

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

### Administration and Operation

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

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

Day Services - Adult, Prevocational Services, Supported Employment Services, Supported Living, and In-Home Respite

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

Select one:

<input checked="" type="radio"/>	<b>Not applicable</b>
<input type="radio"/>	<b>Applicable</b>
Check the applicable authority or authorities:	
<input type="checkbox"/>	<b>Services furnished under the provisions of §1915(a)(1)(a) of the Act.</b> The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and (e) whether the 1915(a) contract has been submitted or previously approved.
<input type="checkbox"/>	<b>Waiver(s) authorized under §1915(b) of the Act.</b> 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 ( <i>check each that applies</i> ):	
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)
<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)
<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	<b>A program operated under §1932(a) of the Act.</b>

	Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
<input type="checkbox"/>	<b>A program authorized under §1115 of the Act.</b> Specify the program:

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

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

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

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

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

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

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

MDMH, in addition to the Division of Medicaid (DOM) performs 2, 3, 4, 5, 6, 8, 9, 10. The Diagnostic and Evaluation (D&E) team, which is a part of MDMH, performs #2.

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

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

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

6.  **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7.  **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8.  **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

## Number Served

**1. Projected Number of Unduplicated Individuals To Be Served Annually.**

*(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	11/01/2023	10/31/2024	1,150
Year 2	11/01/2024	10/31/2025	1,350
Year 3	11/01/2025	10/31/2026	1,550
Year 4	11/01/2026	10/31/2027	1,750
Year 5	11/01/2027	10/31/2028	1,950

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

## Financial Eligibility

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

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

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

## Evaluation/Reevaluation of Eligibility

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

○	Directly by the Medicaid agency
●	By Other <i>(specify State agency or entity under contract with the State Medicaid agency):</i>

MDMH

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

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

Targeted Case Managers conducts the reevaluation for eligibility. Targeted Case Management is provided by an individual with at least a Bachelor’s degree in a human service field with no experience required or bachelor’s degree in a non-related field and at least one year relevant experience. Targeted Case Management can also be provided by a Registered Nurse with at least one-year relevant experience.

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

The process for evaluation/reevaluating needs-based eligibility for State plan HCBS involves a review of current pertinent information in the individual’s record, such as medical, social and psychological evaluations, and standardized instruments to measure intellectual functioning, the individual service plan, progress notes, case management notes and other assessment information. The review verifies the determination that the individual meets the needs-based eligibility criteria including the existence of significant functional limitations in two (2) or more areas of major life activity including: receptive/expressive language, learning, self-care, mobility, self-direction, capacity for independent living and economic self-sufficiency. The State determines whether an individual meets the needs-based criteria through the use of the Inventory for Client and Agency Planning (ICAP).

The ICAP is administered by both the Diagnostic and Evaluation Team during the initial evaluation and by the Targeted Case Managers during the annual reevaluation.

4.  **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.
5.  **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

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

The person has a need for assistance typically demonstrated by meeting the following criteria on a continuing or intermittent basis: The individual must have significant limitations of functioning in two (2) or more areas of major live activity including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual must have significant limitations of functioning in two (2) or more of the following seven (7) areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.	For an individual to meet NF LOC, their assessed limitations related to activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services must result in an algorithm-based LOC score that meets/exceeds the state designated threshold. Persons scoring below the threshold may qualify for a secondary review and a tertiary review by a physician before waiver services are denied.	For an individual to be eligible for services in an ICF/IID, the individual must have an intellectual disability, a developmental disability, or Autism Spectrum Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.  The individual must have limitations of functioning in three (3) or more of the following seven (7) areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.	For an individual to be eligible for services in a Hospital, the individual must have continuous need of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis, or treatment of acute illness or injury certified by a physician.

\*Long Term Care/Chronic Care Hospital  
 \*\*LOC= level of care

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

The state is targeting Individuals with Intellectual Disabilities, Developmental Disabilities, or Autism Spectrum Disorder. Persons must be at a minimum 18 years old to receive services through the IDD Community Support Program.

**Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe:

(1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

<b>i.</b>	<p><b>Minimum number of services.</b></p> <p>The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">One</div>
<b>ii.</b>	<p><b>Frequency of services.</b> The state requires (select one):</p> <p><input checked="" type="radio"/> <b>The provision of 1915(i) services at least monthly</b></p> <p><input type="radio"/> <b>Monthly monitoring of the individual when services are furnished on a less than monthly basis</b></p> <p>If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:</p>

## Home and Community-Based Settings

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

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



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

The Mississippi Division of Medicaid received notice from the Center for Medicare and Medicaid Services (CMS) of Final Approval of the Statewide Transition Plan on July 11, 2022. The State outlined the State's efforts in bringing Home and Community Based Services (HCBS) into full compliance prior to the March 17, 2023, transition period deadline. All non-residential settings (Day Services Adult and Prevocational Services) and residential settings (Supported Living— owned and controlled by the provider) were assessed and brought into compliance through remediation.

Ongoing monitoring is crucial to assure continued compliance with the HCBS Final Rule. MDMH will provide ongoing monitoring of compliance with the HCBS Final Rule across all HCBS through certification of services and settings. Current certified CSP providers are surveyed through MDMH Certification each year. Any areas of noncompliance will result in a Written Report of Findings and subsequent remediation process. MDMH may take administrative action to suspend, revoke, or terminate certification. DOM will be notified of any such administrative action. New interested providers must also go through the Certification process which includes review of policies and procedures to ensure compliance with MDMH Operational Standards including Final Rule requirements and an on-site inspection of each new setting prior to service provision and with all newly certified agencies providing HCBS (including non-setting-based services) within six (6) months of beginning service provision. MDMH staff will also conduct an on-site visit and survey of random sample of at least two people from each new setting certified under new providers within one (1) year of beginning service provision. Any areas of noncompliance will be identified through a Written Report of Findings, followed by Plan of Compliance, and validation by MDMH that strategies were implemented.

Targeted Case Managers are required to complete person-centered training and use those techniques in developing a person-centered plan (Plan of Services and Supports – PSS) for each individual. Through monthly contact(s) Targeted Case Managers follow up to see the PSS is implemented. Targeted Case Managers also are trained on federal HCBS settings requirements and will monitor and follow up on issues of noncompliance. Targeted Case Managers complete a Final Rule Monitoring Tool at least annually which includes interview with the person/legal representative and service providers (as needed). The Monitoring Tool will be submitted with the person's recertification packet. Targeted Case Managers will consult with MDMH as needed. Any unresolved issues must be followed up on until resolved. Unresolved or egregious issues of noncompliance will be reported to MDMH/Certification and result in appropriate administrative action. MDMH will conduct Technical Assistance and training opportunities for Targeted Case Managers and certified providers.

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

1.  There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2.  Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3.  The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

5.

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

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

Targeted Case Managers (TCM) are responsible for the development of a Plan of Service and Supports (PSS) for each person receiving 1915(i) Services. Targeted Case Management is provided by an individual with at least a Bachelor's degree in a human services field with no experience required or a bachelor's degree in a non-related field and at least one year relevant experience. Targeted Case Management can also be provided by a Registered Nurse with at least one-year relevant experience. Additionally, Targeted Case Managers must complete training in Person-Centered Planning and demonstrate competencies associated with that process.

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

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

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

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

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

Targeted Case Managers will assist individuals in selecting qualified providers of the 1915(i) services. A qualified provider must be a Medicaid provider and be certified by MDMH to provide the services. During

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

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

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

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

MDMH then forwards the Plan of Services and Supports to the State for review and approval. Once approved, the State enters a lock-in for the individual.

On an annual basis, MDMH will verify through a representative sample of beneficiaries PSSs to ensure all service plan requirements have been met. PSSs are housed in a Document Management System allowing MDMH and DOM access to PSSs at any time.

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

<input checked="" type="checkbox"/>	Medicaid agency	<input checked="" type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other <i>(specify)</i> :				

## Services

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

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Day Services – Adult
Service Definition (Scope):	

Day Services-Adult is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the person's private residence or other residential living arrangements. Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each person are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented and maintained in each person's record.

Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact. Day Services-Adult must have a community component that is individualized and based upon the choices of each person. Transportation must be provided to and from the program and for community participation activities.

The setting location must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving CSP services. The setting must be physically accessible to persons. Settings where Day Services Adult are provided must meet all federal standards for HCBS settings.

Day Services-Adult includes assistance for people who cannot manage their personal toileting and hygiene needs during the day. People who have a high level of support need must be offered the opportunity to participate in all activities, including those offered on site and in the community.

Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and is no longer attending school.

Settings where Day Services-Adult services are provided must meet all federal standards for HCBS settings.

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

N/A

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

Categorically needy (*specify limits*):

	<p>The State covers Day Services – Adult for individuals enrolled in the Community Support Program up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by MDMH or the State. People receiving Day Services-Adult may also receive Prevocational Services but not at the same time of day. Maximum hours for one service or combination of the two services cannot exceed 138 hours per month.</p>		
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p>		
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Day Services – Adult Providers	MDMH Certification	Certified every four years by MDMH after initial certification. MDMH conducts an annual provider compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.  The minimum staffing ratio is based on the individuals ICAP Support Level.  Providers must comply with Title 23 of the Mississippi Administrative Code. Specific provider enrollment and compliance requirements are detailed in Part 208 of the Code. Providers must also comply with MDMH Operational Standards.
<p><b>Verification of Provider Qualifications</b> (<i>For each provider type listed above. Copy rows as needed</i>):</p>			

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Day Services - Adult Providers	Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Day Services-Adult staff.	Annually
<p><b>Service Delivery Method.</b> (<i>Check each that applies</i>):</p>		
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
Service Title:	Prevocational Services
Service Definition (Scope):	
<p>Prevocational Services provide meaningful activities of learning and work experiences, including volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team. There must be a written plan to include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.</p> <p>People receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be individualized and designed to support such employment outcomes. Prevocational Services must enable each person to attain the highest level of work in an integrated setting with the job matched to the person’s interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills associated with building skills necessary to perform work in a competitive, integrated employment.</p> <p>Participation in Prevocational Services is not a prerequisite for Supported Employment. A person receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force. At least annually, providers will conduct an orientation informing people receiving services about Supported Employment and other competitive employment opportunities in the community. This documentation must be maintained on site. Representative(s) from the Mississippi Department of Rehabilitation Services must be invited to participate in the orientation.</p> <p>Settings where Prevocational Services are provided must meet all federal standards for HCBS settings. The setting must be physically accessible to persons. Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each person based on choices/requests of the persons and be provided individually or in small groups. Documentation of the choices offered, and the chosen activities must be documented in each person’s record. People who have a high level of support need must be included in community job exploration activities. Transportation must be provided to and from the program and for community integration/job exploration.</p> <p>Mobile crews and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be documented as part of the Plan of Services and Supports.</p> <p>Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and/or is no longer attending school.</p> <p>People under the age of 22 must be referred to the Mississippi Department of Rehabilitation Services and exhaust those Supported Employment benefits before being able to enroll in Prevocational Services.</p>	

Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. <i>(Choose each that applies):</i>	
<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b> The State covers Prevocational Services for individuals enrolled in CSP up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by MDMH or the State. People receiving Prevocational Services may also receive Day Services-Adult but not at the same time of day. Maximum hours for one or combination of the two services cannot exceed 138 hours per month.

<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Prevocational Services Providers	MDMH Certification	Certified every four years by MDMH after initial certification. MDMH conducts an annual provider compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.  The minimum staffing ratio is based on the individuals ICAP Support Level.  Providers must comply with Title 23 of the Mississippi Administrative Code. Specific provider enrollment and compliance requirements are detailed in Part 208 of the Code. Providers must also comply with MDMH Operational Standards.
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):		Frequency of Verification ( <i>Specify</i> ):
Prevocational Services Providers	Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Prevocational Services staff.		Annually
<b>Service Delivery Method.</b> ( <i>Check each that applies</i> ):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	



<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
<b>Service Title:</b>	<b>Supported Employment</b>
<b>Service Definition (Scope):</b>	
<p>Before a person can receive Supported Employment services, he/she must be referred by his/her Targeted Case Manager to the MS Department of Rehabilitation Services to determine his/her eligibility for services from that agency. Documentation must be maintained in the person’s record that verifies the service is not available under an agency provider funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et. Seq.). Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and are no longer attending school.</p> <p>Supported Employment is ongoing support for people who, because of their support needs, will need intensive, ongoing services to obtain or maintain a job in competitive, integrated employment or self-employment.</p> <p>Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported Employment does not include volunteer work or unpaid internships.</p> <p>Providers must work to reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. Supported Employment Services are provided in a work location where individuals without disabilities are employed; therefore, payment is made only for adaptations, supervision, and training required by individuals receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting (i.e., appropriate attire, social skills, etc.).</p> <p>Providers must be able to provide all activities that constitute Supported Employment as outlined in MDMH Operational Standards. Job Development activities assist an individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Maintenance activities assist an individual to learn and maintain a job in the community. Supported Employment may also include services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based.</p> <p>Transportation will be provided between the individual's place of residence for job seeking and job coaching as well as between the site of the individual’s job or between day program sites as a component part of Supported Employment. Transportation cannot comprise the entirety of the service. If local or other transportation is available, the individual may choose to use it but the provider is ultimately responsible for ensuring the availability of transportation.</p> <p>Self-employment is limited to max of fifty-two (52) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product and max of thirty-five (35) hours per month for assistance in the community by a job coach. Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be made to the Mississippi Department of Rehabilitation Services. There must be documentation of the referral in the person’s record.</p>	

TN#:23-0018  
Supersedes

Received:  
Approved:

<b>Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):</b>			
N/A			
<p><b>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</b></p> <p><i>(Choose each that applies):</i></p>			
<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b>		
	The State covers Supported Employment Services for individuals enrolled in CSP up to 90 hours per year for Job Development and up to the maximum amount of 100 hours per month for Job Maintenance. In instances in which a person requires additional amounts of services, as identified through Person Centered Planning, those services must be authorized by MDMH or the State.		
<input type="checkbox"/>	<b>Medically needy (<i>specify limits</i>):</b>		
<b>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</b>			
<b>Provider Type (<i>Specify</i>):</b>	<b>License (<i>Specify</i>):</b>	<b>Certification (<i>Specify</i>):</b>	<b>Other Standard (<i>Specify</i>):</b>

Supported Employment Providers	MDMH Certification	Certified every four years by MDMH after initial certification. MDMH conducts an annual provider compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health. Providers must comply with Title 23 of the Mississippi Administrative Code. Specific provider enrollment and compliance requirements are detailed in Part 208 of the Code. Providers must also comply with MDMH Operational Standards.
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>		<b>Frequency of Verification</b> <i>(Specify):</i>
Supported Employment Provider	Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Supported-Employment staff.		Annually
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed		

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
<b>Service Title:</b>	Supported Living
<b>Service Definition (Scope):</b>	
<p>Supported Living Services are provided to people who reside in their own residences (either owned or leased by themselves or a certified agency provider) for the purposes of increasing and enhancing independent living in the community. Supported Living Services are for people who need only intermittent support, less than twenty-four (24) hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Activities are designed to promote independence yet provide necessary support and assistance based on each person’s individual needs. Agency providers should focus on working with the person to gain independence and opportunity in all life activities.</p> <p>The person may choose to rent or lease in a MDMH certified supervised living, shared supported living, or supported living location for four (4) or fewer individuals. All provider owned or controlled settings must meet HCBS federal setting requirements. Providers must ensure each person’s rights of privacy, dignity and respect and freedom from coercion. Services must optimize, but not regiment, a person’s initiative, autonomy and independence in making life choices, including, but not limited to daily activities, physical environment, and with whom to interact. Persons have choices about housemates and with whom they share a room. Persons must have keys to their home and their room if they so choose.</p> <p>Nursing services are a component of Supported Living Services and must be provided in accordance with the MS Nurse Practice Act. Examples of nursing activities include monitoring vital signs or blood sugar; administration of medication; weight monitoring, and accompanying people on medical appointments, etc. Non-licensed personnel may assist a person with medication usage for certain procedures not requiring a nurse to perform as outlined in the MDMH Operational Standards once completion of all training requirements are met.</p> <p>Persons must have control over their personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. For persons living in provider owned/controlled settings, there must be documentation in each person’s record regarding all income received and expenses incurred and how/when it is reviewed with the person. Persons must have a lease or written financial agreement and afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to 125 and §89-8-1 to 89-8-1 to 89).</p> <p>Individuals in Supported Living cannot also receive In-Home Respite services. Supported Living cannot be provided to someone who is an inpatient of a hospital, ICF/IID, nursing facility, inpatient psychiatric facility or any type of rehabilitation facility when the inpatient facility is billing Medicaid, Medicare, or private insurance.</p>	
<b>Additional needs-based criteria for receiving the service, if applicable</b> ( <i>specify</i> ):	

N/A			
<p><b>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</b></p> <p><i>(Choose each that applies):</i></p>			
<input checked="" type="checkbox"/>	<b>Categorically needy (specify limits):</b>		
	The State covers Supported Living Services for individuals enrolled in CSP up to the maximum amount of eight (8) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by MDMH or the State.		
<input type="checkbox"/>	<b>Medically needy (specify limits):</b>		
<b>Provider Qualifications (For each type of provider. Copy rows as needed):</b>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Supported Living Providers	MDMH Certification	Certified every four years by MDMH after initial certification. MDMH conducts an annual provider compliance review.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.  Providers must comply with Title 23 of the Mississippi Administrative Code. Specific provider enrollment and compliance requirements are detailed in Part 208 of the Code. Providers must also comply with MDMH Operational Standards.
<b>Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):</b>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Supported Living Providers	Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Supported Living staff.		Annually
<b>Service Delivery Method. (Check each that applies):</b>			

<input type="checkbox"/> <b>Participant-directed</b>	<input checked="" type="checkbox"/> <b>Provider managed</b>
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<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	In-Home Respite
Service Definition (Scope):	
<p>A new service, In-Home Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Respite staff provides all the necessary care the usual caregiver would provide during the same time period. In-Home Respite is only available to individuals living in a family home and is not permitted for individuals living independently, either with or without a roommate. In-Home Respite is not available for people who receive Supported Living. In-Home Respite is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance. This includes inpatient psychiatric facilities. In-Home Respite cannot be provided in the provider’s residence. Staff cannot accompany individuals to medical appointments. In-Home Respite staff are not permitted to provide medical treatment as defined in the MS Nursing Practice Act and Rules and Regulations.</p> <p>Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan. Allowable activities include:</p> <ul style="list-style-type: none"> <li>* Assistance with personal care needs such as bathing, dressing, toileting, grooming</li> <li>* Assistance with eating and meal preparation</li> <li>* Assistance with transferring and/or mobility</li> <li>* Assistance with cleaning the individual’s personal space</li> <li>* Leisure activities</li> </ul> <p>MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all In-Home Respite staff.</p>	

Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. ( <i>Choose each that applies</i> ):			
<input checked="" type="checkbox"/>	Categorically needy ( <i>specify limits</i> ):		
<p>The State covers In-Home Respite for individuals enrolled in CSP up to the maximum amount of four (4) hours per day. In instances in which a person requires an additional amount of services, as identified through Person-Centered Planning, those services must be authorized by MDMH or the State.</p> <p>Family members are allowed to provide In-Home Respite if employed by a certified MDMH provider. Family members are required to meet all personnel and training requirements as required for all in-home respite staff as outlined in the MDMH Operational Standards. The following types of family members are excluded from being providers of In-Home Respite: (1) anyone who lives in the same home with the person, regardless of relationship; (2) parents/step-parents, spouses, or children of the person receiving the services; (3) those who are normally expected to provide care for the person receiving the services including legal guardians, conservators, or representative payee of the person’s Social Security benefits.</p> <p>Family members providing In-Home Respite must be identified in the Plan of Services and Supports.</p>			
<input type="checkbox"/>	Medically needy ( <i>specify limits</i> ):		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
In-Home Respite Providers	MDMH Certification	Certified every four years by MDMH after initial certification. MDMH conducts an annual provider compliance review.	<p>Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.</p> <p>Providers must comply with Title 23 of the Mississippi Administrative Code. Specific provider enrollment and compliance requirements are detailed in Part 208 of the Code. Providers must also comply with MDMH Operational Standards.</p>
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
In-Home Respite Providers	Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all In-Home Respite staff.	Annually
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	



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

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 in-home respite 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 stated above.
- 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 was providing for the participant without payment prior to enrollment.

Providers employing a family member to serve as In-Home Respite must maintain the following documentation in each staffs' personnel record:

- Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address, evidencing the fact that he/she does not live in the same home as the person receiving services.
- Evidence the individual's Targeted Case Manager has been notified the agency is seeking approval of a family member to provide In-Home Respite.
- Participant or other designated representative is available to sign verifying that services were rendered by the selected relative.

Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:

- Observation of the family member's interactions with the person receiving services.
- Review of Plan of Services and Supports and Service Notes to determine if outcomes are being met.
- Review of utilization to determine if contents of Service Notes support the amount of service provided.

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 provider from the provision of services, the participant will be asked to select an alternate qualified provider.

# Participant-Direction of Services

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

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

<input checked="" type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>

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

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
N/A	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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6.  **Participant-Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
- Specifies the State plan HCBS that the individual will be responsible for directing;
  - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
  - Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
  - Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
  - Specifies the financial management supports to be provided.

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

N/A

8. **Opportunities for Participant-Direction**

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

<input checked="" type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> 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.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input checked="" type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant-Budget Authority.
	<b>Participant-Directed Budget.</b> <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):</i>
	<b>Expenditure Safeguards.</b> <i>(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.</i>

# Quality Improvement Strategy

## Quality Measures

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

- 1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.**
- 2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
- 3. Providers meet required qualifications.**
- 4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
- 5. The SMA retains authority and responsibility for program operations and oversight.**
- 6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
- 7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

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

<i>Requirement</i>	<i>Service plans a) address assessed needs of 1915(i) participants</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of PSSs reviewed in which the services and supports align with assessed needs.  N: Number of PSSs reviewed in which the services and supports align with assessed needs.  D: Total number of PSSs reviewed.
<b>Discovery Activity</b> <i>(Source of Data &amp;</i>	Data Source – LTSS  Sample – 100%

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

<b>Requirement</b>	<b>Service plans a) address assessed needs of 1915(i) participants</b>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of persons' PSSs reviewed where the individual's signature indicates involvement in the PSS development.  N: Number of persons' PSSs reviewed with signature indicating involvement in PSS development D: Total number of PSS reviewed.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – LTSS  Sample Size: 100% Review
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and</i>	DOM
<i>aggregates remediation activities; required timeframes for remediation)</i>	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	<b>Service plans a) address assessed needs of 1915(i) participants</b>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of persons reported receiving services and supports that were provided in the type, scope, amount, duration and frequency as defined in the PSS.  N: Number persons reported receiving services and supports were provided in the type, scope, amount, duration and frequency as defined in the Plan of Services and Supports.  D: Total number of persons reviewed who reported receiving services.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – Final Rule Monitoring Tool  Sample Size – 95% +/- 5% margin of error
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Annually at recertification
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	4. MDMH/DOM
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	4. Annually



<i>Requirement</i>	<i>Service plans b) are updated annually</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of PSSs reviewed which are updated at least once per certification period. N: Number of PSSs reviewed that are updated annually. D: Number of PSSs reviewed.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source –IDD Community Support Program PSS Review Checklists Sample Size – 100% review
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Discovery is continuous and ongoing
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDMH/DOM
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Quarterly

<b>Requirement</b>		<i>Service plans c) document choice of services and providers.</i>
<b>Discovery</b>		
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of 1915 (i) Choice of Service and Provider forms completed. N: Number of 1915(i) Choice of Service and Provider forms completed. D: Number of records reviewed.	
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source –IDD Community Support Program PSS Review Checklists Sample Size – 100% review	
<b>Monitoring Responsibilities</b>	MDMH	
<i>(Agency or entity that conducts discovery activities)</i>		
<b>Frequency</b>	Discovery is continuous and ongoing	
<b>Remediation</b>		
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDMH	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Quarterly	

<b>Requirement</b>	<i>Eligibility Requirements: a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of new benefit applicants, where there is a reasonable indication that services may be needed in the future that a received a level of need evaluation. N: Number and percent of new benefit applicants, where there is a reasonable indication that services may be needed in the future that a received a level of need evaluation. D: Total number of new benefit applicants.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – Long Term Services and Supports (LTSS) Sample Size -100% Review
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Quarterly
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects,</i>	MDMH/DOM
<i>analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Quarterly

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

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

<b>Requirement</b>	<b>Providers meet required qualifications.</b>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of providers who met, and continue to meet, required certification standards throughout service provision.  N: Number of providers who met, and continue to meet, required certification standards throughout service provision.  D: Total number of providers reviewed.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source - DMH Certification Database  Sample – 100% Review
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DOM/MDMH
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Discovery</b>	
<b>Requirement</b>	<b>Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).</b>
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of providers reviewed that meet or continue to meet HCBS settings criteria as defined by federal regulations.  N: Number of providers reviewed who meet or continue to meet HCBS setting criteria as defined by federal regulations D: Total number of providers reviewed
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – MDMH Written Report of Findings  Sample size -100% reviewed
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDMH/DOM
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	<b><i>The SMA retains authority and responsibility for program operations and oversight.</i></b>	
<b>Discovery</b>		
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of quarterly quality improvement strategy meetings held in accordance with the requirements of the 1915(i). N: Number of quarterly quality improvement strategy meetings held in accordance with the requirements in the 1915(i). D: Total number of quarterly quality improvement strategy meetings.	
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source - QIS Tracking Spreadsheet Sample size – 100% review	
<b>Monitoring</b>	DOM/MDMH	
<b>Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>		
<b>Frequency</b>	Annually	
<b>Remediation</b>		
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DOM	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually	



<b>Requirement</b>	<i>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number of and percent of claims for each payment made for services included in the beneficiary's PSS. N: Number of claims paid that were included in the individuals PSS. D: Number of total claims paid.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source - MMIS system. Data are claims paid for 1915(i) services. Sample Size - Less than 100% Review; Representative Sample: Confidence Interval = 95%
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	DOM
<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DOM
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of all critical incidents that were reported or remediated in accordance with the requirements of the 1915(i). N: Number of all critical incidents that were reported or remediated in accordance with the requirements of the 1915(i). D: Total number of critical incidents.
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – Critical Incident Tracking Database Sample Size – 100% review
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH
<b>Frequency</b>	Quarterly
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDMH/DOM
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Quarterly

<b>Requirement</b>	<b><i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i></b>	
<b>Discovery</b>		
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	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.	
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – LTSS Sample Size – 100% Review	
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	MDMH/DOM	
<b>Frequency</b>	Annually	
<b>Remediation</b>		
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDMH/DOM	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually	

<b>Requirement</b>	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>	
<b>Discovery</b>		
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	Number and percent of complaints that were addressed/resolved as approved in the 1915(i). N: Number of complaints that were addressed/resolved as approved in the 1915(i) D: Total number of complaints.	
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Data Source – DMH Complaint Tracking Database Sample Size– 100% review	
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	DOM/MDMH	
<b>Frequency</b>	Monthly	
<b>Remediation</b>		
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and</i>	MDMH/DOM	
<i>aggregates remediation activities; required timeframes for remediation)</i>		
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Continuously and Ongoing	

<p><b>Discovery Evidence</b> <i>(Performance Measure)</i></p>	<p>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.</p> <p>N: Number of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible</p> <p>D: Total number of annual complaint reviews.</p>
<p><b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i></p>	<p>Complaint Tracking Database</p> <p>Sample Size – 100%</p>
<p><b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i></p>	<p>MDMH/DOM</p>
<p><b>Frequency</b></p>	<p>Annually</p>
<p><b>Remediation</b></p>	
<p><b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>MDMH/DOM</p>
<p><b>Frequency</b> <i>(of Analysis and Aggregation)</i></p>	<p>Annually</p>

## System Improvement

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

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

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

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 may involve participation from the DOM Office of Mental Health, Office of 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 DOM and operating agency staff are held routinely for the purpose of addressing needs and resolving issues that may involve system 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. 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.

### 2. Roles and Responsibilities

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

DOM operates two (2) audit units to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud, waste and abuse reported or identified through the SURS program. The Office of Financial and Performance Review conducts routine monitoring of cost reports and contracts with other agencies. In addition, these 1915(i) services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the CSP program to identify areas of misuse.

#### Frequency

DOM and the MDMH monitor the quality improvement strategy on a quarterly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes.

### 3. Method for Evaluating Effectiveness of System Changes

Evaluation of the quality improvement strategy is a continuous and ongoing endeavor. When change in the quality improvement strategy is necessary, a collaborative effort between DOM and the MDMH is made. The quality improvement strategy is reviewed to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible.