SUMMARY

Mississippi Division of Medicaid
Revised Statewide Transition Plan Summary
1915(c) and 1915(i) Home and Community-Based (HCB) Programs
Compliance with HCB Settings
September 16, 2015

Background

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, effective March 17, 2014, which amends the requirements for qualities of home and community-based (HCB) settings. These requirements reflect CMS's intent that individuals receive services and supports in settings that are integrated in and support full access to the greater community. The final rule requires the use of a person-centered planning process to develop a participant/beneficiary's annual Plan for Services and Supports (PSS). A summary of the requirements included in the final rule is provided below. The complete set of federal regulations for the final regulations can be found on the CMS website *at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html*

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. The setting must:

- Be integrated in and support full access to the greater community;
- Be selected by the individual from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices; and
- Facilitate choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include that the individual:

- Has a lease or other legally enforceable agreement providing similar protections;
- Has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;

- Has Control over his/her own schedule including access to food at any time;
- Can have visitors at any time; and
- Has Physical access to the setting.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

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

Overview of Mississippi's 1915(c) and 1915(i) HCBS Programs

Mississippi's 1915(c) and 1915(i) HCB programs use a person directed, person focused planning process in determining the type and level of supports to incorporate each participant/beneficiary's unique desires and wishes in the HCB services they receive. The goal is to provide supports for participants/beneficiaries to receive services in settings that meet the requirements of the final rule.

Mississippi's Statewide Transition Plan for HCB Residential and Non-Residential Settings include the following 1915(c) and 1915(i) HCB programs:

1. **1915(i) State Plan Services:**
   The 1915(i) State Plan provides habilitation services in non-residential settings which must meet the HCB settings to beneficiaries including:
   - Day Habilitation, and
   - Prevocational.

   The 1915(i) State Plan provides habilitative services in a setting which does not apply to the final rule including:
   - Supported Employment.

2. **1915(c) Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver:**
   ID/DD Waiver services provided in non-residential settings which must meet the requirements of the HCB settings include:
   - Behavior Support,

- Day Services-Adult,
- Community Respite,
- Supported Employment,
- Prevocational Services, and
- Job Discovery.

ID/DD Waiver services provided in a residential setting which must meet the requirements of the HCB settings include:

- Supervised Living.

ID/DD Waiver services provided in the participant's private home or a relative's home which the Division of Medicaid presumes meet the requirements of the HCB settings include:

- Home and Community Supports,
- Occupational Therapy,
- Physical Therapy,
- Speech Therapy,
- Crisis Support,
- Crisis Intervention,
- In-Home Nursing Respite,
- Supported Living,
- Transition Assistance,
- Support Coordination and
- Specialized Medical Supplies.

3. 1915(c) Elderly and Disabled (E&D) Waiver:

E&D Waiver services provided in a non-residential setting which must meet the requirements of the HCB settings include:

- Adult day care services.

E&D Waiver services provided in the participant's private home or a relative's home which the Division of Medicaid presumes meet the requirements of the HCB settings include:

- Case management,
- Home-delivered meals,
- Personal care services,
- Institutional respite services,
- In-home respite,
- Transition Assistance, and
- Expanded home health visits.

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

- Institutional respite services.

4. 1915(c) Assisted Living (AL) Waiver:

AL Waiver services are provided in a residential setting which must meet the requirements of the HCB settings.

- Case management,
- Personal care,
- Homemaker services,
- Attendant care,
- Medication oversight,
- Medication administration,
- Therapeutic social recreational programming,
- Intermittent skilled nursing services,
- Assisted residential care for acquired traumatic brain injury,
- Transportation, and
- Attendant call system.

5. 1915(c) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver:

Based upon the State's assessment of the HCBS settings in the TBI/SCI waiver, the State confirms that services in this waiver are rendered in a HCB setting. Waiver participants reside in private homes or a relative's home which the Division of Medicaid presumes meet the requirements of the HCB settings. The TBI/SCI waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

6. 1915(c) Independent Living (IL) Waiver:

Based upon the State's assessment of the HCB settings in the IL waiver, the State confirms that services in this waiver are rendered in a HCB setting. Waiver participants reside in private homes or a relative's home which the Division of Medicaid presumes meet the requirements of the HCB settings. The IL waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

The October 21, 2014, submission to CMS of the four (4) Transition Plans for HCB settings consisted of the required elements listed below:

1. Two (2) public notices were published on September 17, 2014, and September 24, 2014, in the Clarion Ledger which notified the public of public hearings which were held at the following times:
    - Assisted Living (AL) Waiver – 9 a.m.
    - Independent Living (IL) Waiver – 10 a.m.
    - Elderly and Disabled (E&D) Waiver – 11 a.m.
    - Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver – 1 p.m.
    - 1915(i) State Plan Services – 2 p.m.
2. Two (2) Public Hearings held on September 26, 2014, at the Woolfolk Building in Jackson, MS, with teleconference, and October 3, 2014, at the War Memorial Building in Jackson, MS,

3. Comments received during the thirty (30) day comment period September 17 – October 17, 2014 were:
    - The Arc of Mississippi requested the Personal Outcome Measures as either a substitute for or accompaniment to the NCI for data collection for measuring quality.
      Response: The Division of Medicaid has not elected to use the Personal Outcome Measures for data collection for measuring quality for the E&D and AL waivers because the Division of Medicaid is using the NCI performance measure for the IDD population. To use the POM would be a duplication of efforts. The Division of Medicaid currently is expanding the NCI data collection for the Aged and Disabled population which will achieve the same result.
    - Beth Porter with Disability Rights Mississippi commented that the MS Statewide Transition Plan was not accessible to the constituents being served and the plan needed to be more accessible.
      Response: Ms. Porter was referred to the Division of Medicaid's website and the location of the transition plans as well as instructed her to contact the Division of Medicaid to obtain a copy of the transition plan if unable to download and print.
    - Beth Porter with Disability Rights Mississippi commented "Under Section 3, Quality Management Provider Monitoring it doesn't look like you're doing any changes. It just says annually. You're just going to leave it annually instead of changing any of that? I think that should be changed -- well, that's my comment. I think that should be changed to quarterly. Thank you."
      Response: The Division of Medicaid and DMH presently do not have the staffing capacity to perform quarterly monitoring. However, a committee consisting of stakeholders will be formed and will meet by June 30, 2015, to assist in evaluating the feasibility of performing quarterly or biannual monitoring activities.
    - Bobby Barton, the Executive Director of Warren Yazoo Mental Health Service, Region 15 in Vicksburg, MS, commented that he would like for all community mental health centers in Mississippi be given the opportunity to provide IDD waiver services and/or the privilege to apply for waivers prior to private providers coming from outside of Mississippi.
      Response: The Division of Medicaid and DMH do not prohibit any qualified provider from providing waiver services.
    - Suzette Marrow, a parent of a participant living in a Supervised Living apartment, commented that she would like her son to remain living at his current residence and to be able to continue in the Supervised Living Program.
      Response: Every Medicaid provider will be afforded the opportunity to meet the requirements in the federal rule. Participants//beneficiaries who receive HCBS in HCB settings not in compliance with the federal regulations and/or their legal representative will be notified by the Division of Medicaid in writing no later than March 1, 2018. The participant/beneficiary will be required to choose and relocate to an alternative HCB setting which meets federal regulations to receive their HCBS before March 1, 2019. This will allow participants/beneficiaries one (1) years' time to make an informed choice of alternate HCB settings and HCBSs

which are in compliance with the federal rule. The notification will include the Division of Medicaid's appeal process according to Miss. Admin. Code Title 23, Part 300 and for IDD individuals will also include the appeals process for DMH. The participant/beneficiary's case manager/Support Coordinator will convene a person-centered planning meeting with the participant/beneficiary and/or their legal representative to adequately plan for the relocation.

CMS Review and Revised Statewide Transition Plan

On February 6, 2015, the Mississippi Division of Medicaid received a review from CMS of the October 21, 2014, submission of the Transition Plans which requires the following revisions to the Transition Plans for HCB settings.

1. The combination of each of the four (4) individual Transition Plans into one (1) Revised Statewide Transition plan. See attached Revised Statewide Transition Plan Timeline.

2. Two (2) public notices published on Wednesday, March 11, 2015, and Sunday, March 15, 2015, in the following newspapers: Clarion Ledger, Commercial Appeal and the Sun Herald. The public notices contained the dates, times and locations of three (3) additional public hearings and how the public could submit comments via a teleconference number during the public hearings, e-mail or standard mail. See attached public notices. Additionally, the Division of Medicaid broadcasted radio announcements regarding the public hearings and availability of the Revised Statewide Transition Plan.

3. Availability of the 1915(c) and 1915(i) HCB settings public notice, Revised Statewide Transition Plan, public comments and the Division of Medicaid's responses on the Division of Medicaid's website homepage at www.medicaid.ms.gov, and for those individuals without electronic/internet access, at each Medicaid Regional Office, at each Mississippi State Department of Health clinic, and at the Issaquena Department of Human Services office, at each Assisted Living facility, at each Adult Daycare facility, and Case Management agency. To request a copy be mailed or e-mailed contact the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi, 39201 or by calling 601-359-5248 or by e-mailing at Margaret.wilson@medicaid.ms.gov. Additionally, the Division of Medicaid notified the following stakeholders of the Revised Statewide Transition Plan, the public notice and public hearings and requested them to assist in notifying their constituents, including, but not limited to:

    - Disability Rights of Mississippi,
    - The Arc of Mississippi,
    - Mississippi Council on Developmental Disabilities,
    - The Five DMH IDD Regional Centers,
    - The Ten Planning and Development Districts (PDDs),
    - DMH, and
    - Mississippi Access to Care (MAC) stakeholders.

4. A thirty (30) day comment period from March 11, 2015, through April 10, 2015:
   a. Verbal and written comments will be received at the following three (3) public hearings and teleconferences:
      1) Thursday, March 19, 2015, at 2:30 and 6:30 p.m. at the Hattiesburg Regional Office, 6971 Lincoln Road Extension, Hattiesburg, MS 39402. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
      2) Tuesday, March 24, 2015 at 2:30 and 6:30 p.m. at the Grenada Regional Office, 1109 Sunwood Drive, Grenada, MS 38901-6601. To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
      3) Thursday, March 26, 2015, at 2:30 and 6:30p.m., at the Jackson Regional Office, 5360 I-55 North, Jackson, MS 39211 To join the teleconference dial toll-free 1-877-820-7831 and enter the participant passcode 3599662.
   b. Written comments will be received via:
      1) Mail at the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi, 39201, or
      2) E-mail to Margaret.Wilson@medicaid.ms.gov.

5. Comments received during the 30 day comment period from March 11, 2015, through April 10, 2015:
   - Pandora Redmond with Professional Staffing Solutions, Greenville, Mississippi, Adult Daycare Center commented: In all due respect, with all the requirements that are asked and all the changes that have been made, we have been in compliance with a lot and we are working on enforcing some of the things that have been implemented. But one of the concerns we have had in the past is the expense of doing a lot of things, especially with the meals having variety. We do cater to the diet each client is supposed to have according to their doctor. My question is; with all the requirements, it's going to incur an expense. This is more of an expense for the daycare centers or whatever facility that is, especially if you have a lower census than most of the ones that have been in business for years. And my question is; will there be an increase in compensation to these centers for the types of services that you're offering? We are in compliance, but like I said, in order to make it even a greater individualized plan of care, we have a limited budget. And most of these clients that we serve do have some type of deficit in their care. I'm a registered nurse and I have two LPNs on staff, as well as two RNs, and that is an expense by itself. To give the care that is needed, like I said, we will have to have more compensation for the services.
     Response: The Division of Medicaid will take into consideration the new requirements when the fee schedule is reviewed by the actuary firm.
   - Carrol Hudspeth with Runnels Creek commented: Is there a new set of regulatory minimum standards issued for Adult Day Care Services to comply with the transition? If so, how may I get an updated copy?
     Response: The Division of Medicaid is in the process of reviewing our policies, procedures and The Mississippi Administrative Code Title 23 Division of

Medicaid to ensure compliance with the CMS Final Rule for Home and Community-Based Settings. New policies, procedures and/or administrative code rules will be published on our website as they are updated. Additionally, the new minimum federal regulatory requirements can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

- Beth Porter with Disability Rights Mississippi commented: In general, DRMS would like to express its concern that person centered planning be provided to all waiver participants, not just those who live in residential settings. The plan should be clear that person centered planning will be provided to all who may live independently in the community, such as IL and TBI/SCI waiver participants. In addition, we express our concern that the plan is still too general and should include transportation if needed, for all waiver participants to have access to fully integrated activities in the community.
  Response: The Person-Centered Planning process is required for all waiver participants, including in the Independent Living(IL) and Traumatic Brain Injury/Spinal Cord Injury(TBI/SCI) waivers. An update to Mississippi's Statewide Transition Plan will be made to reflect that Person Centered Planning is required throughout each of the 1915(C) and 1915(i) HCB waivers. Please see response below to question regarding transportation.
- Specific Issues related to the Currently Proposed Statewide Transition Plan received from Disability Rights of Mississippi on April 10, 2015.
  - We are disappointed in the relatively non-specific nature of the plan. We would like to see a much greater level of detail and more specific tasks.
    Response: The purpose of the Statewide Transition Plan is to describe how the state will bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements at 42 CFR §441.301(c)(4)(5) and § 441.710(a)(1)(2). CMS provided a HCBS Basic Element Review Tool for Statewide Transition Plans Version 1.0 to describe the level of detail required for the Statewide Transition Plan. The Division of Medicaid used this review tool to ensure that the required level of detail was present in the Revised Statewide Transition Plan in order to successfully bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements
  - The plan is not clear as to whether any of the compilations of information, such as the compilations of self-assessment results, assignment of providers to categories, or written report of findings, will be available to the public. We believe that they should be. It is important that such information be transparent, so that the public can offer the State information as to the accuracy of the conclusions. There should be similar transparency in regard to the plans of correction. The disability community has direct experience with and knowledge of these settings and how they operate on a day-to-day basis, often from the perspective of the participants. We ask that the state make the assessment results and information publicly available, and that it provide a period of

public comment so the community may offer information as to the accuracy of the classification of the settings or other information. There should be similar transparency in regard to the plans of correction. We also request that any determination that a setting should be submitted to heightened scrutiny be publicly posted, along with information providing the justification for this decision. The community should be allowed to comment on this information and decision before it is submitted to CMS for heightened scrutiny.

Response: The category in which each provider falls into will be posted to the Division of Medicaid website. The Division of Medicaid understands the importance of the public's notice of and input on the Statewide Transition Plan and will continue to comply with all state and federal regulations during the implementation of the Statewide Transition Plan.

- We have a growing concern about the decision to make the waiver agents responsible for performing assessments.

  Response: CMS has offered guidance in regard to complying with 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2) which states that providers can "self-assess" their compliance with the Federal requirements. The Division of Medicaid has used this guidance by including self-assessments as part of the Revised Statewide Transition Plan. Additionally, the Revised Statewide Transition Plan also includes an action item in which the participants/legal representatives assess the settings and the Division of Medicaid conducts on-site visits to assess the settings.

- It is critical that HCBS participants be educated throughout this process, as their settings may be undergoing changes, which they need to understand. They should also know what their experience in the HCBS programs is supposed to be, so they can self-advocate and complain to the appropriate people or entities. The plan does not identify a process for a person to complain about a setting's adherence to the rules, but there should be a clearly identified entity responsible for receiving complaints about a setting and the process through which they respond to an individual's complaint. We appreciate that there is some indication of education for participants and families in the timeline (p. 18), but these groups are not included in the education mentioned in the narrative (p. 11). We ask that the plan clearly describe educational activities to participants, families, and community members, and that the State plan do so at points throughout implementation.

  Response: The Division of Medicaid, with guidance from CMS, will train state level and field staff of the Division of Medicaid and DMH, as well as participants, families and other stakeholders about the requirements of the final rule to correct non-compliance issues. The Division of Medicaid and DMH will require case managers/Support Coordinators to provide a handout to currently enrolled participants and/or legal representatives that lists the specific requirements of HCB settings as outlined in federal

regulations including the ways of submitting a complaint about a setting's adherence to the rules and will require that this handout also be included in the participant's admission process.

- The plan does not mention Mississippi's plans to evaluate the current system at the point of the 2017 revision to determine the gaps in the provider system, and evaluate the need to develop new providers or settings to ensure the choices that an individual is supposed to have in the person-centered planning process, and to ensure that individuals will have providers to switch to after the 2018 notices of noncompliance. We commend the State for providing at least one year of advance notice and due process protections to individuals who need to switch settings, but are concerned that the date is very close to the end of the transition period, and there may not be sufficient time to develop sufficient settings to meet the need. We encourage the State to include an analysis of need early on in the transition process, so new providers can be developed.
  Response: The Division of Medicaid implements an ongoing provider enrollment process which includes education and outreach that will continue to be used to meet participant needs.
- It is not clear from Mississippi's plan how the different state agencies are working together and whether the same surveys are being used. It is important that there be overarching supervision so that there is consistency in assessment and implementation across the different agencies running the HCBS programs.
  Response: The same surveys are being utilized for residential and non-residential settings by each appropriate state agency. The Division of Medicaid understands the need for consistency in the evaluation process and will develop a uniform set of standards for surveying. The Division of Medicaid will provide staff training to ensure consistency during the assessment and implementation process.
- Transportation is a barrier to community integration in the HCBS program. Transportation is a barrier to integration for individuals on the waivers. The review of the services provided by the waiver needs to look at how well the waiver services are accomplishing the stated goals, and whether the funding of the service is sufficient to meet the community integration requirement—e.g., whether the rate of pay is sufficient and policies are sufficiently lenient to attract well-qualified personal care assistants who would be willing and able to assist in community integration activities, such as community outings, errands, etc. When evaluating the community nature of any setting, transportation from that setting should be evaluated, as should how or whether the setting overcomes the lack of readily available transportation with other services. Transportation is an important piece of community integration, because a person needs to be able to get to activities and places in the community; therefore, it should be a constant consideration when evaluating settings, services, and the overall effectiveness of the State's various HCBS

programs.

Response: The Division of Medicaid requires all providers to comply with federal and state regulations regarding access to transportation in HCB settings. The Administrative Code will be revised to include requirements regarding access to transportation.

- There appears to be a lack of opportunity for input from the numerous disability agencies and organizations that constitute the disability advocacy community. There is no mention of disability advocacy organizations being involved in the vetting process for the statewide assessment tool or other pieces of this plan. The plan is largely centered on providers, assistance to providers, and provider compliance. We ask that the State more equally include all relevant stakeholders throughout implementation of the plan. We ask that the State establish a Transition Plan Stakeholder committee with a fair representation of advocacy organizations that will be allowed to review information and provide comment. We think this would be helpful to the State and ease implementation.

  Response: A Statewide Transition Plan stakeholder committee will be formed and will meet no later than June 30, 2015.

- CMS officials have confirmed that any comment period for a transition work plan, or for an interim transition plan, does not lessen a state's obligation to solicit and accept public comment on a final substantive transition plan. We expect that the State will clearly announce when updates to the plan are available, and will do so in such a way that the information will reach all stakeholders, including specific efforts to reach participants and their families. Relying on electronic notices or mechanisms used to communicate with provider networks is insufficient, and the State should make a communication plan that will ensure reliable dissemination of information in an accessible way. We would also suggest that, for the next iteration of the transition plan, the State hold information sessions across the state that can be accessed by telephone, so that the plan may be explained to participants, families, providers and community members. We also suggest that the state take comments at these sessions by making note of the questions and concerns raised at the meetings, rather than requiring that people formally comment at the meetings.

  Response: The Division of Medicaid has complied with 42 CFR 441.301(c)(4) regarding public input and notice requirements for the transition plan. The public notice for the four (4) Transition Plans for HCB settings, submitted to CMS on October 21, 2014, consisted of two public notices in the Clarion Ledger, two public hearings, and a thirty (30) day comment period. The public notice for the Revised Statewide Transition Plan, to be submitted to CMS on April 24, 2015, consisted of two public notices which were published in three different newspapers, three public hearings at three separate locations throughout the state of

Mississippi, a radio announcement regarding the public hearings and availability of the Revised Statewide Transition Plan, availability of the Revised Statewide Transition Plan at, at www.medicaid.ms.gov, and for those individuals without electronic/internet access, paper copies at the public hearings, at each Medicaid Regional Office, at each Mississippi State Department of Health clinic, and at the Issaquena Department of Human Services office, at each Assisted Living facility, at each Adult Daycare facility, and Case Management agency. The public was notified of the opportunity to request a copy be through standard mail or e-mail. Additionally, the Division of Medicaid notified the following stakeholders of the Revised Statewide Transition Plan, the public notice and public hearings and requested them to assist in notifying their constituents, including, but not limited to:

- *Disability Rights of Mississippi,*
- *The Arc of Mississippi,*
- *Mississippi Council on Developmental Disabilities,*
- *The Five DMH IDD Regional Centers,*
- *The Ten Planning and Development Districts (PDDs),*
- *DMH, and*
- *Mississippi Access to Care (MAC) stakeholders.*

The public was also given the opportunity to give comments on the Revised Statewide Transition plan at the three public hearings, via email and via standard mail.

The Division of Medicaid understands the importance of the public's notice of and input on the Statewide Transition Plan and will continue to comply with all state and federal regulations during the implementation of the Statewide Transition Plan.

CMS Review and Revised Statewide Transition Plans

6. The comprehensive assessment will be completed by October 27, 2015, and include the following:

   Review of the following waivers for compliance with HCB setting requirements including, but not limited to, Appendix C and D, and submit waiver amendments as applicable:
   - AL,
   - E&D,
   - IL, and
   - ID/DD.

   The Miss. Admin. Code Title 23: Division of Medicaid, Part 208: Home and Community-Based Services Long-term Care will be filed with the Mississippi Secretary of State's Office with an effective date of June 1, 2016, as follows:

- Divide Part 208 Home and Community- Based Services Long-term Care into two Sub-Parts to include:
  - New Sub-Part 1: Home and Community-Based Services General Requirements to include:
    - New Chapter 1: Residential Settings, and
    - New Chapter 2: Non-Residential Settings.
  - New Sub-Part 2: Home and Community-Based Services to include:
    - Chapter 1: Elderly and Disabled (E&D) Waiver, Rule 1.6.A.a.2.: Covered Services, Adult Day Care Services,
    - Chapter 2: Independent Living (IL) Waiver, Rule 2.7: Participant Direction of Services,
    - Chapter 3: Assisted Living Waiver, Rule 3.6.C.: Covered Services,
    - Chapter: Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI), Rule 4.5: Covered Services ,
    - Chapter 5: Individuals with Intellectual/Developmental Disabilities Waiver, Rule 5.5: Covered Services, and
    - Chapter 7: 1915(i) State Plan Services, Rule 7.5.C: Covered Services.

The DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers, Title 24: Mississippi Administrative Code, Pt. 2, R. 1.1 – 59.6. Rules cited below contain specific qualities of home and community based settings and will be revised.

Rule	Content Related to HCBS Settings
13.5	Accessibility of residential and non-residential settings
14.1	Rights of people receiving services
14.2	Staff roles in protecting the rights of people receiving services
14.3	Ethical conduct
14.4	Cultural competency
14.5	Grievance policies and procedures
16.5	Service and program design – promotion of independent decision making
16.7	Confidentiality
28.1	Requirements for the provision of Day Services – Adult
28.3	Requirements for the provision of Prevocational Services
30.1	Definitions of community living services
30.2	Community living policies and handbook for people receiving services
30.5	Fee agreements
32.1-4	Environment and safety requirements for Supervised Living Services
33.1-2	Requirements for the provision of Supervised Living Services

An amendment will be made to add a rule in Chapter 16 of the DMH Operational Standards to address specific HCBS setting requirements not already addressed in the above referenced rules. An amendment will be made to add a rule in Chapter 30 of the DMH Operational Standards to address rental and/or lease agreements in addition to the already required fee agreements.

Identified HCB setting requirements are located in the following documents and guidance contains specific qualities of home and community based settings:

- Consent to Receive Services
- Rights of Individuals Receiving Services
- Consent to Obtain/Release Information
- Telephone/Visitation Agreement
- Plan of Services and Supports Guidance

Additional documents and guidance included in the comprehensive assessment are the Provider Reference Guide, On-Site Compliance Review (OSCR) processes, and HCB settings monitoring procedures. The revisions to these documents will be completed by the Division of Medicaid and other respective state agencies by June 1, 2016.

7. A sequential timeline which includes the completion and validation of the provider self-assessment tool. The provider self-assessment tool was developed by the Division of Medicaid for residential and non-residential HCB settings based on the Exploratory Questions issued by CMS.

   The provider self-assessments are to be completed and returned to the Division of Medicaid and DMH by the April 15, 2015, via Survey Monkey and hard copy. The provider self-assessments will help providers and the Division of Medicaid and DMH determine the extent providers currently meet the final rule, will be able to meet the final rule with modifications, or cannot meet the final rule. Training for providers on how to complete the provider self-assessment tool was held during December 15-31, 2014. The results of the provider self-assessments will be compiled by the Division of Medicaid and DMH by June 30, 2015.

   Each provider's self-assessment will be checked for validity by the validation review committee which consists of the Division of Medicaid, Offices of Long-Term Care and Mental Health, and DMH. The validation process will include an on-site validation visit of each provider's setting(s) and a representative "per setting" random sample of participant/beneficiary surveys during October 1, 2015, through February 28, 2016.

   The validation review will include a review of the CMS Exploratory Questions, DMH Operational Standards, Miss. Admin. Code Title 23, Part 208, licensing reports, MSDH and DMH surveys, the provider's policies and procedures, review of a sample of participant/beneficiary records, review of the residential and non-residential physical location and operations to ensure proximity to community resources and supports in practice, environment and safety reviews, personnel training and requirements including staffing patterns, staff qualifications, staff training, and the provider's responses to reported grievances and serious incidents. Participant/beneficiary surveys will be conducted by e-mail, hard copy mailings and/or phone surveys to a sample of participants/beneficiaries asking about their experiences in the HCB settings in order to

validate provider self-assessments. The participant/beneficiary surveys will be cross walked against specific setting criteria to provide their experiences in the settings during the on-site validation visit for comparison to the provider self-assessment.

The results of the validation review will determine each provider's category: Category I: Provider is in full compliance with the final rule; Category II: Provider is not in full compliance with the final rule and will require modifications; Category III: Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals; or Category IV: Provider is presumptively non-HCB. The outcome of the validation reviews will determine what, if any, remediation strategies are needed to bring each provider into compliance. Providers will be notified of their assigned category based on the completion of the validation review process by the Division of Medicaid and DMH. New providers seeking to provide HCBS who do not meet the HCB setting requirements in the final rule will not be approved as a Medicaid provider or receive DMH certification.

By April 1, 2017, the Division of Medicaid will submit an amended Statewide Transition Plan that includes the number of settings within each of the following categories consisting of PCH-AL facility services, Adult Day Services, Supervised Living, Pre-vocational Services, Day Habilitation and Day Services-Adult that: 1) fully align with the Federal requirements; 2) do not comply with the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or relocation of individuals; 4) are presumptively non-HCB, but for which the State will provide a date in which evidence and justification will be submitted to CMS to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings for evaluation by CMS through the heightened scrutiny process. These heightened scrutiny settings include the following:

- Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

- Settings in a building on the grounds of, or immediately adjacent to, a public institution;

- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

8. The process for non-compliant providers to submit a written Plan of Compliance (POC) based on results of the validation of the provider self-assessment. Non-compliance of HCB settings is determined during the validation of the provider self-assessment as described in #5 above. Providers determined to be non-compliant with the final rule will receive a Written Report of Findings (WRF) from the Division of Medicaid and/or DMH within forty five (45) days of the completion of the on-site validation visit. The Division

of Medicaid and DMH began the validation process on July 1, 2015, and anticipates completion of each of the 423 setting sites by December 31, 2017

Providers who receive a WRF must submit of a POC to the Division of Medicaid and/or DMH detailing changes in HCB settings validated as non-compliant and the timelines the provider will be in full compliance with the final rule. Providers must have their completed POC submitted within forty five (45) days of receipt of the WRF. The Division of Medicaid and DMH will review all submitted POCs for approval or request for additional information, if necessary, within forty five (45) days of receipt. A compilation list showing which category each provider falls into and the reasons for being placed into that category will be posted on the Division of Medicaid's website for public information. All non-compliant providers will be re-assessed through an on-site validation visit and a sample of participant/beneficiary re-surveys according to their submitted POC during the calendar year 2017 to determine if they have met the requirements of their POC. If the provider is still assessed to be non-compliant the provider will receive another WRF. Another POC must be completed and submitted to the Division of Medicaid and DMH within forty five (45) days after the receipt of the WRF. The Division of Medicaid and DMH will review the submitted POC for approval or request for additional information if necessary within forty five (45) days of receipt. A second on-site validation visit will be conducted following receipt the receipt of the POC during the calendar year 2017.

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

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

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

During calendar years 2015 and 2016, non-compliant providers will receive ongoing technical assistance, training and follow-up on-site validation visits to determine progress toward meeting their POC. The Division of Medicaid, with guidance from CMS, will train state level and field staff of the Division of Medicaid and DMH, as well as participants, families and other stakeholders about the requirements of the final rule to correct non-compliance issues. The Division of Medicaid will require case managers to provide a handout to currently enrolled participants and/or legal representatives that lists the specific requirements of HCB settings as outlined in federal regulations including the ways of submitting a complaint about a setting's adherence to the rules and will require that this handout be included in the participant's admission process. During Calendar Year 2017, the Division of Medicaid will conduct follow-up on-site validation visits for those providers determined to continue to be non-compliant of the final rule. This timeline allows providers two (2) years to meet the HCB setting requirements of the final rule.

By April 1, 2017, the Division of Medicaid will submit an amended Statewide Transition Plan that includes a detailed remediation plan on the systemic regulatory standards and policy assessment findings that detail the dates and actions that will need to occur to assure compliance for all 1915(c) or 1915(i) HCB programs. The Division of Medicaid will identify in the amended Statewide Transition Plan the number of individuals that will need to be re-located.

9. The process for monitoring for provider compliance. Provider compliance monitoring includes annual or every three (3) years certification reviews by the State's licensing and/or certifying agencies for residential and non-residential settings. Monitoring also encompasses annual On-Site Compliance Reviews (OSCR), on-site investigations, waiver participant/beneficiary and/or their legal representative survey results, provider records, participant/beneficiary records, staff licensing requirements and qualifications, and case management/support coordination visit reports.

Mississippi Division of Medicaid
Revised Statewide Transition Plan Timeline
1915(c) and 1915(i) Home and Community-Based (HCB) Programs
Compliance with HCB Settings
September 16, 2015

	Action item	Description	Who	Start Date	End Date	Progress
	Section 1: Assessment					
1.	Provider residential and non-residential settings self-assessment tool development	DOM develops provider self-assessment tool for residential and non-residential settings based on federal requirements for meeting HCB setting	DOM/DMH staff	12/1/14	02/15/15	Complete
2.	Provider meeting	Meet with providers to provide training to conduct the self-assessment tool	DOM/DMH staff, providers, key stakeholders	12/15/14	12/31/14	Complete
3.	Providers conduct self-assessment	Provider self-assessments of residential and non-residential settings must be completed and submitted to DOM or DMH if services for IID. Provider's Quality Management Committees must review assessments of all settings before submission to DMH.	All Providers	1/1/15	05/15/15	Complete
4.	Systemic Assessment	Assessment of DOMs Miss. Admin. Code Part 208, Chapters 1, 2, 3, 4, 5, which pertain to 1915(c) waiver and Chapter 7 which pertains to 1915(i) State Plan services. and DMH's Record Guide, DMH Standards, Medicaid's Provider Reference Guide, On-Site Compliance Review processes, and HCB settings monitoring procedures. Review of AL, E&D, ID/DD, IL. Review of 1915(i) State Plan pages Attachment 3.1-i.	DOM/DMH staff, key stakeholders	4/1/15	10/27/15	
5.	Provider self-assessments	Provider self-assessment data is compiled	DOM/DMH staff	5/1/15	6/30/15	Complete

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	Action item	Description	Who	Start Date	End Date	Progress
6.	Participant/legal representative Survey	Surveys by e-mail, hard copy mailings and/or phone surveys to a representative "per setting" random sample of participants inquiring about the HCB settings they receive HCBS to validate provider self-assessments	DOM/DMH and a representative sample size of participants	10/1/15	2/28/16	
7.	Develop a Statewide Transition Plan committee consisting of stakeholders	Committee consisting of stakeholders will be formed and meet to discuss the Statewide Transition Plan implementation	DOM/DMH staff, key stakeholders	6/30/2015	03/2019	
8.	On-site Validation and Re-Validation Visits	Validation process begins for provider self-assessments of each HCB setting site for a total of 423 setting sites to be validated	DOM/DMH staff	7/15/15	12/31/17	
9.	Provider Category Assigned	The state will identify the provider category I-IV based on the validation of the provider self-assessment and participant surveys	DOM/DMH staff	9/1/15	12/31/17	
10.	Provider Notification of Assigned Category	DOM/DMH will notify providers of their assigned category. If provider is a Category II or III refer to Remedial Strategies	DOM/DMH	9/1/15	12/31/17	
11.	Miss. Admin. Code Secretary of State filings	Proposed and final filing Administrative Code changes with the for Secretary of State according to the Administrative Procedures Act	DOM/DMH staff	4/1/16	6/30/16	
12.	Amended Statewide Transition Plan	Amended Statewide Transition Plan submitted to CMS that includes the actual number of settings within each category I-IV	DOM	12/31/17	12/31/17	
	Section 2: Remedial Strategies					

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	Action item	Description	Who	Start Date	End Date	Progress
1.	Written Report of Findings (WRF)	DOM/DMH notifies providers of non-compliance of through a WRF within 45 days as the state agencies complete the validation process	DOM/DMH	9/1/15	12/31/17	
2.	Plan of Compliance (POC)	Non-compliant providers must submit POC to DOM/DMH within 45 days of receipt of WRF	Non-compliant Providers	10/15/15	12/31/17	
3.	Provider Categorization Made Public	The category in which provider falls into and the reason(s) it is in that category will be posted to the DOM website	DOM	10/01/15	12/31/15	
3.	Review of POC	DOM/DMH staff reviews all provider POCs to determine compliance to HCB settings requirements	DOM/DMH	12/1/15	12/31/17	
4.	Follow-up On-site Validation Visit	DOM/DMH staff conducts an on-site validation visit for compliance with POC	DOM/DMH	1/1/16	2/1/18	
5.	Provider Notification of Non-Compliance	DOM/DMH notifies the provider that they are non-compliant with HCB settings final rule and will no longer be an approved Medicare provider or DMH certified.	DOM/DMH	2/1/18	2/1/18	
6.	Participant Relocation Notification	DOM/DMH notifies the participant that the provider does not meet the HCB settings as required in the final rule and the participant must choose another provider for the HCBS service they are receiving.	DOM/DMH	3/1/18	3/1/18	

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	Action item	Description	Who	Start Date	End Date	Progress
7.	Relocation plans	Providers that do not/cannot comply with the HCB settings final rule requirements must submit to DOM/DMH a collaborative transition plan for each participant outlining the relocation process to an appropriate residential or non-residential HCB compliant setting through a person-centered plan developed jointly with the assigned case manager/support coordinator.	DOM/DMH, case managers	3/1/18	11/1/18	
8.	Relocation	Relocation of each participant to a HCB setting in compliance of the final rule of the participant's choosing.	DMH, providers, case manager / Support Coordinator	11/1/18	3/1/19	
	Section 3: Quality Management					
1.	On-going Monitoring	Provider compliance monitoring includes certification reviews by the State's licensing agencies for residential and non-residential settings. Monitoring also encompasses reviews On-Site Compliance Reviews (OSCR) of on-site investigations, waiver participant/legal representative survey results, provider records, participant records, staff licensing requirements and qualifications, and case management/support coordination visit reports.	DOM/DMH	Annually	On-going	
	Section 4: Public Input					
1.	Tribal notice	The Tribe is notified by letter of the intent to submit the transition plan.	DOM	8/22/14	8/22/14	Complete

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	Action item	Description	Who	Start Date	End Date	Progress
2.	Public notice to newspaper	DOM publishes public notice in newspaper	DOM	9/17/14	9/17/14	Complete
3.	Transition Plan posted on DOM website	DOM/DMH begins collection of public comments through multiple methods including public hearings and web postings and an email address specifically for comments regarding the Transition Plan	DOM	9/17/14	9/17/14	Complete
4.	Public Hearings	DOM conducts public hearings to gather input regarding Transition Plan – written as well as oral comments will be accepted	DOM/DMH	9/26/14 and 10/3/14	9/26/14 and 10/3/14	Complete
5.	CMS Review	CMS requires revision of the Transitions Plans submitted	CMS	2/6/15	4/22/15	Complete
6.	Public Notice	DOM publishes public notice in newspaper and allows the public the opportunity to send questions and/or comments via email or standard mail.	DOM	3/11/15 and 3/15/15	3/11/15	Complete
7.	Thirty (30) Day Comment Period	DOM posts a link that takes the user directly to the Revised Statewide Transition Plan on the main page of the DOM website during the thirty (30) day comment period	DOM	3/11/15 – 4/10/15		Complete
8.	Public Hearings for Revised Statewide Transition Plan	DOM will hold three (3) public hearings regarding the Revised Statewide Transition Plan at the Jackson Regional Office, the Hattiesburg Regional Office and the Grenada Regional Office. The public hearings will allow DOM to gather input regarding the Statewide Transition Plan – written as well as oral comments will be accepted	DOM	Jackson: 3/26/15 Hattiesburg: 3/29/2015 Grenada: 3/24/15		Complete

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	Action item	Description	Who	Start Date	End Date	Progress
9.	State Responses to Comments	DOM/DMH will retain public comments and state responses for CMS and general public review	DOM/DMH staff	4/22/15		Complete
10.	Implementation of Revised Transition Plan	DOM/DMH will work with various stakeholder groups to periodically present and seek feedback on the implementation of the Statewide Transition Plan, including status reports, results of surveys, revisions to the Transition Plan, revisions to DOM/DMH Administrative Code, and amendments to 1915(c) waivers and/or 1915(i) State Plan services	DOM/DMH staff, key stakeholders	4/22/15	On-Going	
11.	Stakeholder Training and Education	DOM/DMH will design, schedule and conduct multiple trainings for people receiving supports, their families, and other stakeholders~~,~~ changes they can expect to see which could affect their services.	DOM/DMH staff	7/1/15	On-going	