedback and assess the sufficiency and effectiveness of the PSS. Additionally, the MDRS case manager ensures that services remain in place without issue and identifies any problems or changes that are required. If changes in the person's circumstances and needs are identified, the PSS may be updated to meet the person's needs and goals.~~

~~DOM monitors the implementation of the PSS through annual on-site audits, record reviews, phone calls to persons on the waiver, and face-to-face interviews with individuals and their caregivers. DOM reviews records for required documentation and confirms services are delivered during face-to-face interviews within the representative sample.~~

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 operating 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:*

~~As part of DOM's on-going quality assurance monitoring, DOM reviews the PSS and individual LTSS assessment to ensure that all services are provided in accordance with the approved PSS including: the emergency preparedness plan, that the person is directing the PSS process, and that activities provided meet service definitions of the approved waiver. DOM verifies that the MDRS case manager makes contact with the person at least monthly by phone through record review. DOM also monitors the delivery of the PSS by reviewing the person's clinical record during on-site provider compliance reviews conducted at least annually, and during technical assistance provider site visits. Face-to-face interviews allow DOM to monitor that the individual is provided with information regarding the Mississippi Vulnerable Persons Act and waiver participant rights.~~

The operating 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 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**	☒ **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**	☒ **X Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **X 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 2: Number and percent of persons' PSSs where the individual's signature indicates involvement in the PSS development. N: Number of persons' PSSs reviewed with signature indicating involvement in PSS development. D: Total number of PSS reviewed.

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

LTSS

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 3: Number and percent of persons 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):
~~Operating agency performance monitoring~~ 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** ☐ **Operating Agency** ☐ **Sub-State Entity** ☐ **Other** Specify:	☐ **Weekly** ☐ **Monthly** ☒ **Quarterly** ☐ **X Annually** ☐ **Continuously and Ongoing**	☐ **100% Review** ☒ ☒ **X Less than 100% Review** **Representative Sample** Confidence Interval = 95% ☐ **Stratified** Describe Group: ☐ **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**	☒ **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**	☒ **X Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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 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):
~~**Operating agency performance monitoring**~~ **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% with a +/- 5% margin of error
☐ **Other** Specify:	☒ **X Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	~~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**	☒ **X Monthly**	☒ **X 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**
☐ **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 manager of deficiency via unable to process notice/clarification request; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve plan of care within seven business days of receipt of notification of case manager's correction/ clarification.~~
~~For PM 2, DOM (a) immediately notify case manager of deficiency via unable to process notice/clarification request; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve PSS within seven business days of receipt of notification of case manager's correction/clarification.~~
~~For PM 3, DOM will (a) require MDRS to complete quarterly update; (b) require MDRS to submit a corrective action plan within thirty days; (c) require MDRS to refund payment within thirty days; and (d) provide case manager training annually.~~
~~For PM 4, DOM will (a) immediately notify case manager of deficiency via unable to process notice/clarification request; (b) require MDRS case manager to respond to deficiency and include reason for the lapse of the PSS within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve PSS within seven business days of receipt of notification of case manager's correction/clarification.~~
~~For PM 5, DOM will (a) notify MDRS of identified PSS where services were provided outside of the type, scope, amount, duration, and frequency (b) require MDRS 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 MDRS to submit a revised PSS within seven business days; (d) require MDRS to submit a corrective action plan and/or an adjust/void within thirty days, if warranted; and (e) provide case manager training annually, if deemed necessary.~~
~~For PM 6, DOM will (a) require the case manager to document freedom of choice and presentation of option within seven business days; and (b) require MDRS to provide additional case manager training immediately; (c) provide case manager training annually.~~
~~For PM 7, DOM will (a) immediately notify case manager of deficiency via unable to process notice/clarification request; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; (d) approve PSS within seven business days of receipt of notification of case manager's correction/clarification.~~

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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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**~~
☒ **X Operating Agency**	☒ **X 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 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)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

~~This waiver engages the person to make choices in regards to their needs, preferences and desires with all aspects of the services provided. Once a person has been determined eligible for waiver services they are allowed to self-direct their personal care services. The person recruits, hires and may terminate employment of the PCAs with assistance from their case manager. The person does not exercise budgetary authority (including salary negotiations, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance). Those functions are completed as an administrative activity. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case management team.~~

~~The person also continually evaluates their medical equipment/supply needs, and informs their case manager if their needs change. The person and their case manager work together to meet these needs as quickly, safely and efficiently as possible. Medical equipment and environmental accessibility adaptation needs are evaluated by MDRS' Assistive Technology Division.~~

~~Each person is involved in the formation of their PSS, including input into the number of hours of PCA services they need per day/week.~~

This waiver engages the person to make choices in regards to their needs, preferences and desires with all aspects of the services provided. Once a person has been determined eligible for waiver services they are allowed to self-direct their personal care services. The person recruits, hires and may terminate employment of

the PCAs with assistance from their case manager. The person does not exercise budgetary authority (including salary negotiations, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance). Those functions are completed as an administrative activity by the operating agency. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case manager(s). The person also continually evaluates their medical equipment/supply needs and informs their case manager(s) if their needs change. The person and their case manager(s) work together to meet these needs as quickly, safely and efficiently as possible. Medical equipment and environmental accessibility adaptation needs are evaluated by MDRS' Assistive Technology Division. Each person is involved in the formation of their PSS, including input into the number of hours of PCA services they need per day/week.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

The individual may live with several other persons in a private residence/apartment.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ◉ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

~~Applicants and other interested parties expressing an interest in the IL waiver are provided information on participant-directed personal care services. MDRS and DOM waiver staff are trained to provide this information upon referral, at initial application intake, and ongoing while the participant is enrolled in the waiver. Information is provided to each applicant to assure informed decision making is based on an understanding of the participant directed service delivery method. The case manager also outlines the roles and responsibilities for the person or the legal representative, the case manager, and the providers. It is explained to the person that PCA services will not begin prior to the PCA being certified as competent according to the IL waiver.~~

~~The IL waiver affords each person the opportunity to select the PCA of their choice. The benefit of participant-direction allows the person to choose a PCA that is proven competent. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements as set forth in the IL Waiver, that individual is allowed to provide the direct care for the person on the waiver. The Case manager will assist the person with locating potential PCA candidates for them to interview.~~

~~In the event that the case manager determines that the PCA poses potential safety concerns or threats of harm to the person or other service providers, or poses a threat for potentially fraudulent activities, the case manager may immediately terminate the PCA. The person may then choose a replacement PCA, provided they meet all of the minimum requirements, and are certified to be competent.~~

~~All reports of abuse, neglect, exploitation or fraud are to be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS.~~

~~If the person has not located or chosen a PCA within six months after admission to the waiver, or after being without a PCA for six consecutive months, the person will be reevaluated for the need for waiver services and to determine if the IL waiver can best meet their needs.~~

~~Each person also chooses State approved vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services.~~

Applicants and other interested parties expressing an interest in this waiver are provided information on participant-directed personal care services. MDRS and DOM waiver staff are trained to provide this information upon referral, at initial application intake, and ongoing while the participant is enrolled in the waiver. Information is provided to each applicant to assure informed decision making is based on an understanding of the participant directed service delivery method. The case manager also outlines the roles and responsibilities for the person or the legal representative, the case manager, and the providers. It is explained to the person that PCA services will not begin prior to the PCA being certified as competent in accordance with the Part 208 of the Medicaid Administrative Code. This waiver affords each person the opportunity to select the PCA of their choice. The benefit of participant-direction allows the person to choose a PCA that is proven competent. If a person knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements as set forth in the approved wavier application and the Administrative Code, that individual is allowed to provide direct care for the person on the waiver. The case manager will assist the person with locating potential PCA candidates for them to interview. In the event that the case manager determines that the PCA poses potential safety concerns or threats of harm to the person or other service providers, or poses a threat for potentially fraudulent activities, the case manager may immediately terminate the PCA. The person may then choose a replacement PCA, provided they meet minimum requirements, and are certified by the case manager to be competent. All reports of abuse, neglect, exploitation or fraud are to be reported in accordance with the process outlined in Appendix G of this waiver. If the person been without a PCA for six consecutive months, the person will be reevaluated and the operating agency in consultation with DOM will determine alternatives available to better meet the participant's needs. Those alternatives will be presented to the participant and, if

appropriate, the case manager will assist the participant with referral/transition to the selected alternative. Each person also chooses State approved vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care Attendant (PCA)	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental**
☐ **entities Private**
◉ **entities**

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

~~Once a waiver applicant has been determined eligible for IL waiver services, the case manager provides information to each applicant on the participant directed service delivery method.~~

~~The person recruits, hires, and may terminate employment of their PCAs with assistance from the case manager. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case manager.~~

~~The case manager confers with the person to determine who they would desire to provide their personal care services. After the person has determined who they would desire, the case manager goes through the specified steps to determine if the requested PCA meets the minimum requirements. Once it has been determined that the person meets the minimal requirements, completes training, and is certified, the PCA begins working for the person. Ongoing evaluation of the care provided and the satisfaction of the person is done and alterations, if needed, are made to the PSS.~~

Once a waiver applicant has been determined eligible for waiver services, the case manager provides information to each applicant on the participant directed service delivery method. The person recruits, hires, and may terminate employment of their PCAs with assistance from the case manager. All PCA providers must meet provider standards and be certified competent to perform the required tasks by the person and the case manager. The case manager confers with the person to determine who they would desire to provide their personal care services. After the person has determined who they would desire, the case manager goes through the specified steps to determine if the requested PCA meets the minimum requirements. Once it has been determined that the person meets the minimal requirements, completes training, and is certified, the PCA begins working for the person. Ongoing evaluation of the care provided and the satisfaction of the person is done and alterations, if needed, are made to the PSS.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care Attendant (PCA)	☐
Transition Assistance Services	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

MDRS provides case management as an administrative activity. As component of this case management, MDRS staff provide information and assistance in support of participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- ◉ **No. Arrangements have not been made for independent advocacy.**
- ○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

~~If a person decides that the IL Waiver is not the waiver that they can benefit the most from at a certain time, they may choose to transfer to another Home and Community based waiver that they qualify. There is coordination with program areas in DOM, MDRS and other waiver providers to which the person will be transitioning.~~

If a person decides to terminate participant direction at any time, they may choose to transfer to an alternate home and community-based waiver for which they qualify. There is coordination amongst DOM, MDRS and other waiver providers to which the person will be transitioning.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

~~Immediate termination of the Participant-Directed personal care service option can occur if the following circumstances arise including, but not limited to:~~

~~*The participant's and/or service provider's health, safety, or welfare is immediately jeopardized or it is recognized that there is potential for threat of harm.~~
~~*Fraudulent Activity~~
~~*Non-compliance related to the PSS~~

~~When it is decided that a person can no longer direct their personal care services, there is coordination by the case manager to provide continuity of services and ensure the person's health and welfare while coordinating transition to an alternate service/setting options.~~

Immediate termination of the Participant-Directed personal care service option can occur if the following circumstances arise including, but not limited to: - The participant's and/or service provider's health, safety, or welfare is immediately jeopardized or there is potential for threat of harm. - Fraudulent activity by the participant/their representative or the provider is detected. - There is non-compliance related to implementing the approved PSS. When it is decided that a person can no longer direct their personal care services, there is coordination by the case manager to provide continuity of services and ensure the person's health and welfare while transitioning the participant to an alternate service/setting options.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	Number of Participants			Number of Participants		
Year 1		5800				
Year 2		5800				

Year 3		5800				
Year 4		5800				
Year 5		5800				

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in*

Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The operating Agency, MDRS, completes the necessary payroll and human resource functions, as an administrative activity, to support the person as the co-employer of their PCAs.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☐ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**
☐ **Determine the amount paid for services within the state's established limits**
☐ **Substitute service providers**
☐ **Schedule the provision of services**
☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐ **Identify service providers and refer for provider enrollment**
☐ **Authorize payment for waiver goods and services**
☐ **Review and approve provider invoices for services rendered**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

State Fair Hearing procedures are based on the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100 Chapters 4-5, and Part 300, Chapter 1. The Hearing Process

A Case Manager sends a Notice of Action (NOA) to the person by certified mail (Signature return requested).

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

The person or their representative may request to present an appeal through a local-level hearing, a state-level State Fair Hearing, or both. In an attempt to resolve issues at the lowest level possible, individuals should be encouraged to request a local hearing first. The request for a State Fair Hearing or local hearing must be made in writing by the person or his legal representative.

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

The person has 30 days from the date the appropriate notice is received to request either a local or State Fair 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 MDRS or the State DOM office. If the written request is not received within the 30 days of the NOA, services will be discontinued. If the request is not received in writing within 30 days, a State Fair Hearing will not be scheduled unless good cause exists as specified in the Mississippi Medicaid Administrative Code.

At the local hearing level, MDRS holds a local hearing and issues a determination within 30 days of the date of the initial request for a hearing. The local hearing will be held at the person's home or at the local MDRS office of the case manager, unless the determination for a telephone hearing is made. A telephone hearing will be conducted if there is potential for safety concerns or threats of harm of the person or service providers. 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 Fair hearing; however, the State Fair Hearing request must be made within fifteen (15) days of receiving the local hearing decision. Upon receipt of the request for a State Fair hearing, the Division of Medicaid, Office of Appeals will assign a hearing officer.

At the State Fair Hearing level, DOM will issue a determination within ninety (90) days of the date of the initial request for a hearing. Although regulations allow ninety (90) days, the agency will make every effort to hold hearings promptly, and render decisions in a shorter timeframe. The Division of Medicaid has the final authority over the State Fair Hearing decision, and will inform the person and MDRS in writing of the final decision. Once the Division of Medicaid has issued their authoritative decision, the decision is final, and the person cannot appeal the same matter to MDRS or the Division of Medicaid.

The person or their representative has the following rights in connection with a local or State Fair Hearing:

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

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 determination is made that there are safety concerns, threats

~~of harm to the participant or service providers, or suspected illegal or fraudulent activities by the participant. In those instances, services will be terminated immediately.~~

~~Notices are maintained in person's file at the Case Management Agency.~~

With DOM approval, a person may be terminated from waiver services for any of the following reasons: (1) The person or his/her legal representative request termination; (2) The person no longer meets program eligibility requirements; (3) The person refuses to accept services; (4) The person is not available for services after thirty days; (5) The person is in an environment that is hazardous to self or service providers; (6) The person and/or individuals in the person's home become abusive and belligerent including, but not limited to, sexual harassment, racial discrimination, threats. State Fair Hearing procedures are based on the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Applicant is informed of Fair Hearing process during entrance to waiver by the Case Manager. A case manager sends a Notice of Action (NOA) to the person by certified mail (signature return requested) on any adverse action related to choice of provider or service; or denial, reduction, suspension or termination of service. Fair Hearing Notices are maintained in person's file at the operating agency. Contents of Notice of Action include: a. Description of the action the operating agency 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 (AL Waiver should note waiver case manager or DOM state office, IL and TBI/SCI Waivers should note MDRS 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 operating 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. Case management staff will notify person if services will remain in place during the appeal process. Upon receipt of the request for a state hearing, the DOM Office of Appeals will assign a hearing officer.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The state operates an additional dispute resolution process**

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

~~The types of disputes that can be addressed by an informal dispute resolution process are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Persons are encouraged to report disputes to their case manager. However, dispute resolution can start at any level in the process.~~

~~If a resolution is not reached between the participant and Case Manager within seventy-two (72) hours of the initial report by the participant, the Case Manager is required to report the dispute to their supervisor. The supervisor must reach a resolution with the client within seven (7) days. If a resolution is not reached within this time frame, the dispute must be reported to DOM. In these events, DOM along with MDRS collaborate to achieve a resolution within seven (7) days. Participants are advised that 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.~~

~~In the event the dispute is with the case manager, MDRS will analyze each case on an individual basis to determine the appropriate plan of action. If a new case manager is assigned, the case manager's supervisor evaluates the person's satisfaction with the new case manager and notifies DOM of the final resolution. DOM and MDRS are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The person is given their bill of rights which addresses disputes, complaints/grievances and State Fair Hearings.~~

~~The right to a State Fair Hearing is preserved by allowing the person to request a formal hearing at any time during the informal dispute resolution process unless a formal Notice of Action has been presented to the person. Once the notice of action is given to a person, the person must follow DOMs State Fair Hearing policy.~~

The informal dispute resolution process is initiated with the case manager(s) at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. A person may address disputes to DOM at any time. The types of disputes that can be addressed are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Persons are encouraged to report disputes to their case manager(s). However, dispute resolution can start at any level in the process. If a resolution is not reached by the person and the case manager within seventy-two (72) hours of the initial report by the person, the case manager(s) reports the issue to the case management supervisor. The supervisor must reach a resolution with the person within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the operating agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case manager(s) then the operating agency and DOM work with the person to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the person's satisfaction with the new case management staff within the following month and notifies DOM of the final resolution. DOM and the operating agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The person is informed by the operating 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:

The Division of Medicaid (DOM) and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

DOM and the operating 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. The person must first address any complaint/grievance by reporting it to their case manager. The case manager begins to address the complaint/grievance with the person within 24 hours. If a resolution is not reached within 72 hours the case manager reports the complaint/grievance to the 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 MDRS will collaborate to achieve a resolution within seven days. In the event the complaint and/or grievance is with the case manager, then MDRS and DOM work with the person. The person is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievance and hearing. Participants are advised that filing a grievance or making a complaint is not a pre-requisite to, or substitute for, a Fair Hearing. All participants are notified of their rights in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code.~~

~~Local Hearing - Must be requested in writing by the person or their representative.~~

~~State Fair Hearing - Must be requested in writing to DOM.~~

~~The person and/or representative has thirty (30) days from the date of Notice of Action to request either a State Fair Hearing, or a local hearing.~~

The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints/grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Persons should first address any complaints/grievance by reporting it to their case manager(s), but may address any complaint/grievance to DOM at any time. The case manager(s) begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case manager(s) reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the operating agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case manager then the operating agency and DOM work with the participant to assign a new case manager. Once a new case manager is assigned the case management supervisor evaluates the participant's satisfaction with the new case management staff within the following month and 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 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 between the two agencies to ensure the health and welfare of waiver participants.~~

~~If the person is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. All allegations of abuse, neglect or exploitation are to be reported by phone and written report immediately by the appropriate case manager to their supervisor at the Department of Rehabilitation Services. The potential A, N, or E is also reported to the Department of Human Services and Division of Medicaid/Long Term Care. DOM and MDRS case managers will 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.~~

~~All allegations of abuse, neglect or exploitation are to be reported by phone and written report immediately by the appropriate Case Manager to their supervisor at the Department of Rehabilitation Services. The potential A, N, or E is then reported to the Department of Human Services and Division of Medicaid/Long Term Care within twenty-four (24) hours by the operating agency.~~

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 in accordance with Mississippi Code § 43-47-9. All reports of A, N and E must be reported immediately by the appropriate case manager to their supervisor and the Department of Human Services. The potential incidents are also to be reported in writing to the DOM as it occurs. If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager calls 911 to request immediate assistance. There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver participants. DOM and the operating agency follow up with DHS to ensure that reports are investigated, and action is taken. In cases of Vulnerable Adult Abuser, reports may also be submitted to the Mississippi Attorney General's Office. 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.

~~When a person is initially assessed for the Independent Living (IL) Waiver, they are provided the case manager's name and the phone number. They are educated on the definitions of A, N and E and how/when to report such allegations. The person is also provided the telephone number to the DHS 24 hour hotline.~~

~~Case managers are trained on identifying and reporting any allegations of A, N or E. Monthly phone contact with each person and quarterly home visits are conducted by the case manager to ensure the health and welfare of the person.~~

~~DOM must always be notified of any suspected A, N, or E cases.~~

Training is provided to participants upon initial enrollment, recertification, and during home visits/telephone interviews performed by DOM QA staff. Upon initial entry into the waiver, case manager(s) will provide the person and/or their caregiver education and information concerning the State's protection of the person against abuse, neglect and exploitation including how persons may notify appropriate authorities when the person may have experienced abuse, neglect or exploitation. At that time, they are provided the names and phone numbers of their case manager(s). The person is contacted by the case manager(s) on a monthly basis (by phone or face-to face visit). If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the case manager of their concern by phone, a 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 is notified of any suspected abuse, neglect, exploitation cases as they occur, and is available to provider support in ensuring a prompt resolution, if feasible.

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

~~The 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 the participant and other parties as designated by state law. Time frames for notification of results vary based on investigation.~~

~~Each case will be analyzed on an individual basis to determine the appropriate plan of action. By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM work with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302.~~

~~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 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."~~

~~Communication continues between MDRS, Division of Medicaid, Department of Human Services, and Attorney General's office if necessary, etc. until resolution occurs. Additionally, DHS provides information on critical incidents involving alleged A, N and E of waiver participants on a monthly basis. 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.~~

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 the participant and other parties as designated by State law. Time frames for notification of results vary based on investigation. Each case will be analyzed on an individual basis to determine the appropriate plan of action. By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM works with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302. 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 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." Communication continues between the operating agency, Division of Medicaid, Department of Human Services, and Attorney General's office, if necessary, until resolution occurs. Additionally, DHS provides information on critical incidences involving alleged A, N and E of waiver participants. 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.

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.

~~Division of Medicaid, along with the Department of Human Services (DHS), Division of Aging and Adult Services, is the lead agency responsible for investigation, is also responsible for the notification of investigation results to the participant and other parties as designated by state law. The frequency of oversight is continuous and ongoing.~~

~~An Emergency Preparedness Plan (EPP) and a Plan of Services and Supports (PSS) are completed on each participant based on an assessment of their identified risks (including critical incidents). That information is tracked and compiled in Omnitrack/LTSS. Additionally complaints, critical incidents, and unauthorized use of restrictive interventions are tracked in a tracking database and reviewed at regular QIS meetings to identify opportunities for prevention of reoccurring incidents and future training.~~

The operating agency, DOM, the Department of Human Services, and the Criminal Investigative unit of the Attorney General's Office all become involved in cases of A/N/E as needed. By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended), 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.

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:

~~Case Managers make scheduled visits to the person's home quarterly to allow the case manager to observe actual activities in the person's home, and to ensure there is no unauthorized use of restraints. In addition, unscheduled visits are made randomly as needed. PCAs are provided information on the unauthorized use of restraints. PCAs are instructed to notify the MDRS case manager of any suspected use of restraints. If a concern is present, the case manager makes an unscheduled visit with follow up as needed.~~

~~DOM staff also makes home visits and/or conduct telephone interviews for quality assurance purposes and to monitor for restraints and restrictive interventions.~~

The State prohibits the use of restraints during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that restraints are not used for waiver participant. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

~~Case Managers make scheduled visits to the person's home quarterly to allow the case manager to observe actual activities in the person's home, and to ensure there is no unauthorized use of restrictive interventions. In addition, unscheduled visits are made randomly, as needed. PCAs are provided information on the unauthorized use of restrictive interventions. PCAs are instructed to notify the MDRS case manager of any suspected use of restrictive interventions. If a concern is present, the case manager makes an unscheduled visit with follow up as needed.~~

~~DOM staff also make home visits and/or conduct telephone interviews for quality assurance purposes and to monitor for restraints and restrictive interventions.~~

The State prohibits the use of restrictive interventions during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that restrictive interventions are not used for waiver participants. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

~~Case Managers make scheduled visits to the person's home quarterly to allow the case manager to observe actual activities in the person's home and to ensure there is no unauthorized use of seclusion. In addition, unscheduled visits are made randomly, as needed. PCAs are provided information on the unauthorized use of seclusion. PCAs are instructed to notify the MDRS case manager of any suspected use of seclusion. If a concern is present, the case manager makes an unscheduled visit with follow up as needed.~~

~~DOM staff also make home visits and/or conduct telephone interviews for quality assurance purposes and to monitor for seclusion.~~

The State prohibits the use of seclusion during the course of the delivery of waiver services. DOM and the operating agency are jointly responsible for ensuring that seclusion is not used for waiver participants. The case manager(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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 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 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):
~~**On-site observations, interviews, monitoring**~~ **Other**

If 'Other' is selected, specify:
~~**LTC QA Home Visits/Telephone Interviews**~~ **Critical Incident 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 = 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:

Performance Measure:

~~**PM 1: # and % of critical incidents (alleged A,N,E, and/or unexplained/suspicious death)addressed within required timeframe as in approved waiver. N: #of critical incidents (alleged A,N,E, and/or unexplained/suspicious death)addressed within required timeframe as in approved waiver. D: Total # of all critical incidents regardless of whether they were addressed within the required time frames.**~~

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:
~~**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	**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:	☒ **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 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% with a =/- 5% margin of error
☐ **Other** Specify:	☐ **X Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 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 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	Weekly	X 100% Review

Agency		
☐ **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:	☒ **X Annually**
	☒ **X Continuously and Ongoing**
	☐ **Other**

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

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 5: Number and percent of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. N: Number of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. D: Total number of annual complaint reviews.

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

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

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

Data Aggregation and Analysis:

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

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**	☒ **X Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☒ **X 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 by the Case Manager as required. N: Number of persons whose preventative health care standards were assessed by the Case Manager as required. D: Total number of persons assessed.**~~

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** 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:

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 MDRS to address alleged instances of abuse, neglect, exploitation, and unexplained/suspicious deaths within the required timeframe as specified in the approved waiver; (b) require MDRS to provide case manager or supervisor additional training on reporting requirements; (c) require MDRS to report monthly all alleged instances of abuse, neglect, exploitation, and unexplained/suspicious deaths regardless of whether they were addressed within the required timeframes.~~
~~For PM 2, DOM will (a) immediately notify case manager of deficiency via unable to process notice/clarification request; (b) require MDRS case manager to respond to deficiency within seven business days; (c) immediately indicate deficiency in LTSS System for data collection; and (d) approve case within seven business days of receipt of complete Emergency Preparedness Plan (EPP) and Plan of Services and Supports (PSS) which identify and address risks.~~
~~For PM 3, DOM will (a) require case manager to provide participant with information as part of the corrective action plan within seven business days; and (b) provide training annually.~~
~~For PM 4, DOM will (a) require unresolved complaints to be resolved within seven business days; and (b) address MDRS' administrative staff within seven business days.~~
~~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 restrictive interventions be followed immediately; (b)require MDRS to report unauthorized use of restrictive interventions via email notification within 24 hours of knowledge of the incident; (c) require MDRS to submit a Monthly Activity Report that will include all critical incidents including unauthorized use of restrictive interventions; (d) will require Case Managers to make unscheduled monthly home visits to monitor for the unauthorized use of restrictive interventions with substantiated cases of critical incidents.~~
~~For PM 7, DOM will (a) immediately notify case manager of deficiency via clarification request; and (b) have the case manager conduct a core standardized assessment which assesses a persons preventative health care standards within fifteen (15) days.~~

In any instance in which it is discovered that 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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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**
☒ **X Operating Agency**	☒ **X Monthly**

Sub-State Entity	Quarterly
Other Specify:	**X Annually**
	X 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 Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

~~The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed, to develop Customer Service Requests (CSRs), review progress, and test system changes. The meetings involve participation from DOMs Bureau of Systems Management, LTC staff and others, as may be deemed appropriate, depending on the issue for discussion. Meetings with LTC staff, including QA nurses and MDRS staff are held routinely for the purpose of addressing needs and resolving issues that may involve systems changes.~~

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

The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed, to develop system change requests, review progress, and test system changes. The meetings involve participation from the DOM Offices of Information Technology (iTech) and Long Term Services and Supports (LTSS), along with any other stakeholders deemed appropriate depending on the issue for discussion. Meetings with LTSS staff, including QA nurses and operating agency staff are held routinely for the purpose of addressing needs and resolving issues that may involve systems changes. When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to participants or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff to address issues that require system changes. Additionally, the State has monthly internal Advisory meetings to identify, correct, and implement system changes to improve the State's ability to adhere to state and federal regulations, policies and procedures. System changes have been implemented to allow for electronically capturing data and identifying trends related to the performance measures. Findings are discussed during collaborative Quality Improvement Strategy meetings with the operating agency and DOM. Reporting information from the eLTSS case management system is also utilized in quality improvement strategies as a source of reporting data for multiple quality measures.

ii. System Improvement Activities

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

b. System Design Changes

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

~~Division of Medicaid (DOM) and Mississippi Department of Rehabilitation Services (MDRS) monitor the Quality Improvement Strategy on a monthly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of the sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.~~

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

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

request through the Medicaid agency or the operating agency (if applicable).

~~*MDRS case managers, along with the persons on the waiver are responsible for reviewing time sheets submitted by each personal care attendant. After review and approval, these are submitted to the MDRS State Office staff for further review, and verification of accuracy.*~~

~~*DOM staff also monitors other waiver services for fiscal accountability through post payment audits of paid claims. Audits are conducted as part of the overall monitoring of the waiver during the compliance review. A 95% confidence level random sample with a +/- 5% margin of error is selected from the universe of claims paid for the period utilizing a sample calculator such as Raosoft or Rat-Stats. The universe is randomized with a random number generator and the appropriate number of claims is sampled. If anomalies are noted in the sample, such as claims with overlapping dates of service, additional claims may be selected for review. In instances where claims have been paid erroneously, the provider is notified of any necessary recoupment. Auditors compare the Date of Service, Provider Name/Number, and Units on the claim with the Start/End dates, Provider Name/Number, and Frequencies/Duration on the approved PSS for that period.*~~

~~*The LTC staff also closely review the CMS 372 report for accuracy prior to submittal.*~~

~~*Changes in billing rates, or updates, are discussed in staff meetings and at state-wide in-services. MDRS holds regular training sessions at their facilities to teach staff correct procedures. DOM conducts ongoing training and technical assistance for waiver providers to assure understanding of, and adherence with, DOM Administrative Codes and reimbursement methodology specified in the waiver.*~~

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 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.***~~

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):*

~~***Operating agency performance monitoring***~~ ***Other***

If 'Other' is selected, specify:
~~***Compliance Review***~~ ***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 =*~~ ~~*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***	☐ ***X Quarterly***
☐ ***X Other*** *Specify: Fiscal Agent*	☒ ***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:* *Every 24 months*

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.~~

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:
~~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:* *Fiscal Agent*	☒ ~~***Annually***~~
	☒ ~~***Continuously and Ongoing***~~
	☐ ***X Other*** *Specify: Every 24 months*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
PM 3: Number and percent of provider payment rates that are consistent with rate methodology in the approved waiver application or subsequent amendment. N: Number and percent of provider payment rates that are consistent with rate methodology in approved waiver application or subsequent amendment. D: Total number of payments.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
MMIS

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

Data Aggregation and Analysis:

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

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.*

~~*For PM 1, DOM will (a) recoup money paid erroneously to providers within 30 days of notification; (b) submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; and (c) report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.*~~

~~*For PM 2, DOM will (a) recoup money paid erroneously to providers within 30 days of notification; (b) submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; and (c) report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.*~~

~~*For PM 3: DOM will (a) annually review payment rates in MMIS; (b) submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS; and (c) reimburse money to providers within 30 days identification.t 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 with the operating agency 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 operating agency and/or 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 operating agency and/or 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***

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

~~*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 2021 and will be completed again in June 2022. If it is determined that rates are no longer sufficient, they are increased appropriately.*~~

~~*To set the context for developing service rates, careful consideration was given for service descriptions and provider handbook information for each waiver service. Educational requirements, expectations, and billable productivity levels were also considered.*~~

~~*Current waiver rates were compared to the same non-waiver Medicaid service rates or a ground up analysis was conducted.*~~

~~*For the Personal Care Attendant service, initial rates were updated using the following rating variables:*~~
~~*> Direct service provider salaries and benefits*~~
~~*> Direct service-related expense and overhead costs*~~
~~*> Annual number of hours practitioners are at work*~~
~~*> Percentage of time an at work practitioner is able to convert to billable units (productivity)*~~

~~*The rating variable assumptions were developed using multiple data sources including 2015 Bureau of Labor Statistics (BLS) data trended to 2017, a 2010 proprietary Milliman medical provider compensation survey, and Division of Medicaid 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.*~~

~~*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. Projected rates for waiver years following the initial year were based on an expected one point six (1.6) percent increase in 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. Once Milliman completed their rate analysis, DOM solicited public comments on the rates through stakeholder meetings, public notices, and notification to the tribal government.*~~

~~*Transitional Assistance rate of $800.00 per lifetime usage was based upon past utilization practices across all waivers. Transition assistance is reimbursed based on actual costs; however, the rate outlined in the waiver is the maximum allowable reimbursement. The Specialized Medical Equipment and Supplies and Environmental Accessibility Adaptations rates were determined based on previous utilization patterns and current costs. Specialized Medical Equipment and Supplies are reimbursed based on actual costs identified by invoice and MSRP; however, the estimated rate outlined in the waiver an average based on utilization per the SFY 2020 372 report.*~~

~~*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.*~~

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. DOM reviews all waiver rates annually to ensure that they are sufficient to ensure a qualified pool of providers. If it is determined that rates are no longer sufficient, they are increased appropriately. To set the context for developing service rates, careful consideration was given for service descriptions and provider handbook information for each waiver service. Educational requirements, expectations, and billable productivity levels were also considered. Current waiver rates were compared to the same non-waiver Medicaid service rates or a ground up analysis was conducted.

For the Personal Care Attendant service, initial rates were updated using the following rating variables: > Direct service provider salaries and benefits > Direct service-related expense and overhead costs > Annual number of hours practitioners are at work > Percentage of time an at work practitioner is able to convert to billable units (productivity) The rating variable assumptions were developed using multiple data sources including 2015 Bureau of Labor Statistics (BLS) data trended to 2017, a 2010 proprietary Milliman medical provider compensation survey, and Division of Medicaid 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.

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.

Transitional Assistance rate of $800.00 per lifetime usage was based upon past utilization practices across all waivers. Transition assistance is reimbursed based on actual costs; however, the rate outlined in the waiver is the maximum allowable reimbursement. The Specialized Medical Equipment and Supplies and Environmental Accessibility Adaptations rates were determined based on previous utilization patterns and current costs. Specialized Medical Equipment and Supplies are reimbursed based on actual costs identified by invoice and MSRP; however, the estimated rate outlined in the waiver an average based on utilization per the SFY 2022 372 report. 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 system has audit functions to deny payment for services when an applicant is not Medicaid eligible on the date of service. The MMIS system also has an audit function to deny any participant who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS system requires a person to be an approved, eligible Medicaid waiver participant, documented in the MMIS system, in order for the claim to pay. The lock-in function is housed in the MMIS system under the participant file and is performed by Medicaid HCBS staff or the Medicaid Fiscal Agent.*~~

~~*The State conducts post utilization reviews to ensure the services provided were on the person's approved service plan (plan of services and supports).*~~

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:

The Mississippi Department of Rehabilitation Services (MDRS) is a State agency. MDRS is the provider of case management. Participants choose a provider of their choice for specialized medical equipment and supplies, environmental accessibility adaptations, and personal care attendant services.

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:

~~*a) The Mississippi Department of Rehabilitation Services (MDRS);*~~
~~*b)*~~*a) MDRS pays the state match in advance to Division of Medicaid (DOM) via an IGT based on the prior quarter's claims payments.*

The Mississippi Department of Rehabilitation Services (MDRS) is appropriated the state funds for this waiver. MDRS pays the state match in advance to the Division of Medicaid (DOM) via an intergovernmental transfer (IGT) based on the prior quarter's claims payments.

☐ ***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 this redline version of the waiver. Updated data and projections are included in the "clean" version.***

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	24917.99	6078.68	30996.67	63179.08	8875.76	72054.84	41058.17
2	25344.16	6175.94	31520.10	64189.95	9017.77	73207.72	41687.62

3	25704.59	6274.76	31979.35	65216.98	9162.05	74379.03	42399.68
4	26131.70	6375.15	32506.85	66260.46	9308.65	75569.11	43062.26

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D	Factor G	Factor G'	Total: G+G	Difference (Col 7 less Column4)
5	26559.28	6477.16	33036.44	67320.62	9457.59	76778.21	43741.77

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	5800	5800
Year 2	5800	5800
Year 3	5800	5800
Year 4	5800	5800
Year 5	5800	5800

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 FY2020 CMS 372 Report data, the average length of stay for this waiver is 320 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 10 months.*~~

Based on the unofficial FY2022 CMS 372 Report data, the average length of stay for this waiver is 315 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 10.5 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 Independent Living 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 2020 CMS 372 report. The numbers were then projected as stable for each waiver year. During the development of the current waiver, DOM projected the average costs/unit for year one (1) of the waiver and adjusted the costs incrementally over the following four (4) years based on a 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.*~~

~~*As the state plans to submit an early renewal to be effective 7/1/2023 in order to align all five of our 1915(c) waivers, average number of users and average units per user are projected to remain constant for Years 2-5 of this application. Updated projected will be included in the 2023 renewal.*~~

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 2020 CMS 372 report and is trended forward to FY2023 using a 1.6% average projected 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.

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:*

~~***iii.***~~ 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 with severe orthopedic and/or neurological impairments, 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 a 1.6% average projected CPI Core. The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a nursing facility, including individuals with severe orthopedic and/or neurological impairments, 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 with severe orthopedic and/or neurological impairments, 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	
Personal Care Attendant (PCA)	
Environmental Accessibility Adaptations	

Waiver Services	
Specialized Medical Equipment and Supplies	
Transition Assistance 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
Personal Care Attendant (PCA) Total:						133993943.20
Personal Care Attendant (PCA)	per 15 min	5510	6968.00	3.49	133993943.20	
Environmental Accessibility Adaptations Total:						5869600.00
Environmental Accessibility Adaptations	per modification	290	2.00	10120.00	5869600.00	
Specialized Medical Equipment and Supplies Total:						4640000.00
Specialized Medical Equipment and Supplies	per item	1160	2.00	2000.00	4640000.00	
Transition Assistance Services Total:						20800.00
Transition Assistance Services	per service	26	1.00	800.00	20800.00	
				GRAND TOTAL:		144524343.20
				Total Estimated Unduplicated Participants:		5800
				Factor D (Divide total by number of participants):		24917.99
				Average Length of Stay on the Waiver:		320

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
Personal Care Attendant (PCA) Total:						136297564.00
Personal Care Attendant (PCA)	per 15 min	5510	6968.00	3.55	136297564.00	
Environmental Accessibility Adaptations Total:						5963513.60
Environmental Accessibility Adaptations	per modification	290	2.00	10281.92	5963513.60	
Specialized Medical Equipment and Supplies Total:						4714240.00
Specialized Medical Equipment and Supplies	per item	1160	2.00	2032.00	4714240.00	
Transition Assistance Services Total:						20800.00
Transition Assistance Services	per service	26	1.00	800.00	20800.00	

GRAND TOTAL:	146996117.60
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	25344.16
Average Length of Stay on the Waiver:	320

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
Personal Care Attendant (PCA) Total:						138217248.00
Personal Care Attendant (PCA)	per 15 min	5510	6968.00	3.60	138217248.00	
Environmental Accessibility Adaptations Total:						6058929.40
Environmental Accessibility Adaptations	per modification	290	2.00	10446.43	6058929.40	

GRAND TOTAL:	149086640.60
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	25704.59
Average Length of Stay on the Waiver:	320

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						4789663.20
Specialized Medical Equipment and Supplies	per item	1160	2.00	2064.51	4789663.20	
Transition Assistance Services Total:						20800.00
Transition Assistance Services	per service	26	1.00	800.00	20800.00	
				GRAND TOTAL:		149086640.60
				Total Estimated Unduplicated Participants:		5800
				Factor D (Divide total by number of participants):		25704.59
				Average Length of Stay on the Waiver:		320

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
Personal Care Attendant (PCA) Total:						140520868.80
Personal Care Attendant (PCA)	per 15 min	5510	6968.00	3.66	140520868.80	
Environmental Accessibility Adaptations Total:						6155870.60
Environmental Accessibility Adaptations	per modification	290	2.00	10613.57	6155870.60	
Specialized Medical Equipment and Supplies Total:						4866292.80
Specialized Medical Equipment and Supplies	per item	1160	2.00	2097.54	4866292.80	
Transition Assistance Services Total:						20800.00
Transition Assistance	per service		1.00	800.00	20800.00	
				GRAND TOTAL:		151563832.20
				Total Estimated Unduplicated Participants:		5800
				Factor D (Divide total by number of participants):		26131.70
				Average Length of Stay on the Waiver:		320

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services		26				

GRAND TOTAL:	151563832.20
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	26131.70
Average Length of Stay on the Waiver:	320

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
Personal Care Attendant (PCA) Total:						142824489.60
Personal Care Attendant (PCA)	per 15 min	5510	6968.00	3.72	142824489.60	
Environmental Accessibility Adaptations Total:						6254366.20
Environmental Accessibility Adaptations	per modification	290	2.00	10783.39	6254366.20	
Specialized Medical Equipment and Supplies Total:						4944152.00
Specialized Medical Equipment and Supplies	per item	1160	2.00	2131.10	4944152.00	
Transition Assistance Services Total:						20800.00
Transition Assistance Services	per service	26	1.00	800.00	20800.00	

GRAND TOTAL:	154043807.80
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	26559.28
Average Length of Stay on the Waiver:	320