DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

September 18, 2023

Drew Snyder, Executive Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399

RE: CMS Approves Mississippi State Plan Amendment (SPA) 1915(i) Renewal, MS-23-0018

Dear Drew Snyder:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number MS-23-0018. The purpose of this amendment is to renew Mississippi's 1915(i) State Plan HCBS benefit. The effective date for this renewal is November 1, 2023. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring October 31, 2028, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning

compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

We appreciate the cooperation and effort provided by you and your staff during the review of these waiver renewals. If you have any questions concerning this information, please contact Liz Heintzman via email at Elizabeth.Heintzman@cms.hhs.gov.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Dominique Mathurin, CMS
Jessica Loehr, CMS
Monica Neiman, CMS
Wendy Hill-Petras, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0018

2. STATE: MS

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. § 441.745

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 4,032,067
b. FFY 25 $ 4,228,191

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, Pages 1 - ~~41~~ 46
Attachment 4.19-B, Page 25a, ~~25b~~-25f
Supplement 1C to Attachment 3.1-A, Pages 1-4
~~Attachment 2.2-A~~

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, Pages 1 - 41
Attachment 4.19-B, Page 25a, 25b
Supplement 1C to Attachment 3.1-A, Pages 1-4
~~Attachment 2.2-A~~

9. SUBJECT OF AMENDMENT
MS SPA 23-0018 is being submitted to revise the requirements for Targeted Case Managers providers; Home and Community Based Services compliance with the HCBS final rule through ongoing monitoring and person-centered training; revise service definitions for Day Services, Prevocational Services, Supported Employment Services, Supported Living Services; add coverage

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Drew L. Snyder

13. TITLE
Executive Director

14. DATE SUBMITTED
APR 28 2023

15. RETURN TO
Drew L. Snyder
Miss. Division of Medicaid
Attn: Robin Bradshaw
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR CMS USE ONLY

16. DATE RECEIVED
April 28, 2023

17. DATE APPROVED
September 18, 2023
[redacted]

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
November 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
George Failla

21. TITLE OF APPROVING OFFICIAL
Director, DHCBSO-MCOG

22. REMARKS

9.13.23-State authorized P&I change to block#7

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*:**

●	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(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.

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

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

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

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

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

	Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

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

○	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)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ 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.	
●	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	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☐	☐
6 Qualified provider enrollment	☑	☑	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☐

(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 1, 2, 3, 4, 5, 6, 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*):

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ 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. ☐ 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 (*specify State agency or entity under contract with the State Medicaid agency*):

Received: 4/28/2023
Approved: 9/18/2023
Effective: 11/01/2023

	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 of 50 or greater.	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:

i.	**Minimum number of services**. 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: One	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

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 State Plan HCBS benefit will be furnished to eligible individuals who reside and receive HCBS in their own home/family home or in the community. The state determined that the settings were in compliance with the HCBS as required in 42 CFR 441.710(a)(1)-(2) through review by the MS Department of Mental Health and an Independent Contractor. Final Rule requirements have been incorporated into DMH Operational Standards and are monitored by the Division of Certification and Target Case Managers to ensure continued compliance. New providers will not be enrolled if they do not meet the Final Rule requirements.

Day Services Adult, Prevocational Services provide habilitation services in non-residential settings and must meet the HCB settings requirements. These services are provided in a MDMH certified community setting. Providers are required to assist people in community integration through activities of the participant's choice in the greater community.

Supported Living services are provided for people who reside in their own residences (either owned or leased by themselves or an agency provider) for the purposes of increasing and enhancing independent living in the community. All provider owned or controlled settings providing Supported Living services must meet HCB settings requirements. People receive intermittent support from staff and staff are on call to assist as needed. All provider owned or controlled settings are four person or less with most people having a private bedroom. People may choose roommates of their choice and control their own schedule and activities. Each person has a written financial agreement or lease in provider owned and controlled settings as required by HCB setting requirements.

The following services are provided in integrated community settings with opportunities for full access to the greater community: Supported Employment services provided in an integrated work setting; and In-Home Respite services provided in the participant's home. Targeted Case Managers and IDD providers review rights and grievance process upon enrollment and at least annually. Services are designed to optimize the person's choice of activities to enhance skills and participate in activities important to him/her.
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 by June 30, 2022. 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.

Through monthly contact(s) Targeted Case Managers follow up to see the Plan of Services (PSS) is implemented. The PSS is revised at least annually or at any time the person has a change in support needs or chooses other services or providers. 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.

The State does not cover services to persons in congregate living facilities, institutional settings or on or adjacent to the grounds of institutions for persons enrolled in the 1915(i). The State will not reimburse HCBS for participants in denied or non-complaint settings pursuant to the 1915(i) authority.

(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 individual and their families and/or legal guardians are provided with information regarding all certified providers and services available based on the individuals support needs, including the process for submitting any grievances and complaints. The PSS is developed based on the person's choice of services and providers. Cultural and communication needs are taken into account by the Case Managers.

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. A lock-in is a MMIS system-based identifier in the member area that identifies the individual has been assigned to a specific program such as a waiver. The lock-in includes the specific program the individual has been assigned, identifies which MDMH regional program assigned, date range, and status of enrollment. The lock-in allows for payment of the 1915(i) services to enrolled providers. Each person's PSS will be reviewed and revised at a minimum of annually. TCM maintains monthly contact and the PSS can be changed at any time the person requests or changes are identified.

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):*

☑	Medicaid agency	☑	Operating agency	☑	Case manager
☐	Other (*specify):*				

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
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. Non-medical transportation must be provided to and from the program and for community participation activities. Providers must assure accessibility for all participants.

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 services in this benefit. 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.

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):*

	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.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Day Services – Adult Providers	MDMH Certification	Certified every four years by M DMH 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.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
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

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Prevocational Services

Service Definition (Scope):

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 employability in 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.

The distinction between Vocational and Prevocational Services is that Prevocational Services, regardless of setting, are developed for the purpose of furthering habilitation goals that will lead to greater job opportunities. Vocational services teach job specific task skills required by a participant for the primary purpose of completing these tasks for a specific job and are delivered in an integrated work setting through Supported Employment. 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.

Individuals may be compensated in accordance with applicable Federal Laws.

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.

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.

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 certified MDMH program locations or in the greater community for the purpose of job exploration. 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. Non-Medical transportation must be provided to and from the program and for community integration/job exploration. Providers must assure accessibility for all participants.

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):*

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.

☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
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.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
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

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications ***(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):***

Service Title:	**Supported Employment**

Service Definition (Scope):

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.).

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.

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. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported Employment does not include volunteer work or unpaid internships.

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.).

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.

Assistance with toileting and hygiene may be a component part of Supported Employment but may not comprise the entirety of the service.

Non-medical 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. Providers must assure accessibility for all participants. 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.

Supported Employment includes services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include: assisting the individual to identify potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and starting a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.
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. Supported Employment is available after a business is launched to provide guidance and support, is not time limited, and may be needed for the life of the business based on the needs of the person. Medicaid funds may not be used to defray the 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.

Supported Employment does not include facility based or other types of services furnished in a specialized facility not part of the general workforce. Supported Employment cannot take place in a facility-based program.

Incentive payments that are made to an employer to encourage or subsidize the employer's hiring an individual with disabilities is not permissible.

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):***
	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.
☐	**Medically needy *(specify limits):***

Provider Qualifications ***(For each type of provider. Copy rows as needed)*:**

Provider Type ***(Specify)*:**	**License** ***(Specify):***	**Certification** ***(Specify):***	**Other Standard** ***(Specify):***

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.

Verification of Provider Qualifications (***For each provider type listed above. Copy rows as needed)***:

Provider Type ***(Specify)***:	**Entity Responsible for Verification** ***(Specify):***	**Frequency of Verification** ***(Specify):***
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

Service Delivery Method. ***(Check each that applies)***:

☐	**Participant-directed**	☑	**Provider managed**

Service Specifications ***(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):***

Service Title:	Supported Living

Service Definition (Scope)*:*

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.

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.

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, periodic assessments to identify unique needs and concerns as well as potential barriers that may affect the person's health and wellbeing, 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.

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 to125 and §89-8-1 to 89-8-1 to 89).

Each individual must have an Activity Support Plan that is developed based on his/her PSS. Information from the PSS and Initial Discovery (which takes place during the first thirty (30) days of services) is to be included in the Activity Support Plan and must address the outcomes on his/her approved PSS.

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.

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):***

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.

☐ **Medically needy** ***(specify limits):***

Provider Qualifications ***(For each type of provider. Copy rows as needed)*:**

Provider Type ***(Specify)*:**	**License** ***(Specify):***	**Certification** ***(Specify):***	**Other Standard** ***(Specify):***
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.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type ***(Specify)*:**	**Entity Responsible for Verification** ***(Specify):***	**Frequency of Verification** ***(Specify):***
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

Service Delivery Method. ***(Check each that applies)*:**

☐	**Participant-directed**	☑	**Provider managed**

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: In-Home Respite

Service Definition (Scope):

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.

Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan. Allowable activities include:

* Assistance with personal care needs such as bathing, dressing, toileting, grooming

* Assistance with eating and meal preparation

* Assistance with transferring and/or mobility

* Assistance with cleaning the individual's personal space

* Leisure activities

MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all In-Home Respite staff.

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)*:

The State covers In-Home Respite for individuals enrolled in services in this benefit 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.

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.

Family members providing In-Home Respite must be identified in the Plan of Services and Supports.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
In-Home Respite 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.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
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

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	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):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	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.
○	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. *(Specify criteria):*

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

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):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	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. (*Specify the areas of the state affected by this option)*:

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	☐	☐
	☐	☐

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

●	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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):*

●	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
	☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

●	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(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.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

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.)

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data &*	Data Source – LTSS Sample – 100%

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

Requirement	*Service plans a) address assessed needs of 1915(i) participants*
Discovery	
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data & sample size)*	Data Source – LTSS Sample Size: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	*Service plans a) address assessed needs of 1915(i) participants*
Discovery	
Discovery Evidence *(Performance Measure)*	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 who reported receiving services.
Discovery Activity *(Source of Data & sample size)*	Data Source – Final Rule Monitoring Tool Sample Size – 95% confidence interval +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually at recertification
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

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

Requirement	***Service plans c) document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data & sample size)*	Data Source –IDD Community Support Program PSS Review Checklists Sample Size – 100% review
Monitoring Responsibilities	MDMH
(Agency or entity that conducts discovery activities)	
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH
Frequency *(of Analysis and Aggregation)*	Quarterly

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

Requirement	***Eligibility Requirements: b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS State Plan. N: Number of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. D: Total number of 1915(i) evaluations.
Discovery Activity *(Source of Data & sample size)*	Data Source - LTSS Sample Size - 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***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.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrolled recipients whose 1915(i) benefits needs-based eligibility criteria was re-evaluated annually. N: Number of enrolled recipients whose 1915(i) benefits needs-based eligibility criteria was re-evaluated annually. D: Number of enrolled recipients.
Discovery Activity *(Source of Data & sample size)*	Data Source: Monitoring Checklist, LTSS Sample Size: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data & sample size)*	Data Source - DMH Certification Database Sample – 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM/MDMH
Frequency *(of Analysis and Aggregation)*	Annually

Discovery	
Requirement	***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).***
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data & sample size)*	Data Source – MDMH Written Report of Findings Sample size -100% reviewed
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	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.
Discovery Activity *(Source of Data & sample size)*	Data Source - QIS Tracking Spreadsheet Sample size – 100% review
Monitoring	DOM/MDMH
Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery		
	Discovery Evidence *(Performance Measure)*	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.
	Discovery Activity *(Source of Data & sample size)*	Data Source - MMIS system. Data are claims paid for 1915(i) services. Sample Size - Less than 100% Review; Representative Sample: = +/-5% margin of error to 95% confidence interval.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and*	DOM
	aggregates remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

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

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

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations that were initiated/completed regarding unexplained deaths, abuse, neglect, exploitation, and unapproved restraints as required by MDMH. N: Number of incident reviews/investigations that were addressed/resolved as approved in the 1915(i). D: Total number of incident reviews/investigations.
Discovery Activity *(Source of Data & sample size)*	Data Source – MDMH Serious Incidents Tracking System Sample Size– 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDMH
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDMH/DOM
Frequency *(of Analysis and Aggregation)*	Continuously and Ongoing

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

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 qualify 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.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

TARGETED CASE MANAGEMENT SERVICES FOR BENEFICIARIES WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES (IDD) IN COMMUNITY-BASED SETTINGS

A. Target Group:

The target group is defined as beneficiaries with a confirmed diagnosis of Intellectual and/or Developmental Disabilities (IDD) and Autism Spectrum Disorders as defined by 42 C.F.R. § 483.102 and 45 C.F.R. § 1385.3, and is likely to continue indefinitely resulting in substantial functional limitations with two (2) or more life activities which include receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

The target group does not include individuals between ages twenty-two (22) and sixty-four (64) who are served in Institutions for Mental Disease (IMD) or individuals who are inmates of public institutions.

B. Areas of the State in which services will be provided:

_X_ Entire State,

___ Only in the following areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide),

C. Comparability of Services:

____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act,

_X_ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted Case Management services are defined as the coordination of services to assist beneficiaries, eligible under the State Plan within the target group, in gaining access to needed medical, social, educational and other services. Targeted Case Management is responsible for identifying individual problems, needs, strengths, resources and coordinating and monitoring appropriate services to meet those needs. Targeted Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the beneficiary access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the beneficiary's needs (42 CFR § 440.169(e)). Targeted Case Management ensures the changing needs of the beneficiary within the target group are addressed on an ongoing basis, that appropriate choices are provided from the widest array of options for meeting those needs, and includes the following services:

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1. A Comprehensive Assessment

   A comprehensive assessment is completed annually to determine a beneficiary's needs for services and supports including identification of any medical, educational, social, or other service needs. The assessment must include obtaining a beneficiary's history, identifying and documenting the needs of the beneficiary, and gathering information from sources such as family members, medical providers, social workers, and educators, as appropriate. Reassessments are conducted when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs.

2. Plan of Services and Supports

   An individualized Plan of Services and Supports (PSS) is developed based on the information collected through the comprehensive assessment. The PSS will be reviewed at a minimum every twelve (12) months or when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs which includes the following:

   a) Specific goals to address the medical, social, educational, and other services needed by the beneficiary,

   b) Activities to meet identified goals ensuring the active participation of the beneficiary and/or the beneficiary's authorized representative for health care decisions, and

   c) A course of action to respond to the assessed needs of the beneficiary.

3. Referral and Related Activities

   Referral and related activities help the beneficiary to obtain needed medical, social, and educational services by scheduling appointments and coordinating resources with providers and other programs to address identified needs and achieve specified goals from the PSS.

4. Monitoring and Follow-up Activities
   Performance of monitoring and follow-up activities include activities and contacts necessary to ensure that the PSS is effectively implemented and adequately addresses the needs of the beneficiary. Monitoring and follow-up activities may include involvement of the beneficiary, family members, service providers, or other entities or individuals. Contacts with a beneficiary's family or others for the purpose of helping the beneficiary access services are included in Targeted Case Management. Monitoring and follow-up activities are conducted monthly, or more often, depending on the needs of the beneficiary, with quarterly face-to-face visits to determine if:

   a) Services are being furnished in accordance with the beneficiary's PSS,

   b) Services in the PSS are adequate to meet the beneficiary's needs, and

   c) Changes in the needs or status of the beneficiary require adjustments to the PSS and service arrangements.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

5. Case Records

   Targeted Case Management providers maintain case records that document for all individuals receiving targeted case management as follows:

   (a) The name of the individual,

   (b) The dates of the case management service,

   (c) The name of the provider agency and the person providing the case management service,

   (d) The nature, content, units of the case management service received and whether goals specified in the care plan have been achieved,

   (e) Whether the individual has declined services in the care plan,

   (f) The need for, and occurrences of, coordination with other case managers,

   (g) A timeline for obtaining needed services, and

   (h) A timeline for reevaluation of the plan.

E. Qualifications of Providers:

Targeted Case Management services must be provided by a service provider certified by the Mississippi Department of Mental Health (DMH) as meeting the Operational Standards for Targeted Case Management for beneficiaries within the target group.

1. Targeted Case Managers must:

   a) Have a minimum of 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, or

   b) Be a Registered nurse with at least one-year relevant experience.

2. All Targeted Case Management staff must successfully complete training in Person-Centered Planning. Targeted Case Managers must demonstrate competencies in the application of the principles of Person Centered Planning (PCP) in Plans of Services and Supports (PSS) as identified in the DMH Record Guide. All PSSs are submitted to DMH for approval. The PSS must adhere to the DMH Record Guide requirements in order to demonstrate competencies in PCP.

3. The Division of Medicaid will implement methods and procedures to enroll DMH Targeted Case Management service providers who serve beneficiaries within the target group. Targeted Case Management providers must demonstrate:

   a) Capacity to provide Targeted Case Management services,

   b) At least one (1) year of experience with coordination of services for individuals within the target group, and

   c) Maintenance of financial accountability rules as for any other provider participating in the

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Medicaid program.

F. Freedom of Choice:

The state assures that the provision of Targeted Case Management services to the target group will not restrict an individual's freedom of choice of providers in violation of Section 1902(a)(23) of the Act.

1. Targeted Case Management services will be available at the option of the beneficiary.

2. A beneficiary who wishes to receive Targeted Case Management services will have freedom of choice to receive Targeted Case Management services from any qualified provider of these services.

3. Beneficiaries will have freedom of choice of the qualified Medicaid providers of other medical care as covered elsewhere in this Plan.

G. Access to Services:

1. Targeted case management services will not be used to restrict an individual's access to other services under the state plan,

2. Individuals will not be compelled to receive targeted case management services, condition receipt of targeted case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted case management services, and

3. Providers of targeted case management services do not have the authority to authorize or deny the provision of other services under the state plan.

H. Targeted Case Management services are not provided to beneficiaries who are in institutions except for individuals transitioning to a community setting. Case management services will be made available for up to one-hundred eighty (180) consecutive days of a covered stay in a medical institution.

I. Limitations:

Targeted Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted Case Management does not include, and FFP is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which a beneficiary has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR § 441.18(c)).

FFP is only available for Targeted Case Management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).”

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☑	HCBS Personal Care

Supported Living

Supported Living is reimbursed for a maximum of eight (8) hours per day in 15-minute units. The rate is tiered according to the number of person's served by the same staff member at one time.

Effective November 1, 2023, a link to the published fee schedule can be found by going to the Home and Community Based Services (HCBS) Waivers section of https://medicaid.ms.gov/providers/fee-schedules-and-rates/#, clicking on the date for Intellectual and Developmental Disabilities 1915(i) Community Support Program.

State-developed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i. The agency's fee schedule rate was set as of November 1, 2023, and is effective for services provided on or after that date. All rates are published on the agencies website at Fee Schedules and Rates - Mississippi Division of Medicaid (ms.gov).

Payment for Supported Living services as outlined per Attachment 3.1 page 20 – 21 is reimbursed in accordance with the Intellectual and Developmental Disabilities 1915(i) Community Support Program fee schedule found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. This 4.4% average projected MEI was applied annually to the prior 1915(i) Fee For Service rates to develop the 1915(i) Y1 (SFY 2024) estimates. Once the comprehensive studies are completed, DOM will submit amendments to further update rates/methodologies where appropriate. Due to the ongoing rate study, no rate methodologies were updated other than as described as above.

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

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

☐	HCBS Adult Day Health
☑	HCBS Habilitation

Day Services Adult

Day Services Adult is reimbursed for a maximum of six (6) hours per day in 15-minute units. The rate is tiered according to the person's level of need identified by their ICAP score. People receiving Day Services-Adult may also receive Prevocational Services but not at the same time of day.

Effective November 1, 2023, a link to the published fee schedule can be found by going to the Home and Community Based Services (HCBS) Waivers section of https://medicaid.ms.gov/providers/fee-schedules-and-rates/#, clicking on the date for Intellectual and Developmental Disabilities 1915(i) Community Support Program.

State-developed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i. The agency's fee schedule rate was set as of November 1, 2023, and is effective for services provided on or after that date. All rates are published on the agencies website at Fee Schedules and Rates - Mississippi Division of Medicaid (ms.gov).

Payment for Day Services Adult as outlined per Attachment 3.1 page 11 – 13 is reimbursed in accordance with the Intellectual and Developmental Disabilities 1915(i) Community Support Program fee schedule found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. This 4.4% average projected MEI was applied annually to the prior 1915(i) Fee For Service rates to develop the 1915(i) Y1 (SFY 2024) estimates. Once the comprehensive studies are completed, DOM will submit amendments to further update rates/methodologies where appropriate. Due to the ongoing rate study, no rate methodologies were updated other than as described as above.

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

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

Prevocational Services

Prevocational Services are reimbursed for a maximum of six (6) hours per day in 15-minute units. The rate is tiered according to the person's level of need identified by their ICAP score. People receiving Prevocational Services may also receive Day Services-Adult but not at the same time of day.

Effective November 1, 2023, a link to the published fee schedule can be found by going to the Home and Community Based Services (HCBS) Waivers section of https://medicaid.ms.gov/providers/fee-schedules-and-rates/#, clicking on the date for Intellectual and Developmental Disabilities 1915(i) Community Support Program.

State-developed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i. The agency's fee schedule rate was set as of November 1, 2023, and is effective for services provided on or after that date. All rates are published on the agencies website at Fee Schedules and Rates - Mississippi Division of Medicaid (ms.gov).

Payment for Prevocational services as outlined per Attachment 3.1 page 14 – 16 is reimbursed in accordance with the Intellectual and Developmental Disabilities 1915(i) Community Support Program fee schedule found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. This 4.4% average projected MEI was applied annually to the prior 1915(i) Fee For Service rates to develop the 1915(i) Y1 (SFY 2024) estimates. Once the comprehensive studies are completed, DOM will submit amendments to further update rates/methodologies where appropriate. Due to the ongoing rate study, no rate methodologies were updated other than as described as above.

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

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

Supported Employment
Supported Employment Services – Job Development is reimbursed for a maximum of 90 hours per year in 15-minute units.

Supported Employment Services – Job Maintenance is reimbursed up to a maximum amount of 100 hours per month in 15-minute units. The rate is tiered according to the number of person's served by the same staff member at one time.

Effective November 1, 2023, a link to the published fee schedule can be found by going to the Home and Community Based Services (HCBS) Waivers section of https://medicaid.ms.gov/providers/fee-schedules-and-rates/#, clicking on the date for Intellectual and Developmental Disabilities 1915(i) Community Support Program.

State-developed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i. The agency's fee schedule rate was set as of November 1, 2023, and is effective for services provided on or after that date. All rates are published on the agencies website at Fee Schedules and Rates - Mississippi Division of Medicaid (ms.gov).

Payment for Supported Employment services as outlined per Attachment 3.1 pages 17-19 is reimbursed in accordance with the Intellectual and Developmental Disabilities 1915(i) Community Support Program fee

schedule found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. This 4.4% average projected MEI was applied annually to the prior 1915(i) Fee For Service rates to develop the 1915(i) Y1 (SFY 2024) estimates. Once the comprehensive studies are completed, DOM will submit amendments to further update rates/methodologies where appropriate. Due to the ongoing rate study, no rate methodologies were updated other than as described as above.

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

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

☑ HCBS Respite Care

In-Home Respite services are reimbursed for a maximum of four (4) hours per day billed in 15-minute units. The rate is tiered according to the number of person's served by the same staff member at one time.

Effective November 1, 2023, a link to the published fee schedule can be found by going to the Home and Community Based Services (HCBS) Waivers section of https://medicaid.ms.gov/providers/fee-schedules-and-rates/#, clicking on the date for Intellectual and Developmental Disabilities 1915(i) Community Support Program.

State-developed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i. The agency's fee schedule rate was set as of November 1, 2023, and is effective for services provided on or after that date. All rates are published on the agencies website at Fee Schedules and Rates - Mississippi Division of Medicaid (ms.gov).

Payment for In-Home Respite services as outlined per Attachment 3.1 page 22 – 24 is reimbursed in accordance with the Intellectual and Developmental Disabilities 1915(i) Community Support Program fee schedule found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. As In-Home Respite is a new service and comparable to the ID/DD Waiver In-Home Respite service, a 4.4% average projected MEI was applied annually to the existing In-Home Respite waiver rate to develop the 1915(i) Y1 (SFY 2024) estimate. Once the comprehensive studies are completed, DOM will submit amendments to further update rates/methodologies where appropriate. Due to the ongoing rate study, no rate methodologies were updated other than as described as above.

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

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

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	