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
December 20, 2021

Background

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, effective March 17, 2014, which amended 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) and can be located at the following link: https://medicaid.ms.gov/1915c-and-1915i-home-and-community-based-hcb-setting-transition-plan-and-timeline/. 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. Due to the COVID-19 public health emergency, the completion date has been extended until March 1, 2023.

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 persons/beneficiaries to receive services in settings that meet the requirements of the final rule. Persons/beneficiaries are able to choose non-disability specific settings to receive services.

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 and be physically accessible to beneficiaries including:
   - Day Services Adult, previously referred as Day Habilitation services until 11/1/2018, support meaningful day opportunities for the person to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice This service is provided in a Department of Mental Health certified, non-residential setting, and
   - Prevocational Services provide learning and work experiences, where the individual can develop general, non-job-task specific strengths and skills to contribute to paid employment in integrated community settings. This service is provided in a Department of Mental Health certified, non-residential setting.

The 1915(i) service provided in a residential setting which must meet the requirements of the HCB settings include:

- 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 the HCB requirements.

The 1915(i) State Plan provides habilitative services in an integrated work setting which is fully integrated with opportunities for full access to the greater community include:

- Supported Employment services are not provided in settings that group or cluster individuals.

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 and be physically accessible to persons include:

- Day Services-Adult assists the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. This service is provided in a Department of Mental Health certified, non-residential setting.
- Community Respite provides periodic support and relief to the participant's primary caregiver and promotes the health and socialization of the participant through scheduled activities. This service is provided in a Department of Mental Health certified, non-residential setting.
- Prevocational Services are time-limited and intended to develop and teach a participant general skills that contribute to paid employment in an integrated community setting. This service is provided in a Department of Mental Health certified, non-residential setting.

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

- Supervised Living services are designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. This service is provided in a Department of Mental Health certified, residential setting in the community.
- Shared Supported Living Services, added in the ID/DD Waiver amendment effective 5/1/2017, include individually tailored supports which assist a person to live in a home or apartment with the greatest degree of independence possible. Shared Supported Living Services are provided in compact geographical areas (e.g. an apartment complex) in residences either owned or leased by themselves or an agency provider. All provider owned or controlled settings providing Shared Supported Living must meet HCB requirements.
- 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 the HCB requirements.

Other ID/DD Waiver services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community and/or are individualized and do not meet group settings assessment requirement under Final Rule include:

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

Although only IDD residential and day program settings were assessed, HCBS Final Rule requirements applies across all HCB Services. All HCBS providers were required to participate in four (4) training webinars on HCBS Final Rule conducted by DMH and Independent Contractor in 2019. Final Rule requirements have been incorporated into DMH Operational Standards and are monitored by the Division of Certification and Support Coordinators/Target Case Managers (refer to page 167-169 for ongoing monitoring). DMH staff review 100% of initial, recertification, and change request Plan of Services and Supports (PSS). Support Coordination conducts quarterly face to face visits with at least one visit in the person's home per year.

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

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

E&D Waiver services provided in the participant's private home or a relative's home which is fully integrated with opportunities for full access to the greater community include:

- Case management,
- Home-delivered meals,
- Personal care services,
- In-home respite,

- Transition Assistance, and
- Expanded home health visits.

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

- Institutional respite services.

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

AL Waiver services are provided to residents living in a personal care home/assisted living facility and a neurological rehabilitative living center in a residential setting which must meet the requirements of the HCB settings and include:

- 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 persons reside in private homes which are fully integrated with opportunities for full access to the greater community and meet the requirements of the HCB settings. The TBI/SCI waiver does not provide services to persons in congregate living facilities, institutional settings or on or adjacent to the grounds of institutions. Therefore, no further transition plan is required for this waiver.

A person's home environment is assessed prior to admission to the TBI/SCI Waiver. The State verifies, through ongoing monitoring that all persons on the these waivers reside in a private home of their choosing. The State also conducts random home visits throughout the year to ensure that the person's home continues to meet their health and safety needs as well as waiver requirements. Lastly as a component of Personal Care Services on these waivers, direct care workers (PCAs) are able to provide support for community participation by accompanying and assisting the person as necessary to access community resources and participate in community activities including shopping, community recreation/leisure resources, and socialization opportunities to ensure that persons on the waiver are not isolated.

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 persons reside in private homes which are fully integrated with opportunities for full access to the greater community and meet the requirements of the HCB settings. The IL waiver does not provide services to persons in congregate living facilities, institutional settings or on or adjacent to the grounds of institutions. Therefore, no further transition plan is required for this waiver.

"A person's home environment is assessed prior to admission to the IL Waiver. The State verifies, through ongoing monitoring that all persons on the these waivers reside in a private home of their choosing. The State also conducts random home visits throughout the year to ensure that the person's home continues to meet their health and safety needs as well as waiver requirements. Lastly as a component of Personal Care Services on these waivers, direct care workers (PCAs) are able to provide support for community participation by accompanying and assisting the person as necessary to access community resources and participate in community activities including shopping, community recreation/leisure resources, and socialization opportunities to ensure that persons on the waiver are not isolated."

Public Comments for Proposed Plan

The Mississippi Band of Choctaw Indians (MCBI) was notified on August 22, 2014, of the intent of submitting the Statewide Transition Plan to CMS.

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. An adapted, accessible version of the STP was available during the public comment period on the Division of Medicaid's website.
3. 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,
4. 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. An adapted, accessible version of the STP was available during the public comment period on the Division of Medicaid's website. The Mississippi Division of Medicaid strives to reasonably accommodate all target audiences through communications tools, including the external website at http://medicaid.ms.gov. The website was developed with a variety of audiences in mind and includes tools to address issues for non-English speaking, aged, disabled and impaired such as font size buttons, a Google language translator tool, prominent search features, a site map and it is built on a response website frame within a content management system. The Division of Medicaid also routinely performs Web Content Accessibility Guidelines checks to ensure adherence to web standard guidelines, as well as HTML validation to be in line with W3C standards.
- 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 took 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 reviewed 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 Administrative Code effective January 1, 2017, 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 were 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 effective January 1, 2017, 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 was formed and met on June 23, 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, was submitted to CMS on April 24, 2015, and 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.

6. The Division of Medicaid published the following public notice on November 28, 2016 on the agency's website and in three (3) major newspapers: The SunHerald, The Clarion-Ledger, and The Commercial Appeal. The public notice and waiver document were available for review in each county health department office and in the Department of Human Services office in Issaquena County. Stakeholders and advocate organizations were notified to inform interested individuals as well.

   Public notice is hereby given to the submission of the revised Mississippi Statewide Transition Plan (STP) for initial approval from the Centers for Medicare and Medicaid Services (CMS).

   The Division of Medicaid (DOM) has completed the assessment of its state standards, rules, regulations and other requirements to determine its current level of compliance with the federal Home and Community-Based (HCB) settings final rule. During this assessment, DOM identified gaps between the State Plan, Administrative Code and the Department of

Mental Health's (DMH) al Standards and federal HCB settings regulations. In addition, revisions to the STP were in response to CMS's request for supplemental information and clarifications. The revision of these documents and the timeframes for completion are included in the revised STP.

Once the initial approval has been received, DOM must complete the following actions in order to obtain final approval of the STP:

- Complete site-specific assessment of all HCB settings,
- Develop a remediation plan for providers that do not comply with the HCB settings federal regulations,
- Validate documentation from providers who have undergone remediation,
- Identify and assess HCB settings that are presumed to have institutional characteristics,
- Identify a plan for participants who live in non-compliant settings to transition to compliant HCB settings, and
- Establish a plan for ongoing monitoring of HCB settings in Mississippi.

Prior to the submission for final approval, DOM will submit its final draft of the STP for public comment.

A copy of the revised STP will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081.

Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

The only comments received during the thirty (30) day comment period from November 28, 2016, through December 28, 2016, were from Micah Dutro from Disability Rights Mississippi:

- We believe that all of the waivers offered by MS Medicaid should include both transportation services and employment supports/job discovery services. Transportation is vital to full integration into the greater community. Similarly, employment supports/job discovery services encourage integration and greater independence among waiver participants. The level of integration contemplated by the Final Rule cannot be achieved without services that facilitate the ability to move about the community and the opportunity to engage in competitive employment.
  Response: The Division of Medicaid covers medically necessary transportation for persons on all waivers through a NET broker program. Transportation for person's

receiving E&D Waiver Adult Day Care (ADC) services is provided by the ADC provider and included in the rate. Transportation services are included in the rates for the following services: Supported Employment, Supervised Living, Day-Services Adult and Prevocational Services. Employment Supports/Job Discovery is not included in the Statewide Transition Plan (STP) as this service is not applicable to the HCB settings final rule.

- Behavioral supports were removed from the list of 1915(c) ID/DD waiver services on page 3 of the "clean" version of the Revised Statewide Transition Plan Summary and Timeline. We believe such services to be essential to efforts of ID/DD waiver participants to integrate into the community. We respectfully request the reasoning behind the decision to remove this essential service from the State Transition Plan.
  Response: On the guidance from the CMS, Behavioral Supports was removed because this service is not applicable to the HCB settings final rule.
- The Revised Statewide Transition Plan Summary and Timeline states that both the TBI/SCI waiver and the Independent Living waiver are already in full compliance with the Final Rule and that no services are performed, in either waiver, in segregated settings. Generally, CMS allows such a presumption. But the state is still supposed to have a system in place to ensure that participants are receiving services in such a way as to meet the standards of the Final Rule. What system does the Mississippi Division of Medicaid propose to ensure that the standards are met for these waivers?
  Response: The Division of Medicaid, through the Person Centered Planning (PCP) process, ensures that TBI/SCI and IL Waiver persons reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community and meet the requirements of the HCB settings. The Division of Medicaid 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 TBI/SCI and IL Waivers.
- Supported living arrangements (i.e. "supervised living" as outlined in Part 208, Chapter 5, Rule 5.5) seem to be receiving the presumption of compliance in some instances. Supported living is often provided in such a way that there is provider control over the setting, even if the setting is leased in the name of the participant. We do not believe that such settings should be granted that presumption. By their very nature, residential settings of this type will inevitably vary widely from community to community across the state. Instead, such settings should be included in the category of settings that must perform self-assessments and possibly make changes to come into full compliance.
  Response: Supported Living is not included in the Statewide Transition Plan as it is not applicable to the settings requirement. Supported Living settings and activities that take place in those settings and in the community, are chosen by the person receiving services. Supported Living settings are not provider controlled. Supported Living settings are comprised of people who live in their own homes/apartments and receive services according to a Person Centered Plan either in the home and/or their community including, but not limited to, grocery shopping, leisure activities, etc. Therefore, as the person is in control and not a provider, it

was deemed not appropriate for provider self-assessments be conducted for these settings. The Division of Medicaid, through the Person Centered Planning (PCP) process, ensures that people in Supported Living reside in private homes/apartments which are fully integrated with opportunities for full access to the greater community and meet the requirements of the HCB settings. The Division of Medicaid 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 ID/DD Waiver.

- There are two issues with Part 208, Chapter 1, Rule 1.1 as it appears on pages 17-18 of the Revised Statewide Transition Plan Summary and Timeline (clean). First, the federal rule referenced in the far right column appears to be in error. 42 CFR 441.301(c)(4)(iv) of the Final Rule does not appear to have anything to do with the due process requirements that Rule 1.1 of the state rules outlines. The referenced federal rule reads, "Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact." Meanwhile, the state Rule 1.1 concerns due process protections and outlines notice requirements for participants in the waiver. We would suggest that notice requirements in the federal rules can be found at 42 CFR 431.210 through 431.214.
  Secondly, the state Rule 1.1 does not accurately reflect the requirements of the federal regulation that is applicable. Part C of the rule states that "Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the participant must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services." However, 42 CFR 431.211 requires that notice be given to the participant at least 10 days ***before*** the date of the action. The federal rules define the term "action" in 42 CFR 431.201 as, "a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by
  skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act." The state rules should be amended to be in compliance with the provisions of the Final Rule accordingly. We would also encourage the Division
  of Medicaid to require that notices of adverse actions include the contact information of Disability Rights Mississippi, the designated Protection and Advocacy organization for the state of Mississippi, where participants may be able to receive legal services at no cost.
  Response: It appears the comment is referring to Rule 1.11: Due Process Protection. This Rule has been deleted from the STP as it is not applicable to the settings requirement; however, the Admin. Code will be revised.
- The Transition Plan Summary and Time line states that the settings requirements have been incorporated into documents and other guidance that are directed at waiver participants. However, it is not clear whether these documents are fully accessible to participants such that they will be able to fully understand and

appreciate the requirements, their rights, how to file complaints or grievances if a setting is not in compliance, and how complaints will be handled once they are made. Information directed at waiver participants must be accessible, including being written at an appropriate reading level, in order to be meaningful and effective.

Response: The Division of Medicaid will ensure that all documents regarding HCB settings are fully accessible to persons and their legal representatives such that they are meaningful and effective.

- The validation process for provider self-assessments should be clarified. It is unclear whether providers will be notified as to the exact date and time of the validation review and when the random sample of participant surveys will be conducted. We urge the Division not to give notice of the precise date and time that the validation reviews will take place. This will ensure that the random sample of participant surveys is truly random and makes it difficult for any provider who wishes to act in bad faith to skew the results of the validation review. Furthermore, the language regarding how the random sample of participant surveys will be conducted should be clarified. How will they be chosen? What about participants who may not be physically present at the facility at the time of the validation review because they are working or participating in some other activity out in the community? Why does the plan propose to survey 100% of Assisted Living waiver participants while other settings of a similar, isolating nature (e.g. adult daycare facilities) are not proposed to be surveyed to the same extent?

  Response: The Division of Medicaid made the decision to validate AL at one hundred percent (100%) because of the small number of persons enrolled in the waiver. The number of validations required to create a statistically valid sample is not significantly different than the total number of persons who have elected the waiver. ADC persons were chosen when the reviewer conducted the validation survey at the ADC. The ADC was not notified in advance of the exact time and date of the validation review nor when the random sample of participant's surveys would be conducted. All ADCs were reviewed not just a portion. However, there are still three (3) to be completed. ID/DD Waiver providers were notified the Friday before a site visit. The random sample was pulled from a report generated by the Division of Medicaid which indicates all persons served by each provider. Providers do not know in advance which persons or records will be reviewed. If a person's name is chosen to be reviewed who is absent during the visit, DMH staff will make a concerted effort to remain at the site until the person returns. If it appears the reviewer must leave before the person returns, another person will be chosen to review.

- We believe that the provisions that provide notice to waiver participants who will be transitioning from non-compliant settings into compliant ones is a positive step. We encourage the Division of Medicaid to use the information gathered through the provider self-assessment process (and transition plan process in general) to work with providers to identify areas where provider availability may be reduced due to the full implementation of the Final Rule and make plans to increase capacity in those areas. The state should be working with providers and planning to increase

the capacity of non-disability specific settings to ensure that participants have real, meaningful choices as required by the Final Rule.
Response: The Division of Medicaid is currently working with providers to ensure compliance with the final rule.

CMS Review and Revised Statewide Transition Plans

7. The comprehensive assessment was completed on November 20, 2015, and includes the following:

   The following waivers are silent on the settings requirements as required in the final rule: Appendix C and D:
   - AL - Appendix C and D,
   - E&D - Appendix C and D,
   - IL - Appendix C and D , and
   - ID/DD - Appendix C and D.

   The Miss. Admin. Code Title 23: Division of Medicaid, Part 208: Home and Community-Based Services Long-term Care were filed with the Mississippi Secretary of State's Office and became effective on January 1, 2017, with the following changes and can be located on the Division of Medicaid's website at https://medicaid.ms.gov/providers/administrative-code/:

Administrative Code Title 23: Division of Medicaid	**Rule Content**	**Determination**
Part 208, Chapter 1: *1915c Elderly and Disabled Waiver* **Rule 1.1:***General*	A. Medicaid covers certain home and community based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D). B. The E & D Waiver is administered and operated by the Division of Medicaid.	Current language is silent on the following verbiage from 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule which will be added as Rule 1.4.C.: *1. Persons enrolled in the E&D waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.* *2. The Division of Medicaid does not cover E&D waiver services to persons in congregate living facilities, institutional settings or*

		on the grounds of or adjacent to institutions or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).
Part 208, Chapter 1: *1915c Elderly and Disabled Waiver* **Rule 1.4:** *Freedom of Choice*	A. Medicaid waiver participants have the right to freedom of choice of Medicaid providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6. B. Each individual found eligible for the Elderly and Disabled (E&D) waiver must be given free choice of all qualified providers.	Persons enrolled in a Medicaid waiver have the right to freedom of choice of providers for Medicaid covered services. Each individual found eligible for the E&D waiver must be given free choice of qualified providers. Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 1.4.C.: *C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).*
Part 208, Chapter 1: *1915c Elderly and Disabled Waiver* **Rule 1.6:** *Covered Services*	2. Adult Day Care Services a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled participants through an	Current language is in compliance with and supports Final Rule except the verbiage in the following which will be revised: Rule 1.6.A.2.a)2) is revised to comply with 42 CFR § 441.301(c)(4)(iv): *2) Provide choices of food and drinks to persons at any time*

	individualized care plan that includes the following: 1) Personal care and supervision, 2) Provision of meals as long as meals do not constitute a full nutritional regimen, 3) Provision of limited health care, 4) Transportation to and from the site, with cost being included in the rate paid to providers, and 5) Social, health, and recreational activities. b. Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the participant's assigned case manager. c. To receive Medicaid reimbursement the participant must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the participant to and from the facility. 4. Institutional or In-Home Respite Services a. Respite Care provides non-medical care and supervision/assistance to participants unable to care for themselves in the absence of the participant's primary full-time, live-in caregiver(s) on a short-term basis. b. Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the participant. c. Institutional Respite Services	*during the day to meet their nutritional needs in addition to the following:* *(a) A mid-morning snack,* *(b) A noon meal, and* *(c) An afternoon snack.* Rule 1.6.A.2.c. is in conflict with 42 CFR § 441.301(c)(4)(iv). *The four (4) hour minimum requirement for provider reimbursement will be removed with the July 2017 E&D Waiver renewal to be submitted by March 2017. There will no longer be a minimum amount of hours required for reimbursement.* The following verbiage from 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5) will be added as Rule 1.6.A.2.d. and 1.6.A.2.e.: *d. Adult Day Care settings must be physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community , to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the*

	1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities. 2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service. 3) Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.	*person's needs, preferences, and, for residential settings, resources available for room and board.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.* *5) Facilitate individual choice regarding services and supports, and who provides them.* *e. Adult Day Care settings do not include the following :* *1)A nursing facility,* *2)An institution for mental diseases,* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),* *4)A hospital, or* *5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
Part 208, Chapter 1: *1915c Elderly*	A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or	Current language is in compliance with and supports 42 CFR §

and Disabled Waiver **Rule 1.12:** *Hearing and Appeals*	reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status. B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change.	441.301(c)(4)(i)-(v) of the Final Rule.

1915(c) HCBS Waiver: MS.0272.R04.01 *Elderly and Disabled Waiver*	**Rule Content**	**Determination**
Appendix C: Participant Services C-1/C-3: Service Specification *1915c Elderly and Disabled Waiver*	A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant.	Current language is in conflict with 42 CFR § 441.301(c)(4)(iv) of the Final Rule. The following verbiage will be deleted with the July 2017 waiver renewal: *"A waiver participant must stay at least four continuous hours in order for the ADC to be reimbursed for a day of services for the individual participant".*
Appendix F: Participant – Rights F-2: Additional Dispute Resolution *1915c Elderly and Disabled Waiver*	b. The informal dispute resolution process is initiated with the case management agencies at the local level and is understood as not being a pre-requisite or substitute for a fair hearing. The types of disputes that can be addressed are issues	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(ii) of the Final Rule

	concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants address disputes by first reporting to their case management team, which is composed of a registered nurse and a licensed social worker. The case management team responds to the participant within 24 hours. If a resolution is not reached within 72 hours the case management team reports the issue to the case management supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the dispute is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once a new case management team is assigned the case management supervisor evaluates the client's	

	satisfaction with the new case management team within the following month and notifies DOM of the final resolution. DOM and the case management agency are responsible for operating the dispute mechanism. DOM has the final authority over any dispute. The participant is informed by the case management agency at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings. At no time will the informal dispute resolution process conflict with the waiver participant's right to a Fair Hearing in accordance with Fair Hearing procedures and processes as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process	
Appendix F: Participant – Rights F-3: State Grievance/Complaint *1915c Elderly and Disabled Waiver*	c. The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints /grievances regarding waiver	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

	services, and other complaints/grievances that directly affect their waiver services. Waiver participants must first address any complaints/grievance by reporting it to their case management team which is composed of a registered nurse and a licensed social worker. The case management team begins to address the complaint/grievance with the client within 24 hours. If a resolution is not reached within 72 hours the case management team reports the complaint/grievance to the case management supervisor. The supervisor must reach a resolution with the participant within seven days. If a resolution is not reached within this time frame it is reported to DOM. DOM along with the case management agency will consult with each other and work towards a resolution within seven days. In the event the complaint/grievance is with the case management team then the case management agency and DOM works with the participant to assign a new case management team. Once	

	a new case management team is assigned the case management supervisor evaluates the participant's satisfaction with the new case management team within the following month and notifies DOM of the final resolution. Upon admission to the waiver, the participant receives a written copy of their bill of rights which addresses disputes, complaints/grievances and hearings. Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Medicaid Administrative Code, Title 23: Medicaid Part 100, Chapter 5: The Hearing Process.	
Safeguards **G-1: Response to Critical Events or Incidents** *1915c Elderly and Disabled Waiver*	Upon entry into the waiver, case managers will provide the waiver participant/and/or caregiver education and information concerning the State's protection of the waiver participant against abuse, neglect and exploitation including how participants may notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation. When participants are initially assessed for the E&D Waiver, they are	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule.

	given the names and phone numbers of their case managers. The case manager maintains monthly contact with each participant by making monthly home visits. If there is a concern regarding abuse, neglect, exploitation, and the participant and/or participant representative has notified the case manager of their concern, a home visit is conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. DOM/LTC requests to always be notified of any suspected abuse, neglect, exploitation cases as they occur, and will offer their support in ensuring a prompt resolution, if feasible.	
Appendix G: Participant Safeguards **G-2: Safeguards Concerning Restraints and Restrictive Interventions** *1915c Elderly and Disabled Waiver*	The State prohibits the use of restraints or seclusion during the course of the delivery of waiver services. DOM and the case management agencies are jointly responsible for ensuring that restraints or seclusions are not used for waiver participants. The case management team is responsible for monthly contact with waiver participants to	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) Final Rule. e

	ensure safety and the quality of waiver services provided.	

Administrative Code Title 23: Division of Medicaid	Rule Content	Determination
Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.1:** *General*	A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.	The following verbiage is being added to Rule 2.1.A. to comply with 42 CFR § 441.301(c)(4)(i)-(iv) Final Rule with the Admin. Code filing effective January 1, 2017: *1. Waiver persons must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.* *2. The Division of Medicaid does not cover IL waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions-or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS)*
Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.3:** *Covered Services*	The Division of Medicaid covers the following Independent Living Waiver services: A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities: 1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule.

	appropriate and reflective of the participant's individual needs, preferences, and goals. 2. Must assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. 3. Are responsible for ongoing monitoring of the provision of services included in the participant's plan of care. 4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants. C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care,	

	which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the Independent Living Waiver program. F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.	
Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.5:** *Freedom of Choice*	A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6. B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual. C. Beneficiaries must be: 1. Informed of any feasible alternatives under the waiver, and 2. Given the choice of either institutional or home and community-based services.	Current language is in compliance with and supports the Final Rule but silent on the following verbiage which is being added to Rule 2.5.C.3 with the Admin. Code filing effective January 1, 2017 to comply with 42 CFR § 441.301(c)(4)(ii): *3. Provided a choice among providers or settings in which to receive HCBS including non-disability specific setting options.*

Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.7:** *Participant Direction of Services*	A. Participants are encouraged to make choices in regards to participant needs, goals, preferences and desires with all aspects of the services provided.	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(v) of the Final Rule.
Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.8:** *Monitoring Safeguards*	A. MDRS case managers are required to provide each waiver participant with written information regarding their rights as a waiver participant at the initial assessment.	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule.
Part 208, Chapter 2: *HCBS Independent Living (IL) Waiver* **Rule 2.9:** *Additional Dispute Resolution Process*	A. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute. B. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services. C. MDRS must inform the participant at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes. D. MDRS must inform the participant of their rights which address disputes, complaints/ grievances and hearings.	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) of the Final Rule.

Administrative Code Title 23: Division of Medicaid	Rule Content	Determination
Part 208, Chapter 3: *HCBS Assisted Living (AL) Waiver* **Rule 3.4:** *Freedom of Choice*	Medicaid beneficiaries have the right to freedom of choice of approved Medicaid providers for services as outlined in Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.	Current language is in compliance with the final rule but is silent on the verbiage from 42 CFR § 441.301(c)(4)(ii) which will be added as Rule 3.4.B. with the Admin. Code filing effective January 1, 2017: *B. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).*
Part 208, Chapter 3: *HCBS Assisted Living (AL) Waiver* **Rule 3.6:** *Covered Services*	C. AL Waiver providers must provide: 1. A setting physically accessible to the participant but is not located in: a) A nursing facility, b) An institution for mental diseases, c) An intermediate care facility for individuals with intellectual disabilities (ICF-IID), d) A hospital providing long-term care services, or e) Any other location that has qualities of an institutional setting. 2. A private, home-like living quarter with a bathroom consisting of a toilet and sink and must: a) Be a unit or room in a specific	Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(5) which will be added to the following with the Admin. Code filing effective January 1, 2017: Rule 3.6. C.1.e): *e)Any other location that has qualities of an institutional setting, as determined by the Division of Medicaid including, but not limited to, any setting:* *1) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,* *2)Located in a building on the grounds of or immediately adjacent to a public institution , or*

	physical place that can be owned, rented or occupied under another legally enforceable agreement by the waiver participant, and the participant has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity.	*3) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).* Rule 3.6.C.2.a) *C. For settings in which landlord tenant laws do not apply, the Division of Medicaid must ensure that:* *(1) A lease, residency agreement or other form of written agreement will be in place for each HCBS person, and* *(2) That the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*

1915(c) HCBS Waiver: MS.0355.R03.00 *1915c Assisted Living Waiver*	**Appendix Content**	**Determination**
Appendix C: Participant Services *1915c Assisted Living Waiver*	ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings. Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). Personal Care Home - Assisted Living Adult Residential Care Facility Facility Type	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(vi) of the Final Rule except 42 CFR § 441.301(c)(4)(vi)(B)(1) regarding lockable doors. The following will be deleted with the 2018 waiver renewal: "This requirement does not apply where it conflicts with fire code."

	A home-like character is maintained in the assisted living or adult residential facilities that can be owned, rented or occupied under a legally enforceable agreement by the waiver participant, and the participant has, at a minimum, the same responsibilities and protections from eviction that tenant have under the landlord/tenant law of the State, county, city or other designated entity. The facility must maintain a living environment which is supportive of the participant to exercise their rights to: 1) attend religious and other activities of their choice; 2) the right to manage own personal financial affairs, or receive a quarterly accounting of financial transactions made on their behalf; 3) not be required to perform services for the facility; 4) communicate with persons of their choice, and may receive mail unopened or in compliance with policies of the facility; 5) be treated with consideration, kindness, respect and full recognition of their dignity and individuality; 6) may retain and use personal clothing and possessions as space permits; 7) voice grievances and recommend changes in licensed facility policies and services; 8) not be confined to the licensed facility against their will, and shall be allowed to move about in the community at liberty. Physical	

	and/or chemical restraints are prohibited; and 9) not be limited in their choice of a pharmacy or pharmacist provider in accordance with State law; 10) decide when to go to bed and get up in the morning; 11) privacy in their sleeping or living unit (Participants may share units only at the participant's discretion); 12) furnish and decorate their sleeping or living space; 13) freedom and support to control their own schedules and activities; 14) have access to food at any time; 15) have visitors of their choosing at any time; 16) have meals available over long periods of time or allows the participant to decide when to eat his or her meal; and 17) have lockable entrance doors, with appropriate staff having keys to the doors. The facility setting is physically accessible to the waiver participants. The facility must supply normal, daily personal hygiene items including at minimum, deodorant, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. The waiver participant may choose to bring in his or her own personal products or brand name products. Waiver participants are encouraged to use their own personal belongings and furniture in the personal care home. Nutritious snacks must be	

	available at all times. The dining room must be available for congregate meals and socialization. Participants choose their own physician. This waiver service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Personalized care is furnished to participants who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. Waiver participants may lock their rooms unless a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. This requirement does not apply where it conflicts with fire code. Each living unit is separate and distinct from each other. The participant retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and must treat each person with dignity and respect. Assisted	

	Living waiver services also include medication administration, transportation specified in the plan of care and attendant call systems. Attendant call systems are emergency response systems for waiver participants who are at risk of falling, becoming disoriented or experiencing some disorder that puts them in physical, mental or emotional jeopardy requiring immediate assistance. The waiver participant either wears an electronic device (e.g. a medallion or a bracelet) or is in proximity to a button that enables him or her to summon emergency help from an assisted living attendant Assisted living services may also include intermittent skilled nursing services. However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. Prior to, or at the time of admission, the operator and the waiver participant or the participant's responsible party shall execute in writing a financial agreement. This agreement shall be prepared and signed in two or more copies, one copy given to the participant or the responsible party, and one copy placed on file in the facility. At a minimum, the agreement shall contain specifically: 1) Basic charges agreed upon separating costs for room and board and personal care.	

	2) Period to be covered in the charges 3) Services for which charges are made 4) Agreement regarding refunds for any payments made in advance, In addition to an admission agreement, Specific to Subchapter 12, Rule 47.12.1, of the Mississippi Administrative Code, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification, the Assisted Living Facilities must have admission and discharge criteria that must be applied and maintained for the protection of rights for waiver participant placement and continued residence in a licensed facility. Based on Title 23, Part 200: General Provider Information, Chapter 3, Rule 3.8 (a) of the Mississippi Division of Medicaid Administrative Code, facilities that have agreed to be a Medicaid provider for this waiver, are expected to bill Medicaid for covered services and accept Medicaid payment in full for said services. Medicaid participants in assisted living facilities may not be held liable for billed charges above the Medicaid maximum allowable for care services. Rule 4.2(A) (9), Conditions of Participation, further states that, "The provider must agree to accept, as payment in full, the amount paid by the Medicaid	

	program for all services covered under the Medicaid program within the beneficiary's service limits…" participants should not be required to make payments on charges for services covered by Medicaid. Regardless of what is agreed upon between the facility and the waiver participant or their representative, the facility cannot bill waiver participants additional fees for care services over and above the current reimbursable rate. Waiver participant room and board rates must not fluctuate on a monthly basis due to less Medicaid reimbursable service days. The admission agreement must clearly distinguish between the room and board rate and the care service costs. ANY CHANGE in the fee agreement must be approved by the Division of Medicaid before executed ANY CHANGE in the fee a with the waiver participant.	

Administrative Code Title 23: Division of Medicaid	**Rule Content**	**Determination**
Part 208, Chapter 4: *HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver* **Rule 4.1:** *General*	A. The Division of Medicaid covers certain Home and Community Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. Waiver services are available statewide. B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by	The following verbiage will be added to Rule 4.1.C. with the Admin. Code filing effective January 1, 2017 to comply with 42 CFR § 441.301(c)(4)(i)-(iv) of the Final Rule: *1. Waiver Persons enrolled in the TBI/SCI Waiver must reside in private homes or a relative's home*

	the Division of Medicaid and MDRS.	*which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings. 2. The Division of Medicaid does not cover TBI/SCI waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).*
Part 208 Chapter 4: *HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver* **Rule 4.3:** *Freedom of Choice*	A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6. B. Personal care services may be furnished by family members provided they are not legally responsible for the individual. 1. The Division of Medicaid defines a person legally responsible for an individual as the parent, or step-parent, of a minor child or an individual's spouse. 2. Family members must meet provider standards and must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse. 3. There must be adequate justification for the family member to function as the attendant.	The following verbiage will be added to Rule 4.3.C with the Admin. Code filing effective January 1, 2017 to comply with 42 CFR § 441.301(c)(4)(ii) of the Final Rule: *C. Persons have the choice among providers or settings in which to receive HCBS including non-disability specific setting options.*

Part 208, Chapter 4: *HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver* **Rule 4.5:** *Covered Services*	A. The Division of Medicaid covers the following TBI/SCI Waiver services: 1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver and other services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services. a) Case Management services must be provided by Mississippi Department of Rehabilitation Services (MDRS) TBI/SCI counselors/registered nurses who meet minimum qualifications listed in the waiver. b) Responsibilities include, but are not limited to, the following: 1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care. 2) Provide ongoing monitoring of the services included in the beneficiary's plan of care. 3) Develop, review, and revise the plan of care at intervals specified in the waiver. 4) Conduct monthly contact and quarterly face-to-face visits with the beneficiary. 5) Document all contacts, progress, needs, and activities carried out on behalf of the beneficiary. 2. Attendant Care services are defined as support services provided to assist the beneficiary in meeting daily living needs and to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. a) Attendant Care is non-medical, hands-on care of both a supportive	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(v) of the Final Rule.

	and health related nature and does not entail hands-on nursing care. b) Services must be provided in accordance with the approved plan of care and is not purely diversional in nature. c) Services may include, but are not limited to the following: 1) Assistance with activities of daily living defined as assistance with eating, bathing, dressing, and personal hygiene. 2) Assistance with preparation of meals, but not the cost of the meals. 3) Housekeeping chores essential to the health of the beneficiary including changing bed linens, cleaning the beneficiary's medical equipment and doing the beneficiary's laundry. 4) Assistance with community related activities including escorting the beneficiary to appointments, shopping facilities and recreational activities. The cost of activities or transportation is excluded. 3. Respite services are defined as services to assistance beneficiaries unable to care for themselves. Respite care is furnished on a short-term basis because of the absence of, or the need to provide relief to, the primary caregiver(s). a) Services must be provided in the beneficiary's home, foster home, group home, or in a Medicaid certified hospital, nursing facility, or licensed respite care facility. 4. Specialized medical equipment and supplies are defined as devices, controls, or appliances that will enhance the beneficiary's ability to perform activities of daily living or to perceive,	

	control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan. 5. Environmental Accessibility Adaptation is defined as those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence, and without which, the beneficiary would require institutionalization. 6. Transition Assistance services are defined as services provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the TBI/SCI Waiver program.	
Part 208, Chapter 4: *HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver* **Rule 4.11:** *Hearings and Appeals*	A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. 1. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision. 2. All appeals must be in writing. B. The beneficiary/legal representative is entitled to initially appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor. C. If the beneficiary/legal representative disagrees with the	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(i)-(v) of the Final Rule.

	decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid no later than five (5) days after notification of the state level appeal.	

Administrative Code Title 23: Division of Medicaid	**Rule Content**	**Determination**
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.3:** *Freedom of Choice of Providers*	A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver participants have the right to freedom of choice of providers for Medicaid covered services. B. The participant and/or guardian or legal representative must be informed of alternatives available through the ID/DD Waiver, and given the option of choosing either institutional or home and community-based services (HCBS) once eligibility requirements for the ID/DD Waiver have been met. C. The choice made by the participant and/or guardian or legal representative must be documented and signed by the participant and/or guardian or legal representative and	Current language is in compliance with and supports Final Rule but is silent on the verbiage from 42 CFR § 441.301(c)(4)(ii). The following verbiage will be added as rule 5.3.C and the current 5.3.C will become 5.3.D. with the Admin. Code filing effective January 1, 2017: *C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings and an option for a private unit in a residential setting with identified resources available for room and board. The setting options must be selected by the person and identified and documented in the plan of services and supports.*

	maintained in the ID/DD Waiver case record.	
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.5:** *Covered Services* *C.3.: Community Respite*	3. Community Respite is defined by the Division of Medicaid as services provided generally in the afternoon, early evening, and on weekends in a DMH certified community setting to give periodic support and relief to the participant's primary caregiver and promote the health and socialization of the participant through scheduled activities. a) Community Respite service providers must: 1) Provide the participant with assistance in toileting and other hygiene needs, 2) Offer participants a choice of snacks and drinks, and 3) Have meals available if respite hours are during normal meal time.	Current language is in compliance with and supports the Final Rule but is silent on verbiage from 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5) which will be added to the following with the Admin. Code filing effective January 1, 2017: Rule 5.5.C.3.c): *c) Community Respite service settings must be physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) Optimize, but not regiment, 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. *5) Facilitate individual choice regarding services and supports, and who provides them.* Rule 5.5.C.3.d): *d) Community Respite settings do not include the following:* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.5:** *Covered Services* *C.4.: Supervised Living*	4. Supervised Living services are defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community	Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(i) through (v); 42 CFR § 441.301(c)(4)(A) through (E); 42 CFR § 441.301(c)(5) and will be added to the following with the Admin. Code filing effective January 1, 2017 and other changes will be made to the Admin Code when the ID/DD waiver

	inclusion, transportation and leisure skill development. Supervised living, learning and instruction include elements of support, supervision and engaging participation to reflect that of daily living in settings owned or leased by a provider agency or by participants. a) Supervised Living providers must: 1) Have staff available on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests or needs of assistance and must not sleep during billable hours. 2) Provide an appropriate level of services and supports twenty-four (24) hours a day during the hours the participant is not receiving day services or is not at work. 3) Oversee the participant's health care needs by assisting with: (a) Scheduling medical appointments, (b) Transporting and accompanying the participant to appointments, and (c) Communicating with medical professionals if the participant gives permission to do so. 4) Provide furnishings used in the following areas if items have not been obtained from other sources including, but not limited to:	amendment is approved which was submitted June 20, 2016: Rule 5.5.C.4.g) *g) Supervised Living settings must be physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) Optimize, but not regiment, 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.*

	(a) Den, (b) Dining, (c) Bathrooms, and (d) Bedrooms such as: (1) Bed frame, (2) Mattress and box springs, (3) Headboard, (4) Chest, (5) Night stand, and (6) Lamp. 5) Provide the following supplies: (a) Kitchen supplies including, but not limited to: (1) Refrigerator, (2) Cooking appliance, or (3) Eating and food preparation utensils, (b) Two (2) sets of linens: (1) Bath towel, (2) Hand towel, and (3) Wash cloth, (c) Cleaning supplies. 6) Train staff regarding the participant's PSS prior to beginning work with the participant. 7) Provide nursing services as a component in accordance with the Mississippi Nurse Practice Act. b) Supervised Living providers cannot: 1) Receive or disburse funds on the part of the individual unless authorized by the Social Security Administration, 2) Bill for the cost of room and board, building maintenance, upkeep, or improvement, or	Rule 5.5.C.4.h) *h) Supervised Living services may be provided in settings owned or leased by a provider agency or settings owned or leased by persons.* *1) The setting can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services which the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.* *2) If the landlord tenant laws do not apply to the setting, the Department of Mental Health must ensure:* *(a) A lease, residency agreement or other form of written agreement is in place for each person, and* *(b) The agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.* *3) Each person must have privacy in their sleeping or living unit which includes:* *(a) Entrance doors lockable by the person with only appropriate staff having keys to doors,* *(b) A choice of roommates is individuals are sharing units that setting, and* *(c) The freedom to furnish and decorate their sleeping or living units within the lease or other agreement.* *4) Persons must have the freedom and support to control their own*

	3) Bill for services provided by a family member of any degree. c) Supervised Living is available to participants who are at least eighteen (18) years of age. d) Supervised Living services are not provided to participants receiving: 1) Home and Community Supports, 2) Supported Living, 3) In-Home Nursing Respite, 4) Community Respite, or 5) Host Home services. e) The cost to transport individuals to work or day programs, social events or community activities when public transportation is not available is included in the payments made to the Supervised Living providers. Supervised Living providers may transport participants in their own vehicles as an incidental component of this service and must have a valid driver's license, current automobile insurance and registration. f) Nursing services are also a component of Supervised Living services and must be provided in accordance with the Mississippi Nurse Practice Act. g) Supervised Living services may be provided in settings owned or leased by a provider agency or settings owned or leased by participants.	*schedules and activities, and have access to food at any time.* *5) Persons are able to have visitors of their choosing at any time.* *6) The setting is physically accessible to the person.* Rule 5.5.C.4.i) *i) Supervised Living settings do not include the following :* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IDD);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.* Rule 5.5.C.4.j) *j) Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all*

		income received and expenses incurred. *a) Each person must have access to food at any time, unless prohibited by his/her individual plan.* *(b) Each person must have choices of the food they eat.* *(c) Each person must have choices about when and with whom they eat* *Supervised Living sites must duplicate a "home-like" environment.* The following language will be added with the approval of the ID/DD waiver amendment. *Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an person's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,* *Supervised Living Services must include the following services as appropriate to each person's support needs:* *Direct personal care assistance activities such as:*

		(a) Grooming *(b) Eating* *(c) Bathing* *(d) Dressing* *(e) Personal care needs* *Instrumental activities of daily living which include:* *(a) Assistance with planning and preparing meals* *(b) Cleaning* *(c) Transportation* *(d) Assistance with mobility both at home and in the community* *(e) Supervision of the person's safety and security* *(f) Banking* *(g) Shopping* *(h) Budgeting* *(i) Facilitation of the person's participation in community activities* *(j) Use of natural supports and typical community services available to everyone* *(k) Social activities* *(l) Participation in leisure activities* *(m) Development of socially valued behaviors (n) Assistance with scheduling and attending appointments* *Methods for assisting people arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:*

		(a)Assistance with making doctor/dentist/optical appointments; *(b)Transporting and accompanying people to such appointments; and* *(c)Conversations with the medical professional, if the person gives consent.* *Transporting the person to and from community activities, other places of his/her choice (within the provider's approved geographic region), work, and other sites as documented in the Plan of Services and Supports and Activity Support Plan.* *If Supervised Living staff members have been unable to participate in the development of someone's Plan of Services and Supports, staff be trained regarding the person's plan prior to beginning work with that person. This training must be documented.* *Orientation of the person, to include but not limited to:* *(a) Familiarization with the living arrangement and neighborhood;* *(b) Introduction to support staff and other residents (if appropriate)* *(c) Description of the written materials provided upon admission and* *(d) Description of the process for informing the person/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.*

		There must be available a description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from those living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared. *(a) Each person must have access to food at any time, unless prohibited by his/her individual plan.* *(b)Each person must have choices of the food they eat.* *(c)Each person must have choices about when and with whom they eat* *People receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.* *In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:* *1. Procedures for setting and collecting fees and/or room and board* *2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)*

		3. The time period covered by each charge (must be reviewed at least annually or at any time charges change) *4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)* *5. The written financial agreement must be explained to and reviewed with the person/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.* *6. A requirement that the person's record contain a copy of the written financial agreement which is signed and dated by the person/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the person/legal guardian.* *7. The written financial agreement must include language specifying the conditions, if any, under which a person might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the person from becoming homeless as a result of discharge/termination from the community living services.* *8. People receiving waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 Duties of the Landlord (§89-8-23) and Duties of the Tenant (§89-8-25).*

		A person must be 18 years or older to participate in Supervised Living. *There must be at least one (1) staff person under the same roof as people receiving services at all times that is able to respond immediately to the requests/needs for assistance from the people in the dwelling.* *People have the freedom and support to control their own schedules and activities.* *1. A person cannot be made to attend a day program if he/she chooses to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if he/she is ill, or otherwise chooses to remain at home.* *2. Staff must be available to support each person's choices.* *There must be a Supervised Living Program Supervisor for a maximum of four (4) Supervised Living homes.* *1. The Supervised Living Program Supervisor is responsible for providing weekly supervision and monitoring at all four (4) homes.* *2. Unannounced visits on all shifts, on a rotating basis must take place monthly.* *3. All supervision activities must be documented and available for DMH review. Supervision activities include but are not limited to: review of daily Service Notes to determine if outcomes identified on a person's Plan of*

		Services and Supports are being met; review of meals, meal plans and food availability; review of purchasing; review of each person's finances and budgeting; review of each person's satisfaction with services, staff, environment, etc. *Each person must have control over his/her personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.* *Nursing services are a component of Supervised Living services and must be provided in accordance with the MS Nursing Practice Act. They must be provided on an as-needed basis. Only activities within the scope of the Nurse Practice Act and Regulations can be provided. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administering of medication; weight monitoring, etc.* *Supervised Living sites must duplicate a "home-like" environment.* *All homes must have furnishings that are safe, up-to-date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen*

		by the people currently living in the home. *All providers must provide access to a washer and dryer in the residence.* *Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:* *1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site* *2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)* *3. Procedures to ensure pets will be kept away from food preparation sites and eating areas* *4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).* *Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, bedding, etc.* *All providers must ensure visiting areas are provided for residents and visitors. There must be visiting hours that area mutually agreed upon by all people living in the residence. Visiting hours cannot be restricted unless mutually*

		agreed upon by all people living in the dwelling. *The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.*
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.5:** *Covered Services* *C.5.: Day Services -Adult*	5. Day Services-Adult is defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies included on the PSS. Activities include environments designed to foster the acquisition and maintenance of skills, build positive social behavior and interpersonal competence which foster the acquisition of skills, greater independence and personal choice. a) Day Services-Adult must: 1) Take place in a non-residential setting, separate from the home or facility in which the participant resides, 2) Have a community integration component that meets each participant's	Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.301(c)(4)(i) through (v) and will be added to the following with the Admin. Code filing effective January 1, 2017 and other changes will be made to the Admin Code when the ID/DD waiver amendment is approved which was submitted June 20, 2016: Rule 5.5.C.a)2): *2) Be physically accessible to the person and must :* *(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.* *(b) Be selected by the person from among setting options including non-disability specific settings The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,* *(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *(d) Optimize, but not regiment, person initiative, autonomy, and independence in making life*

	need for community integration and participation in activities which may be: (a) Provided at a DMH certified day program site or in the community, or (b) Offered individually or in groups of up to three (3) people when provided in the community. b) Day Services-Adult providers must: 1) Not exceed one hundred thirty-eight (138) service hours in a month with twenty-three (23) working days or one hundred thirty-two (132) service hours in a month with twenty-two (22) working days. 2) Provide assistance with personal toileting and hygiene needs during the day as well as a private changing/dressing area. 3) Provide each participant assistance with eating/drinking as needed and as indicated in each participant's PSS. 4) Offer choices of food and drinks to participants and provide: (a) A mid-morning snack, (b) A noon meal, and (c) An afternoon snack. 5) Provide transportation as a component part of Day Services-Adult. (a) The cost for transportation is included in the rate paid to the provider.	*choices, including but not limited to, daily activities, physical environment, and with whom to interact.* *(e) Facilitate individual choice regarding services and supports, and who provides them.* *(f) Allow persons to have visitors of their choosing at any time they are receiving Day Services-Adult services.* *Rule 5.5.C.b)* *b) Day Services-Adult settings do not include the following :* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.* *Revise language in Rule 5.5.C.5.c)4) to state:* *4) Provide choices of food and drinks to persons at any time during the day in addition to the following:* *(a) A mid-morning snack,*

	(b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day. (c) Transportation for community outings can be counted in the total number of service hours provided per day. c) Day Service-Adult participants: 1) Must be at least eighteen (18) years old. 2) Can receive services that include supports designed to maintain skills and prevent or slow regression for participants with degenerative conditions and/or those who are retired. 3) Can also receive Supported Employment, Prevocational services, and Job Discovery, but not during the same time on the same day. 4) Can also receive Crisis Intervention services on same day at the same time. 5) Cannot otherwise be eligible under a program funded under the Rehabilitation Act of 1973, 29 USC § 110 or the Individuals with Disabilities Education Act (IDEA), 20 USC § 1400-01.	*(b) A noon meal, and* *(c) An afternoon snack.* *Deleted Rule 5.5.C.5.c)5)* ~~*5) Cannot otherwise be eligible under a program funded under the Rehabilitation Act of 1973, 29 USC § 110 or the Individuals with Disabilities Education Act (IDEA), 20 USC § 1400-01.*~~ The following will be added to the Admin. Code when the waiver amendment submitted June 20, 2016, is approved: *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.* *The site setting 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 ID/DD Waiver services. The setting must be physically accessible to persons.* *Activities and environments are designed to foster meaningful day*

		activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. *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. Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services.* *People who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.* *Transportation must be provided to and from the program and for community participation activities.* *Day Services-Adult includes assistance for people who cannot manage their personal toileting and hygiene needs during the day.* *People receiving Day Services-Adult may also receive Prevocational, Supported Employment, or Job Discovery services but not at the same time of the day.*

		The following verbiage will be deleted and revised with the 2018 waiver renewal: *Community participation activities occur at times and in places of a person's choosing and address at least one (1) of the following: 1. Activities which address daily living skills 2. Activities which address leisure/social/other community activities and events.*
Past 208: Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.5:** *Covered Services* *C.6.: Prevocational Services*	6. Prevocational Services are defined by the Division of Medicaid as services intended to develop and teach a participant general skills that contribute to paid employment in an integrated community setting. These services cannot otherwise be available under a program funded under the Rehabilitation Act of 1973, 29 USC § 110 or IDEA, 20 USC § 1400-01. a) Prevocational Services must: 1) Be reflected in the participant's PSS and be related to habilitative rather than explicit employment objectives. 2) Not exceed one hundred thirty eight (138) hours per month in a month which has twenty-three (23) working days or one hundred thirty-two (132) hours per month in a month which has twenty-two (22) working days.	Current language is in compliance with and supports Final Rule but is silent on the verbiage from 42 CFR § 441.301(c)(4)(i) through (v) and 42 § CFR 441.301(c)(5)(i)-(v) and will be added to the following with the Admin. Code filing effective January 1, 2017 and other changes, including changing prevocational services to time-limited with a written plan, will be made to the Admin Code when the ID/DD waiver amendment is approved which was submitted June 20, 2016. To be added effective January 1, 2017: Rule 5.5.C.6.a)1) *a) Prevocational Services must:* *1) Be physically accessible to the person and must:* *(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as*

	3) Have procedures to ensure food/drink is available to anyone who might forget lunch/snacks. 4) Include personal care/assistance but cannot comprise the entirety of the service; however, participants cannot be denied Prevocational Services because they require the staff's assistance with toileting and/or personal hygiene. 5) Include a review with staff and the ID/DD Waiver support coordinator for the necessity and appropriateness of the services, when a participant earns more than fifty percent (50%) of the minimum wage. 6) Be furnished in a variety of locations in the community and are not limited to fixed program locations.	*individuals not receiving Medicaid HCBS.* *(b) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, and preferences.* *(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *(d) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.* *(e) Facilitate individual choice regarding services and supports, and who provides them.* Rule 5.5.C.6.4): *4) Provide choices of food and drinks to persons who did not bring their own at any time during the day which includes, at a minimum:* *(a) A mid-morning snack,* *(b) A noon meal, and* *(c) An afternoon snack.* Rule 5.5.C.6.d): *d) Prevocational service settings do not include the following:* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or*

		5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. The following to be added with the approval of the waiver amendment submitted June 20, 2016: *Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.* *Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team. There must be a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.* *People receiving Prevocational Services must have employment related outcomes in their Plan of*

		Services and Supports; the general habilitation activities must be designed to support such employment outcomes. *Services develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples of allowable include, but are not limited to:* *1. Ability to communicate effectively with supervisors, coworkers and customers* *2. Generally accepted community workplace conduct and dress* *3. Ability to follow directions; ability to attend to tasks* *4. Workplace problem solving skills and strategies* *5. General workplace safety and mobility training* *6. Attention span* *7. Ability to manipulate large and small objects* *8. Interpersonal relations* *9. Ability to get around in the community as well as the Prevocational site* *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.* *Prevocational Services may be furnished in a variety of locations*

		in the community and are not limited to fixed program locations. NOTE: The below strike verbiage will be deleted and new verbiage inserted in the 2018 waiver renewal: *Community job exploration activities must be offered ~~to each person at least one (1) time per month~~ based on choices/requests of the persons served and provided individually or in groups of up to three (3) people. Documentation of the choices offered and the chosen activities must be documented in each person's record. People who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.* *Transportation must be provided to and from the program and for community integration/job exploration.* *Any person receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the person receiving services must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.* *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. *Personal care assistance from staff must be a component of Prevocational Services. A person cannot be denied Prevocational Services because he/she requires assistance from staff with toileting and/or personal hygiene.* NOTE: Enclaves will be deleted with the 2018 waiver renewal: *Mobile crews, and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be documented as part of the Plan of Services and Supports.* *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery and/or Supported Employment, but not at the same time of day.* NOTE: The following strike out will be deleted with new verbiage added with the 2018 waiver renewal: *A person must be at least 18 years of age and have documentation in his/her record to indicate if he/she*

		has a diploma, certificate of completion or letter from the school district stating the person is no longer enrolled in school if under the age of 22. *Services must optimize, not regiment personal initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact.* *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery, and/or Supported Employment, but not at the same time of day.*
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.8:** *Serious Events/Incidents and Abuse/Neglect/Exploitation*	G. The following serious events/incidents must be reported to DMH as outlined in the DMH Operational Standards including, but not limited to: 7. Use of seclusion or restraints, either physical or chemical, that is not part of a participant's Plan of Services and Support, Crisis Intervention Plan or Behavior Support Plan. Providers are prohibited from the use of: a)Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of	Current language is not in compliance with 42 CFR § 441.301(c)(4)(iii): *Revise to "Use of seclusion or chemical restraint" and remove the verbiage "that is not part of the participant's Plan of Services and Support, Crisis Intervention Plan or Behavior support Plan".* *Note: The use of restraints or other restrictive practices is documented through the person-centered planning process as outlined in the DMH Operational Standard 14.6.*

	movement or normal access to one's body unless being used for adaptive support, b)Seclusion, c)Time-out, and d)Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition.	
Part 208, Chapter 5: *HCBS Intellectual Disabilities/Developmental Disabilities Waiver* **Rule 5.12:** *Grievances and Complaints*	A. The Department of Mental Health (DMH) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. Grievances may be made via phone, written letter format or email. C. A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site. D. Providers of waiver services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints. E. All grievances must be resolved within thirty (30) days of receipt by DMH unless additional time is	Current language is in compliance with and supports 42 CFR § 441.301(c)(4)(iii) of the Final Rule.

	required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from DMH of the resolution and all activities performed in order to reach the resolution.	

Application for 1915(c) HCBS Waiver: MS.0282.R04.00 *1915c Intellectual Disabilities Developmental Disabilities Waiver*	**Appendix Content**	**Determination**
Appendix B **B-7: Freedom of Choice** *1915c Intellectual Disabilities Developmental Disabilities Waiver*	a. Procedures: Upon determination of eligibility and again when an individual is admitted to the waiver, individuals are informed of their ability to choose between services provided in an ICF/IID setting or those provided through the ID/DD Waiver. The individual/legal representative indicates his/her choice on the appropriate form and signs the form. The forms are maintained in each individual's ID/DD Waiver Support Coordination record. During record reviews DMH staff verifies there is documentation the individual was	Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added to comply with 42 CFR 441.301(c)(4)(ii) with the 2018 ID/DD waiver renewal : *The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings and an option for a private unit in a residential setting with identified resources available for room and board. The setting options must be selected by the person and identified and documented in the plan of services and supports.*

	offered a choice and chose ID/DD Waiver services. b. Maintenance of Forms: written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.	
Appendix C: Participant Services C-1/C-3: Service Specification *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Day Services-Adult is the provision of regularly scheduled activities in a non-residential setting, separate from the individual's private residence or other residential living arrangements, such as assistance and acquisition, retention, or improvement in social, self-help, socialization and other adaptive skills that enhance social development and skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Services-Adult must have a community integration component that meets each individual's need for community	The current language is being deleted and replaced with the following language in Appendix C-2 in the ID/DD waiver amendment submitted 6/20/2016 to comply with 42 CFR 441.301(c)(4)(i)-(iv): *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.* *The site setting 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 ID/DD Waiver services. The settings must be physically accessible to persons.*

	integration and participation in activities. Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day. A private changing/dressing area must be provided to ensure the dignity of each individual. Staff must provide each individual assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports. The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.	*Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice.* *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.* *Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services.* *People who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.* *Transportation must be provided to and from the program and for community participation activities.* *Day Services-Adult includes assistance for people who cannot manage their personal toileting and hygiene needs during the day.* *People receiving Day Services-Adult may also receive Prevocational,*

		Supported Employment, or Job Discovery services but not at the same time of the day. *People must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.* *Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).* The following language will be added during the 2018 waiver renewal in Appendix C -2 in the 2018 ID/DD waiver renewal to comply with 42 CFR 441.301(c)(4)(i)-(v): *Day Services-Adult must be physically accessible to the person and must :* *(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.* *(b) Be selected by the person from among setting options including non-disability specific settings The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,* *(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *(d) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical*

		environment, and with whom to interact. *(e) Facilitate individual choice regarding services and supports, and who provides them.* *(f) Allow persons to have visitors of their choosing at any time they are receiving Day Services-Adult services.* *Providers must provide choices of food and drinks to persons at any time during the day in addition to the following:* *(a) A mid-morning snack,* *(b) A noon meal, and* *(c) An afternoon snack.* *Community activities occur at times and in places of a person's choosing and address at least one (1) of the following: 1. Activities which address daily living skills 2. Activities which address leisure/social/other community activities and events.* The following language will be added during the 2018 waiver renewal: *People must be at least 18 years of age and have documentation in their record to indicate they have received ~~either~~ a diploma, ~~or~~ certificate of completion, <u>or a letter from the school district indicating they are no longer attending school</u> if they are under the age of 22.* The following language will be deleted with the 2018 waiver renewal: *Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with*

		Disabilities Education Act (20 U.S.C. 1401 et seq.). The following language will be added during the 2018 waiver renewal in Appendix C -2 in the ID/DD waiver to comply with 42 CFR 441.301(c)(5)(i)-(v): *Day Services-Adult settings do not include the following :* *1)A nursing facility,* *2)An institution for mental diseases,* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),* *4)A hospital or,* *5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:* *(a)Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,* *(b) including Located in a buildings on the grounds of or immediately adjacent to a public institution the publicly or privately operated facility, or* *(c)Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).*
Appendix C: Participant Services C-1/C-3: Service Specification *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Prevocational Services - Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid	The current language is being deleted and replaced with the following language in Appendix C-2 in the ID/DD waiver amendment submitted 6/20/2016 to comply with 42 CFR 441.301(c)(4)(i)-(iv): *Prevocational Services provide the meaningful day activities of learning and work experiences, including*

	employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Prevocational Services include activities that are not directed at teaching job specific skills but at underlying habilitative goals such as attention span, motor skills, and interpersonal relations that are associated with building skills necessary to perform work and optimally perform in competitive, integrated employment. 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. Prevocational Services may be furnished in a variety of locations in the	*volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.* *Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team.* *There must be a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.* *People receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment outcomes.* *Services develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples of allowable include, but are not limited to:* *1. Ability to communicate effectively with supervisors, coworkers and customers* *2. Generally accepted community workplace conduct and dress* *3. Ability to follow directions; ability to attend to tasks* *4. Workplace problem solving skills and strategies*

	community and are not limited to fixed program locations.	*5. General workplace safety and mobility training* *6. Attention span* *7. Ability to manipulate large and small objects* *8. Interpersonal relations* *9. Ability to get around in the community as well as the Prevocational site* *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.* *Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations.* NOTE: The below strike verbiage will be revised in the 2018 waiver renewal: *Community job exploration activities must be offered ~~to each person at least one time per month and be~~ based on choices/requests of the persons served and provided individually or in groups of up to three (3) people. Documentation of the choices offered and the chosen activities must be documented in each person's record. People who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.*

		Transportation must be provided to and from the program and for community integration/job exploration. *Any person receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the person receiving services must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.* *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.* *Personal care assistance from staff must be a component of Prevocational Services. A person cannot be denied Prevocational Services because he/she requires assistance from staff with toileting and/or personal hygiene.* NOTE: Enclaves will be deleted with the 2018 waiver renewal: *Mobile crews~~, enclaves~~ and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be*

		documented as part of the Plan of Services and Supports. *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery and/or Supported Employment, but not at the same time of day.* NOTE: The following strike out will be deleted with the 2018 waiver renewal and the highlight added: *A person must be at least 18 years of age and have documentation in his/her record to indicate if he/she has ~~a either~~ a diploma, certificate of completion or letter from the school district stating the person is no longer enrolled in school if under the age of 22.* *Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).* *Services must optimize, not regiment personal initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact.* *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery, and/or Supported Employment, but not at the same time of day.* *Students aging out of school services must be referred to the Mississippi Department of Rehabilitation Services and exhaust those*

		Supported Employment benefits before being able to enroll in Prevocational Services. The following language will be added during the 2018 waiver renewal in Appendix C -2 in the 2018 ID/DD waiver renewal to comply with 42 CFR 441.301(c)(4)(i)-(v): *Prevocational services must be physically accessible to the person and must :* *(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.* *(b) Be selected by the person from among setting options including non-disability specific settings The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,* *(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *(d) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.* *(e) Facilitate individual choice regarding services and supports, and who provides them.* *(f) Allow persons to have visitors of their choosing at any time they are receiving Prevocational services.* *Rule 5.5.C.6.4):* *4) Provide choices of food and drinks to persons who did not bring their own at any time during the day which includes, at a minimum:*

		(a) A mid-morning snack, *(b) A noon meal, and* *(c) An afternoon snack.* The following language will be added during the 2018 waiver renewal in Appendix C -2 in the ID/DD waiver to comply with 42 CFR 441.301(c)(5)(i)-(v): *Prevocational settings do not include the following :* *1)A nursing facility,* *2)An institution for mental diseases,* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),* *4)A hospital or,* *5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:* *(a)Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,* *(b) including Located in a buildings on the grounds of or immediately adjacent to a public institution the publicly or privately operated facility, or* *(c)Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).* The following language will be deleted with the 2018 waiver renewal: *Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).*

Appendix C: Participant Services C-1/C-3: Service Specification *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Supervised Living - provides individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Services provided include: direct personal assistance activities such as grooming, eating, bathing, dressing, and personal hygiene as well as instrumental activities of daily living which include assistance with planning and preparing meals, cleaning, transportation or assistance in securing transportation, assistance with ambulation and mobility, supervision of the individual's safety and security, banking, shopping, budgeting, facilitation of the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, participation in leisure activities, and development of socially valued behaviors. It also includes assistance with scheduling and attending appointments. Supervised Living Services may be provided in settings owned or leased by a provider agency or settings owned or leased by waiver participants. Habilitation,	The current language is being deleted and replaced with the following language in Appendix C-2 in the ID/DD waiver amendment submitted 6/20/2016 to comply with 42 CFR 441.301(c)(4)(i)-(iv): *Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an person's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,* *Supervised Living Services must include the following services as appropriate to each person's support needs:* *Direct personal care assistance activities such as:* *(a) Grooming* *(b) Eating* *(c) Bathing* *(d) Dressing* *(e) Personal care needs* *Instrumental activities of daily living which include:* *(a) Assistance with planning and preparing meals* *(b) Cleaning* *(c) Transportation*

	learning and instruction are coupled with the elements of support, supervision, and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. This service includes activities to promote independence as well as care and assistance with activities of daily living when the individual is dependent on others to ensure health and safety. Providers must provide furnishings used in common areas (den, dining, and bathrooms), kitchen supplies, cleaning supplies, and at least 2 sets of linens (including towels-bath towel, hand towel and wash cloth) per person. Providers are responsible for bedroom furnishings (bed frame, box springs, mattress, headboard, chest, night stand and lamp) if an individual has none.	*(d) Assistance with mobility both at home and in the community* *(e) Supervision of the person's safety and security* *(f) Banking* *(g) Shopping* *(h) Budgeting* *(i) Facilitation of the person's participation in community activities* *(j) Use of natural supports and typical community services available to everyone* *(k) Social activities* *(l) Participation in leisure activities* *(m) Development of socially valued behaviors (n) Assistance with scheduling and attending appointments* *Methods for assisting people arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:* *(a)Assistance with making doctor/dentist/optical appointments;* *(b)Transporting and accompanying people to such appointments; and* *(c)Conversations with the medical professional, if the person gives consent.* *Transporting the person to and from community activities, other places of his/her choice (within the provider's approved geographic region), work, and other sites as documented in the Plan of Services and Supports and Activity Support Plan.* *If Supervised Living staff members have been unable to participate in the*

		development of someone's Plan of Services and Supports, staff be trained regarding the person's plan prior to beginning work with that person. This training must be documented. *Orientation of the person, to include but not limited to:* *(a) Familiarization with the living arrangement and neighborhood;* *(b) Introduction to support staff and other residents (if appropriate)* *(c) Description of the written materials provided upon admission and* *(d) Description of the process for informing the person/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.* *There must be available a description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from those living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.* *(a) Each person must have access to food at any time, unless prohibited by his/her individual plan.* *(b)Each person must have choices of the food they eat.* *(c)Each person must have choices about when and with whom they eat* *People receiving services are prohibited from having friends, family members, etc., living with them who*

		are not also receiving services as part of the Supervised Living program. *In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:* *1. Procedures for setting and collecting fees and/or room and board* *2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)* *3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)* *4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)* *5. The written financial agreement must be explained to and reviewed with the person/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.* *6. A requirement that the person's record contain a copy of the written financial agreement which is signed and dated by the person/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the person/legal guardian.* *7. The written financial agreement must include language specifying the conditions, if any, under which a person might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the person from becoming*

		homeless as a result of discharge/termination from the community living services. *8. People receiving waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 Duties of the Landlord (§89-8-23) and Duties of the Tenant (§89-8-25).* *A person must be 18 years or older to participate in Supervised Living.* *There must be at least one (1) staff person under the same roof as people receiving services at all times that is able to respond immediately to the requests/needs for assistance from the people in the dwelling.* *People have the freedom and support to control their own schedules and activities.* *1. A person cannot be made to attend a day program if he/she chooses to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if he/she is ill, or otherwise chooses to remain at home.* *2. Staff must be available to support each person's choices.* *There must be a Supervised Living Program Supervisor for a maximum of four (4) Supervised Living homes.* *1. The Supervised Living Program Supervisor is responsible for providing weekly supervision and monitoring at all four (4) homes.* *2. Unannounced visits on all shifts, on a rotating basis must take place monthly.* *3. All supervision activities must be documented and available for DMH*

		review. Supervision activities include but are not limited to: review of daily Service Notes to determine if outcomes identified on a person's Plan of Services and Supports are being met; review of meals, meal plans and food availability; review of purchasing; review of each person's finances and budgeting; review of each person's satisfaction with services, staff, environment, etc. *Each person must have control over his/her personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.* *Nursing services are a component of Supervised Living services and must be provided in accordance with the MS Nursing Practice Act. They must be provided on an as-needed basis. Only activities within the scope of the Nurse Practice Act and Regulations can be provided. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administering of medication; weight monitoring, etc.* *Supervised Living sites must duplicate a "home-like" environment.* *All homes must have furnishings that are safe, up-to-date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent*

		possible, are chosen by the people currently living in the home. *All providers must provide access to a washer and dryer in the residence.* *Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:* *1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site* *2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)* *3. Procedures to ensure pets will be kept away from food preparation sites and eating areas* *4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).* *Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, bedding, etc.* *All providers must ensure visiting areas are provided for residents and visitors. There must be visiting hours that area mutually agreed upon by all people living in the residence. Visiting hours cannot be restricted unless mutually agreed upon by all people living in the dwelling.* *The setting is integrated in and supports full access to the community*

		to the same extent as people not receiving Supervised Living services. The following language will be added during the 2018 waiver renewal in Appendix C -2 in the 2018 ID/DD waiver renewal to comply with 42 CFR 441.301(c)(4)(i)-(vi): *Supervised Living services must be physically accessible to the person and must :* *(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.* *(b) Be selected by the person from among setting options including non-disability specific settings and the option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and for residential settings, resources available for room and board.* *(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *(d) Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.* *(e) Facilitate individual choice regarding services and supports, and who provides them.* *(f) Allow persons to have visitors of their choosing at any time they are receiving Supervised Living services.*

		1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. *2. Each individual has privacy in their sleeping or living unit:* *• Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.* *• Individuals sharing units have a choice of roommates in that setting.* *• Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.* *3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.* *4. Individuals are able to have visitors of their choosing at any time.* *5. The setting is physically accessible to the individual.* The following language will be added during the 2018 waiver renewal in Appendix C -2 in the ID/DD waiver to comply with 42 CFR 441.301(c)(5)(i)-(v):

		Supervised Living settings do not include the following : *1)A nursing facility,* *2)An institution for mental diseases,* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),* *4)A hospital or,* *5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:* *(a)Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,* *(b) Located in a building on the grounds of or immediately adjacent to a public institution the publicly or privately operated facility, or* *(c)Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).*
Appendix C: Participant Services C-1/C-3: Service Specification *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Community Respite - is provided in a community setting (DMH certified site which is not a private residence) and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home. Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which has scheduled activities to address individual preferences/requirements and also provides for the	Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added in Appendix C-2 in the ID/DD waiver amendment submitted 6/20/2016 to comply with 42 CFR 441.301(c)(4)(i): *The site setting 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 HCB services.* The following language will be added with the 2018 ID/DD renewal to comply with 42 CFR 441.301(c)(4)(i)-(v):

	health and socialization needs of the individual. Community Respite services are generally provided in the afternoon, early evening, and on weekends. The Community Respite provider must assist the individual with toileting and other hygiene needs. Individuals must be offered and provided choices about snacks and drinks. There must be meals available if Community Respite is provided during a normal meal time such as breakfast, lunch or dinner.	*Community Respite service settings must be physically accessible to the person and must:* *1)Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2)Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.* *3)Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4)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.* *5)Facilitate individual choice regarding services and supports, and who provides them.* The following language will be added with the 2018 ID/DD renewal to comply with 42 CFR 441.301(c)(5)(i)-(v): *Community Respite settings do not include the following:* *1)A nursing facility,* *2)An institution for mental diseases,* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID),* *4)A hospital, or*

		5)Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting: *(a)Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,* *(b)Located in a building on the grounds of or immediately adjacent to a public institution the publicly or privately operated facility, or* *(b)Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).* The following language will be deleted with the 2018 ID/DD waiver renewal to comply with 42 CFR 441.301(c)(4)(iv): *Community Respite services are generally provided in the afternoon, early evening, and on weekends.*
Appendix F: Participant-Rights F-3: State Grievance/Complaint System *1915c Intellectual Disabilities Developmental Disabilities Waiver*	The MS Department of Mental Health operates a grievance system through the Office of Consumer Support (OCS) within the Bureau of Quality Management, Operations, and Standards. Within the past year, OCS has revised its grievance system to be more consumer and family friendly and eliminate perceived barriers associated with the grievance process. OCS accepts a broad range of grievances. Grievances often include, but are not	Current language is in compliance with and supports 42 CFR 441.301(c)(4)(i)-(v) of the Final Rule

	limited to, dissatisfaction with an individual service provider, dissatisfaction with a provider agency, alleged violations of individual rights, environmental issues, and access to services. Individuals, family members, caregivers, or other interested parties have multiple avenues for filing a grievance. Grievances are received by phone, written format, or email. Upon receipt of a grievance, a Consumer Advocate within the Office of Consumer Supports categorizes the grievance based on an established level system. Information that differentiates the grievance process from the fair hearing process is disseminated to the individual and their family members during the initial enrollment and annually thereafter. Also, the individual is informed that they do not have to file a grievance prior to requesting a fair hearing. All grievances are resolved within 30 days of OCS receipt. The individual filing the grievance is provided formal notification from the Director of OCS of the resolution and activities performed in order to reach the resolution.	

Appendix G: Participant Safeguards **G-1: Response to Critical Events or Incidents** *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Upon admission and at least annually thereafter, every service provider is required to provide individuals receiving services and/or their legal guardians, both orally and in writing, the DMH's and program's procedures for protecting individuals from abuse exploitation and any other form of abuse. Each individual/legal guardian is provided a written copy of their rights. Program staff reviews the rights with each individual/legal guardian and the individual/legal guardian signs the form indicating the rights have been presented to them both orally and in writing, in a way which is understandable to them. Contained in the rights is information about how the individual/legal representative can report any suspected violation of rights and/or grievances, to the DMH Office of Consumer Supports. The toll free Help Line number is posted in prominent places throughout each program site. Upon admission and at least annually thereafter, individuals are also provided information, in writing and orally, about the procedures for filing a grievance.	Current language is in compliance with and supports 42 CFR 441.301(c)(4)(i)-(v) of the Final Rule

Appendix G: Participant Safeguards **G-2: Safeguards Concerning Restraints and Restrictive Interventions** *1915c Intellectual Disabilities Developmental Disabilities Waiver*	Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition. Providers must ensure that all staff who may utilize physical restraint/escort successfully complete training and hold Mandt certification. Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. In emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others. An emergency is defined as a situation	Current language is in compliance with and supports Final Rule but is silent on the following verbiage which will be added with the 2018 waiver renewal ID/DD submitted 4/20/2016 to comply with 42 CFR 441.301(c)(4)(iii) of the Final Rule: *Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, individuals must not be restrained for more than fifteen (15) minutes at any one time. They must be released after those fifteen (15) minutes. A face-to-face assessment must take place while the individual is being restrained.*

	where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff. Time out may not be used by the ID/DD Waiver providers. K. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support/Crisis Intervention Plan by order of a physician or other licensed independent practitioner as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider and documented in the case record. L. Providers must establish and implement written policies and procedures regarding the use of physical restraint(s)/escort with implementation (as applicable) documented in the Behavior Support Plan and in each individual case record: 1. Orders for the use of physical restraint(s)/escort must never be written as a standing order or on an as needed basis (that is, PRN). 2. A Behavior Support/Crisis Intervention Plan must be developed by	

	the individual's team when these techniques are implemented more than three (3) times within a thirty (30) day period with the same individual. The Behavior Support/Crisis Intervention Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support/Crisis Intervention Plan must be developed with the signature of the program's director. 3. In physical restraint situations, the treating physician must be consulted within twenty-four (24) hours and this consultation must be documented in the individual's case record. 4. A supervisory or senior staff person with training and demonstrated competency in physical restraint(s) who is competent to conduct a face-to-face assessment will conduct such an assessment of the individual's mental and physical well-being as soon as possible but not later than within one (1) hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained monitors the situation for the duration of	

	the intervention. 5. Requirements that staff records an account of the use of a physical restraint(s)/escort in a behavior management log that is maintained in the individual's case record by the end of the working day.	

Administrative Code Title 23: Division of Medicaid	**Rule Content**	**Determination**
Part 208 Chapter 7: *1915(i) HCBS* **Rule 7.3:** *Freedom of Choice*	A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6. B. Case Managers must inform the beneficiary/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider. C. The choice made by the beneficiary/legal representative must be documented and signed by the beneficiary/legal representative and must be maintained in the beneficiary's record.	Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.710(a)(1)(ii) which will be added to rule 7.3.B. and 7.3.C. with the Admin Code filing effective January 1, 2017: *B. Targeted Case Managers must facilitate individual choice regarding services and supports and who provides them. Targeted Case Managers must inform the person/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider. C. Settings are selected by the person from among setting options including non-disability specific settings based on the person's needs and preferences which are identified and documented in the plan of services and supports.*
Part 208, Chapter 7: *1915(i) HCBS* **Rule 7.5** *Covered Services*	C. The 1915(i) State plan services are: 1. Day Support Services defined by the Division of Medicaid as services designed to assist the beneficiary with	Current language is in compliance with and supports Final Rule but is silent on the following verbiage from 42 CFR § 441.710(a)(1) and 42 CFR § 441.710(a)(2) which will be added to the Admin Code when a State Plan Amendment (SPA) is approved which

	acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Support Services: a) Must take place in a non-residential setting separate from the home or facility in which the beneficiary resides. b) Must be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the beneficiary's POC. c) Must be provided in DMH certified sites /community settings.	will be submitted by January 1, 2017 to revise the following: Rule 7.5.C.1.: Change Day Support Services to Services to Day Services-Adult and revise the definition to the following: *1. Day Services-Adult is the provision of regularly scheduled activities in a non-residential setting, separate from the individual's private residence or other residential living arrangements, such as assistance and acquisition, retention, or improvement in social, self-help, socialization and other adaptive skills that enhance social development and skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Services-Adult must have a community integration component that meets each individual's need for community integration and participation in activities. The setting must be physically accessible to persons.* *Rule 7.5.C.1.b) Cannot exceed 138 hours per month.* The following verbiage will be added with the Admin Code filing effective January 1, 2017: *b)Settings must be physically accessible to the person and must:* *1)Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek*

		employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. *2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* Rule 7.5.C.1.c): *c)Do not include the following:* *1)A nursing facility;* *2)An institution for mental diseases;* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4)A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*

	2. Prevocational Services defined by the Division of Medicaid as services to prepare a beneficiary for paid employment. Services address underlying habilitative goals which are associated with performing compensated work. Services include, but are not limited to, teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented but instead are aimed at a generalized result. Prevocational Services: a) Must be included in the beneficiary's Plan of Services and Supports and be directed towards habilitative objectives and not explicit employment objectives. b) Providers are not required to provide meals but must have procedures to ensure food/drink is available for beneficiaries, if necessary. c) May include personal care/assistance as a component but it cannot comprise the entirety of the service. Beneficiaries cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene. d) Beneficiaries must be compensated in accordance	*<u>This verbiage will be added to the Admin Code when a State Plan Amendment (SPA) is approved which will be submitted by January 1, 2017,</u>* *<u>2. Prevocational Services</u> - Prevocational Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Prevocational Services include activities that are not directed at teaching job specific skills but at underlying habilitative goals such as attention span, motor skills, and interpersonal relations that are associated with building skills necessary to perform work and optimally perform in competitive, integrated employment. 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.*

	with applicable federal laws and regulations. If a beneficiary is performing productive work as a trial work experience that benefits the provider or that would have to be performed by someone else if not performed by the beneficiary, the provider must pay the beneficiary commensurate with members of the general work force doing similar work per federal wage and hour regulations. e) Must be reviewed for necessity and appropriateness by the beneficiary, appropriate staff and the Case manager if the beneficiary earns more than fifty percent (50%) of the minimum wage. f) Providers must inform beneficiaries about Supported Employment opportunities and other competitive employment activities in the community on an annual basis. g) May be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each beneficiary at least one (1) time per month. h) Include transportation. Time spent in transportation to and from the program cannot be	

	included in the total number of service hours provided per day, unless it is for the purpose of training.	
Part 208, Chapter 7: *1915(i) HCBS* **Rule 7.6:** *Serious Events/Incidents and Abuse/Neglect/Exploitation*	B. Providers must provide the beneficiary/legal guardian with the provider's procedures for protecting beneficiaries from abuse, neglect, exploitation, and any other form of potential abuse. 1. The procedures must be provided upon admission and at least annually thereafter. 2. The procedures must be given orally and in writing. 3. Documentation must include the beneficiary/legal guardian's signature indicating the rights have been explained in a way that is understandable to them. 4. The beneficiary/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Support (OCS) or Disability Rights Mississippi. 5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the beneficiary/legal representative. C. All providers must have a written policy for documenting and reporting all serious events/incidents.	Current language is in compliance with and supports Final Rule and complies with 42 CFR § 441.710(a)(1)(iii) but is silent on the following which will be added: Rule 7.6.F.8. *8.Use of seclusion or restraint., either mechanical or chemical. Providers are prohibited from the use of:* *a)Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,* *b)Seclusion,* *c)Time-out, and* *d)Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,*

	1. Suspected abuse/neglect/exploitation that occurs in a home setting must be reported to the Vulnerable Adults Unit (VAU) at the Attorney General's Office and the Division of Family and Children Services (DFCS) at the Mississippi Department of Human Services (DHS). 2. Complaints of abuse/neglect/exploitation of beneficiaries in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU), Office of the State Attorney General (AG) and to the Mississippi Department of Health. 3. Suspected abuse/neglect/exploitation that occurs in any Day Support services facility, which Division of Medicaid defines as a community-based group program for adults designed to meet the needs of adults with impairments through individual Plans of Care, which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling beneficiaries to live in the community must be reported to the DMH/BQMOS if the	

	facility is certified by the DMH. 4. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.	

MS 1915(i) State Plan Home and Community-Based Services	SPA Content	Determination
Services *1915(i) HCBS*	Day Habilitation - are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports to enhance an individual's acquisition of skills, appropriate behaviors and personal choice. Day Habilitation activities must aim to improve skills needed for the individuals to function as independently as possible. Day Habilitation will be provided based on a person centered approach with supports tailored to the individual desires and life plan of the individual participant. Day Habilitation Services take place in a non-residential setting that is separate from	Current language is compliance but silent on 42 CFR § 441.710(a)(1)(i)-(v) of the Final Rule which will be added with a SPA to be submitted by April 2017. Also changing the name from Day Habilitation to Day Services-Adult. *Day Services-Adult settings must be physically accessible to the person and must:* *1)Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.*

	the residence of the individuals receiving the service. Individuals will be able to choose their provider of Day Habilitation Services from those certified by the MS Department of Mental Health to provide the service.	*3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* *Current language is silent on 42 CFR § 441.710(a)(2)(i)-(v) of the Final Rule which will be added with a SPA to be submitted by April 2017.* *Day Services-Adult settings do not include the following:* *1)A nursing facility;* *2)An institution for mental diseases;* *3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4)A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
Services *1915(i) HCBS*	Prevocational Services - provide learning and work experiences, including volunteer work, where the individual can develop	Current language is silent on 42 CFR § 441.710(a)(1)(i)-(iv) of the Final Rule which will be added with a SPA to be submitted by April 2017.

	general, non-job-task specific strengths and skills that contribute to paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Individuals receiving Prevocational Services must have employment related goals in their Plans of Care; the general habilitation activities must be designed to support such employment goals.	*Prevocational Service settings must be physically accessible to the person and must:* *1)Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* Current language is silent on 42 CFR § 441.710(a)(2)(i)-(v) of the Final Rule which will be added with a SPA to be submitted by April 2017. *Prevocational Service settings do not include the following:* *1)A nursing facility;* *2)An institution for mental diseases;*

		3)An intermediate care facility for individuals with intellectual disabilities (ICF/IID); *4)A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
Reimbursement *1915(i) HCBS Day Habilitation*	Services cannot exceed five (5) hours a day and must be delivered at least four (4) hours one (1) day per week and are based on the individual's plan of care. A minimum staffing ratio of 1 staff member to every 8 individuals receiving the service will be in place.	Current language is in conflict with 42 CFR § 441.710(a)(1)(i). A State Plan Amendment (SPA) will be submitted by April 2017 to CMS requesting the removal of the Day Habilitation four (4) hour minimum requirement for provider reimbursement and change the maximum to 138 hours per month.

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 as follows and can be located at http://www.dmh.ms.gov/providers/. The verbiage located in the third column was included in the DMH Operational Standards effective July 1, 2016.

DMH Operational Standard Rule Number	Rule Content	Determination
13.5	Facilities and services must be in compliance with Section 504 of the Rehabilitation Act of 1973, as	In compliance with and supports 42 CFR §

	amended, and the Americans with Disabilities Act (P.L. 101-336). Based on the needs of the individuals served in each residence/program, Supervised Living Supported Living, and Host Home Services must make necessary modifications as outlined in 13.5 B-G and Rule 13.6. Services cannot be denied based on the need for modifications.	441.301(c)(4)(i) through (v) of the Final Rule.
14.1	A. There must be written and implemented policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal representative(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. The individual receiving services and/or parent/legal representative must also be given a written copy of these rights, which at a minimum, must include: a. The services within the program and other services available regardless of cultural barriers and limited English proficiency; b. The right to access services that support an individual to live, work and participate in the community to the fullest extent of the individual's capability; c. The right to services and choices, along with program rules and regulations, that support recovery/resiliency and person-centered services and supports; d. The right to be referred to other providers services and supports in the event the provider is unequipped or unable to serve the individual; e. The right to refuse treatment/services;	In compliance with and supports 42 CFR § 441.301(c)(4)(iv) of the Final Rule with the following added effective July 1, 2016: *The right to have visitors of his/her choosing at any time, to the greatest extent possible. Visitation rights cannot be withheld as punishment or in any other manner that unreasonably infringes on the individual's stated rights;* *The right to daily, private communication (phone, email, mail, etc.) without hindrance unless clinically contraindicated. If restrictions to communication are put in place, the individual has the right to the following: (d) For ID/DD Waiver providers, a written plan must be in place which outlines the how and when restrictions will be lifted or faded and be signed by the individual.*

	f. The right to ethical treatment including but not limited to the following: i. The right not to be subjected to corporal punishment ii. The right to be free from all forms of abuse or harassment iii. The right to be free from restraints of any form that are not medically necessary or that are used as a means of coercion, discipline, convenience or retaliation by staff iv. The right to considerate, respectful treatment from all employees and volunteers of the provider program. g. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution; h. The right to personal privacy, including privacy with respect to visitors in day programs and community living programs as much as physically possible; i. The right to not be discriminated against based on HIV or AIDS status; j. The right to considerate, respectful treatment from all employees of the provider program; k. The right to have reasonable access to the clergy and advocates and access to legal counsel at all times; l. The right of the individual being served to review his/her records, except as restricted by law;	

	m. The right to participate in and receive a copy of the individual plan (as defined in Rule 17.1) including, but not limited to, the following: (a) The right to make informed decisions regarding his/her care and services, including being informed of his/her health status (when applicable), being involved in care/service planning and treatment and being able to request or refuse treatment/service(s). This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. (b) The right to access information contained in his/her case record within a reasonable time frame. (A reasonable time frame is within five (5) days; if it takes longer, the reason for the delay must be communicated). The provider must not frustrate the legitimate efforts of individuals being served to gain access to their own case records and must actively seek to meet these requests as quickly as its record keeping system permits. MCA	

	41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated. (c) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel. n. The ability to retain all Constitutional rights, except as restricted by due process and resulting court order; o. The right to have a family member or representative of his/her choice notified promptly of his/her admission to a hospital; p. The right to receive care in a safe setting; q. The right to involve or not involve family and/or others is recognized and respected; and, r. The right to engage in planning, development, delivery and the evaluation of the services an individual is receiving.	
14.2	A. The provider must define each staff member's responsibility in maintaining an individual's rights, as well as the ability to explain these rights to the individuals receiving services or their family members/legal representatives.	In compliance with and supports 42 CFR § 441.301(c)(4)(ii) of the Final Rule with the following added effective July 1, 2016.

	B. The provider's policies and procedures must be written in such a way that staff member's roles in maintaining or explaining these rights are clearly defined. C. The policies and procedures must also clearly explain how the provider will train staff members to develop and retain the skills needed to uphold this role. This includes specific training regarding each right and how to explain it in a manner that is understandable to the individual and/or family member/legal representative. Training must focus on the population being served, but can include other related areas for broadened understanding. D. An individual receiving services cannot be required to do work which would otherwise require payment to other program staff or contractual staff. For work done, wages must be in accordance with local, state, and federal requirements (such as the provision of Peer Support Services by a Certified Peer Support Specialist) or the program must have a policy that the individuals do not work for the program. E. A record of any individuals for whom the provider is the legal representative or a representative payee must be on file with supporting documentation. F. For programs serving as conservator or representative payee, the following action must be taken for each individual: 1. A record of sums of money received for/from each individual and all expenditures of such money must be kept up to date and available for inspection 2. The individual and/or his/her lawful agent must be furnished a receipt, signed by the lawful agent(s) of the program, for all sums of money received and expended at least quarterly.	*14.2.G.4 (new) Individuals must be afforded the same access to the community as people who do not have a mental illness, intellectual/developmental disability, or substance use disorder.*

	G. When planning and implementing services that offer individuals the opportunity for community inclusion, providers shall recognize that: 1. Individuals retain the right to assume risk. The assumption of risk is required to consider and balance the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety; 2. Individuals make choices during the course of the day about his or her everyday life, including daily routines and schedules; and, 3. Individuals have the opportunity to develop self-advocacy skills.	
14.3	A. In addition to complying with ethical standards set forth by any relevant licensing or professional organizations, the governing authority and all staff members and volunteers (regardless of whether they hold a professional license) must adhere to the highest ethical and moral conduct in their interactions with the individuals and family members they serve, as well as in their use of program funds and grants. B. Breaches of ethical or moral conduct toward individuals, their families, or other vulnerable persons, include but are not limited to, the following situations from which a provider is prohibited from engaging in: 1. Borrowing money or property 2. Accepting gifts of monetary value 3. Sexual (or other inappropriate) contact 4. Entering into business transactions or arrangements. An exception can be made by the Executive Director of the certified provider. The Executive Director of the certified provider is responsible for ensuring that there are no ethical concerns associated with the hiring and supervision practices. 5. Physical, mental or emotional abuse	In compliance with and supports 42 CFR § 441.301(c)(4)(iii) of the Final Rule with the following verbiage added effective July 1, 2016: *14.3.B.14* *Failure to report suspected or confirmed abuse, neglect or exploitation of an individual receiving services in accordance with state reporting laws to include but not be limited to the Vulnerable Persons Act and Child Abuse or Neglect reporting requirements.*

	6. Theft, embezzlement, fraud, or other actions involving deception or deceit, or the commission of acts constituting a violation of laws regarding vulnerable adults, violent crimes or moral turpitude, whether or not the employee or volunteer is criminally prosecuted and whether or not directed at individuals or the individuals' families 7. Exploitation 8. Failure to maintain proper professional and emotional boundaries 9. Aiding, encouraging or inciting the performance of illegal or immoral acts 10. Making reasonable treatment-related needs of the individual secondary or subservient to the needs of the employee or volunteer 11. Failure to report knowledge of unethical or immoral conduct or giving false statements during inquiries to such conduct 12. Action or inaction, which indicates a clear failure to act in an ethical, moral, legal, and professional manner 13. Breach of and/or misuse of confidential information. ~~14. Retaliation of any type towards an employee who reports, in good faith, a grievance, serious incident, concern with possible noncompliance with DMH Standards or DMH professional credentialing requirements.~~	
14.4	A. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services. A detailed description of when and how these services will be provided must be clearly explained in the provider's policies and procedures. B. Language assistance services must be offered in a timely manner during all hours of operation.	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (v) of the Final Rule.

	C. Verbal offers and written notices informing individuals receiving services of their rights to receive language assistance services must be provided to individuals in their preferred language. D. Service providers must assure the competence of the language assistance provided. E. Family and/or friends of the individual receiving services should only be utilized to provide interpreter services when requested by the individual receiving services. F. Service providers must make available easily understood consumer related materials and post signage in the language of groups commonly represented in the service area.	
14.5	A. There must be written policies and procedures for implementation of a process through which individuals' grievances can be reported and addressed at the local program/center level. These policies and procedures, minimally, must ensure the following: 1. That individuals receiving services from the provider have access to a fair and impartial process for reporting and resolving grievances; 2. That individuals are informed and provided a copy of the local procedure for filing a grievance with the provider and of the procedure and timelines for resolution of grievances; 3. That individuals receiving services and/or parent(s)/legal representative(s) are informed of the procedures for reporting/filing a grievance with the DMH, including the availability of the toll free telephone number; 4. That the program will post in a prominent public area the Office of Consumer Support (OCS) informational poster containing procedures for filing a	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (v) of the Final Rule.

	grievance with DMH. The information provided by OCS must be posted at each site/service location. B. The policies and procedures for resolution of grievances at the provider level, minimally, must include: 1. Definition of grievances: a written or verbal statement made by an individual receiving services alleging a violation of rights or policy; 2. Statement that grievances can be expressed without retribution; 3. The opportunity to appeal to the executive officer of the provider agency, as well as the governing board of the provider agency; 4. Timelines for resolution of grievances; and, 5. The toll-free number for filing a grievance with the DMH Office of Consumer Support. C. There must be written documentation in the record that each individual and/or parent guardian is informed of and given a copy of the procedures for reporting/filing a grievance described above, at intake and annually thereafter if he/she continues to receive services from the provider. D. The policies and procedures must also include a statement that the DMH Certified Provider will comply with timelines issued by DMH Office of Consumer Support in resolving grievances initially filed with the DMH.	
16.5	A. Activities must be designed to address objectives in the individual plan directing treatment/support for the person. At a minimum, individual plan objectives must reflect individual strengths, needs, and behavioral deficits/excesses of individuals and/or families/guardians (as appropriate)	In compliance with and supports 42 CFR § 441.301(c)(4)(iv) through (v) of the Final Rule.

	served by the program or through the service as reflected by intake/assessments and/or progress notes. B. Services and programs must be designed to promote and allow independent decision making by the individual and encourage independent living, as appropriate. C. Programs must provide each individual with activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care. D. The services provided as specified in the individual plan must be based on the requirements of the individual rather than on the availability of services. E. Unless the behavioral issues put the individual or other individuals receiving services in jeopardy, prior to discharging someone from a service of any type due to challenging behavioral issues, the provider must have documentation of development and implementation of a positive Behavior Management Plan. All efforts to keep the individual enrolled in the day and/or community living program and/or service must be documented in the individual's record. In the event that it is determined that an individual's behavior and/or actions are putting other individuals receiving the service at risk for harm (whether physical or emotional), the development of the Behavior Management Plan is not required. The behavior and/or action that warranted discharge must be documented in the individual's record.	
16.7	A. Personnel must maintain the confidentiality rights of individuals they serve at all times across situations and locations, such as in waiting areas to which the public has access,	In compliance with and supports 42 CFR § 441.301(c)(4)(iii) of the Final Rule.

	while speaking on the telephone or, in conversing with colleagues. B. The provider must have written policies and procedures and related documentation pertaining to the compilation, storage, and dissemination of individual case records that assure an individual's right to privacy and maintains the confidentiality of individuals' records and information.	
27.1	A. Day Services-Adult is the provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements, such as assistance and acquisition, retention, or improvement in social, self- help, socialization and other adaptive skills that enhance social development and skills in performing activities of daily living. B. Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. C. Day Services-Adult must have a community integration component that meets each individual's needs for community integration and participation activities. Community integration can be provided individually or in groups of up to three (3) people. D. Community integration opportunities must be offered at least weekly and address at least one of the following: 1. Activities which address daily living skills/needs 2. Activities which address leisure/social/other community events.	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (iv) of the Final Rule with the following verbiage added effective July 1, 2016: *Day Services-Adult is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements. The settings must be physically accessible to persons. Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each individual are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented and*

	E. All community integration activities must be based on choices/requests of the individuals served. Documentation of the choices offered and the chosen activities must be maintained in each person's record on the designated form. F. Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities. G. Individuals must be offered choices of activities and allowed to make their own decision in which activities they want to participate. H. Transportation must be provided to and from the program and for community outings. I. Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day. J. A private changing/dressing area must be provided to ensure the dignity of each individual. K. All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired. L. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community. M. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports. N. Staff must provide individuals with assistance with eating/drinking as needed and as indicated	*maintained in each person's record.* *Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. 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. Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services. Community integration can be provided individually or in groups of up to three (3) people.* The following strike will be revised in the 2018 waiver renewal:

	in each individual's Plan of Services and Supports. O. The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink. **P.** Each individual must have an Individual Plan that is developed based on his/her Plan of Services and Supports.	*Community integration opportunities must be based on choices/requests of the persons served. and address at least one of the following:* *Activities which address daily living skills* *Activities which address leisure/social/other community activities and events.* *Documentation of the choices offered and the chosen activities must be maintained in each person's record.* *Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.* *Transportation must be provided to and from the program and for community participation activities.* *Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.* *A private changing/dressing area must be provided to*

		ensure the dignity of each individual. *All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.* *The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community.* *Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.* *Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.* *The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be*

		offered choices about what they eat and drink. *Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.* *Individuals receiving Day Services-Adult may also receive Prevocational, Supported Employment, or Job Discovery services but not at the same time of the day.* *The program must be in operation at least five (5) days per week, six (6) hours per day. The number hours of service is based on the individual's approved Plan of Services and Supports.* *Day Services-Adult activities must be distinct from Prevocational Services activities. Community participation activities cannot be comprised of individuals receiving Day Services-Adult with those receiving Prevocational Services. Day Habilitation and Day Services adult can be provided in the same area of a building and community participation activities can be conducted jointly.*

		Staffing ratios are based upon each person's Inventory for Client and Agency Planning (ICAP) score. *The program 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 ID/DD Waiver services.* The following verbiage will be removed and added from the DMH Standards effective 6/1/2017: *Individuals must be at least 18 years of age and have documentation in their record to indicate they have received ~~either~~ a diploma. ~~or~~ certificate of completion or a letter from the school district stating they are no longer receiving school services if they are under the age of 22.* ~~*Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).*~~ Language will be added to the 6/1/2017 DMH

		Operational Standards to comply with 42 CFR § 441.301(c)(4)(i)-(vi) of the Final Rule: *Day Services-Adult services must be delivered in settings physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.—The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.*

		3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint. *4) Optimize, but not regiment, 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* The language is silent on 42 CFR § 441.301(c)(5)(i)-(v) which will be added with the 6/1/2017 revision of DMH Operational Standards: *Day Services-Adult settings do not include the following:* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a*

		publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.
27.2	A. Community Respite is provided in a DMH certified community setting that is not a private residence and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home. B. Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which has scheduled activities to address individual preferences/requirements. C. The Community Respite provider must assist the individual with toileting and other hygiene needs. D. Individuals must be offered and provided choices about snacks and drinks. There must be meals available if Community Respite is provided during a normal mealtime such as breakfast, lunch or dinner. E. For every eight (8) individuals served, there must be at least two (2) staff actively engaged in program activities. One of these staff may be the on-site supervisor. F. Individuals receiving Community Respite cannot be left unattended at any time. G. Community Respite cannot be provided overnight.	Language will be added to the 6/1/2017 DMH Operational Standards to comply with 42 CFR § 441.301(c)(4)(i)-(vi) of the Final Rule: *G. Community Respite services must be delivered in settings physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific.*

	H. Community Respite is not used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adult, Prevocational Services, or services provided through the school system. I. Individuals who receive Host Home Services, Supervised Living, Shared Supported Living or Supported Living cannot receive Community Respite. J. All supplies and equipment must be age appropriate, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired. K. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events. L. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports. M. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports. N. Adults and children cannot be served together in the same area of the building. There must be a clear separation of space and staff. O. The program 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 Home and Community Based Services (HCBS) services. P. Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.	*The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* The language is silent on 42 CFR § 441.301(c)(5)(i)-(v) which will be added with the 6/1/2017 revision of DMH Operational Standards: *H. Community Respite settings do not include the following:* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or*

	Q. There must be a minimum of fifty (50) square feet of usable space per person in the program space. Additional square footage may be required based on the needs of individuals served.	*5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
27.3	A. Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the individual can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings. B. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the individual and his/her team. C. Individuals receiving Prevocational Services must have employment related goals in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment goals. D. Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage,	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (iv) of the Final Rule with the following verbiage added effective July 1, 2016: *Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.*

	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, is considered to be the optimal outcome of Prevocational Services. E. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. F. Services are intended to develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples include but are not limited to: 1. Ability to communicate effectively with supervisors, coworkers and customers 2. Generally accepted community workplace conduct and dress 3. Ability to follow directions; ability to attend to tasks 4. Workplace problem solving skills and strategies 5. General workplace safety and mobility training 6. Attention span 7. Motor skills 8. Interpersonal relations G. Participation in Prevocational Services is not a prerequisite for Supported Employment. An individual receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force. H. Prevocational Services may be furnished in a variety of locations in the community and are	*Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team. There must be a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.* *People receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment outcomes.* *Services develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples of allowable include, but are not limited to:* *1. Ability to communicate effectively*

	not limited to fixed program locations. I. Community job exploration activities must be offered to each individual at least one time per month and be provided individually or in groups of up to three (3) people. Documentation of the choice to participate must be documented in each individual's record. Individuals who require one-on-one assistance must be included in community job exploration activities. J. Individuals may be compensated in accordance with applicable Federal Laws. K. Transportation must be provided to and from the program and for community integration/job exploration. L. Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor. M. At least annually, providers will conduct an orientation informing individuals about Supported Employment and other competitive employment opportunities in the community. N. Personal care assistance from staff must be a component of Prevocational Services. Individuals cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene. O. Mobile crews, enclaves and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site as trial work	*with supervisors, coworkers and customers* *2. Generally accepted community workplace conduct and dress* *3. Ability to follow directions; ability to attend to tasks* *4. Workplace problem solving skills and strategies* *5. General workplace safety and mobility training* *6. Attention span* *7. Ability to manipulate large and small objects* *8. Interpersonal relations* *9. Ability to get around in the community as well as the Prevocational site* *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.* *Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations.*

	experiences. Trial work experiences must be documented as part of the individual plan. P. For every sixteen (16) individuals served, there must be at least two (2) staff actively engaged in program activities during all programmatic hours. One of these staff may be the on-site supervisor. Q. There must be a minimum of fifty (50) square feet of usable space per individual receiving services in the service area. Additional square footage may be required based on the needs of an individual. R. The program must be in operation a minimum of five (5) days per week, six (6) hours per day. Service provision must be based on an individual's approved Plan of Services and Supports. **S.** The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.	The following strike will be deleted from the DMH Operational Standards effective 6/1/2017: *Community job exploration activities must be based on choices/requests of the persons served and be provided individually or in groups of up to three (3) people. Documentation of the choices offered and the chosen activities must be documented in each person's record. People who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.* *Transportation must be provided to and from the program and for community integration/job exploration.* *Any person receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the person receiving services must be paid*

		commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor. 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. *Personal care assistance from staff must be a component of Prevocational Services. A person cannot be denied Prevocational Services because he/she requires assistance from staff with toileting and/or personal hygiene.* The following strike will be removed from the DMH Operational Standards effective 6/1/2016: *Mobile crews, ~~enclaves~~ and entrepreneurial models that do not meet the definition of Supported Employment*

		and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be documented as part of the Plan of Services and Supports. *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery and/or Supported Employment, but not at the same time of day.* The following verbiage will be added to the DMH Operational Standards effective 6/1/2017: *A person must be at least 18 years of age and have documentation in his/her record to indicate if he/she has received either a diploma, or certificate of completion or letter from the school district stating the person is no longer enrolled in school if under the age of 22.* *Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).*

		Services must optimize, not regiment personal initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact. *Persons receiving Prevocational Services may also receive Day Services-Adult, Job Discovery, and/or Supported Employment, but not at the same time of day.* *P. Staffing will be based on tiered levels of support need, depending on their ICAP score. These settings are located at sites in local communities that afford access to the community and job market at large.* Language will be added to the 6/1/2017 DMH Operational Standards to comply with 42 CFR § 441.301(c)(4)(i)-(vi) of the Final Rule: *Q. Prevocational services must be delivered in settings physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the*

		greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. *2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.—The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.* *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) Optimize, but not regiment, 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.*

		5) Facilitate individual choice regarding services and supports, and who provides them. The language is silent on 42 CFR § 441.301(c)(5)(i)-(v) which will be added with the 6/1/2017 revision of DMH Operational Standards: *R. Prevocational settings do not include the following:* *1) A nursing facility;* *2) An institution for mental diseases;* *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of*

		individuals not receiving Medicaid HCBS.
30.1	A. Community Living Services are individually tailored supports that assist individuals with the acquisition, retention, or improvement of skills related to living independently in the community. B. Community Living Services include any type of provider-managed living arrangements and/or services. There are three core types of Community Living Services: Supported Living, Supervised Living, and Host Homes. The level/type of service is determined by skills and needs of each individual. C. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living. Supported living is for individuals who need less than 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. D. Supervised Living is intended for individuals who are determined to need an array of supports and services provided with appropriate staff and resources to support an individual who needs assistance twenty-four (24) hours per day/seven (7) days per week to live in the community. Treatment Foster Care Services and Therapeutic Group Homes are intensive community-based Supervised Living services for children and youth with SED. E. Host Homes are private homes where an individual lives with a family and receives personal care and supportive services. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes direct responsibility	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (iv) of the Final Rule Final Rule; however, this rule is being removed and incorporated with other Standards.

	for the participant's physical, social, and emotional well-being and growth in a family environment.	
30.2	A. In addition to information contained in the provider's policy and procedure manual, providers of each type of Community Living Service must develop a Handbook which includes all policies and procedures for provision of each community living service. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed. B. All providers of Community Living Services (all types) must document that each individual (and/or parent/guardian) served in Community Living Services is provided with a handbook and orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service). C. All Community Living providers must have a written plan for soliciting input from residents to be included in all sections of the handbook. D. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative. E. Community Living providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language. F. The Community Living handbook may not be a book of rules. G. The Handbook may not include any rules or restrictions that infringe on or limit the individual's ability to live in the least	The DMH Operational Standards will be revised, effective 1/1/2016, removing the requirement of a provider handbook. *All appropriate sections of the handbook have been changed to standards.* *The DMH Operational Standard 17.2.C.m.(1)-(8) and n address what must be included in the PSS. Sections have been deleted which limit personal choices and restrictions.* *Supervised Living sites must duplicate a "home-like" environment.* *All sites must have furnishings that are safe, up-to- date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the individuals currently living in the home.* *All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.*

	restricted environment possible or that limit or restrict the rights of individuals receiving services specified in Chapter 14 of these standards. H. At a minimum, the Community Living Handbook must address the following: 1. A person friendly, person first definition and description of the community living service being provided; 2. The philosophy, purpose and overall goals of the service, to include but are not limited to: (a) Methods for accomplishing stated goals and objectives (b) Expected results/outcomes (c) Methods to evaluate expected results/outcomes. 3. Description of the service components, including the minimum levels of staffing required for the safety and guidance of individuals to be served 4. A description of how the community living service addresses the following items, to include but not limited to: (a) Visitation guidelines (applying to family, significant others, friends and other visitors) that are appropriate to the type of community living (Exception: visitation guidelines are not required for Supported Living Services) (1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated (2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be	*Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:* *Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site* *Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks unpleasant odors, etc.)* *Procedures to ensure pets will be kept away from food preparation sites and eating areas* *Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).* *Resident bedrooms must not have windows over forty-four inches off the floor if identified as a means of egress. All windows at all levels must be operable.* *Resident bedrooms must meet the following dimension requirements:*

	documented in the individual's case record (3) Any restrictions on visitors must be reviewed whenever there is an identified need or request by the individual to change any of the restrictions (4) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights. (5) To the greatest extent possible, individuals should have visitors of their choosing at any time. (a) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated (Exception: Supported Living Services): (1) Any restrictions on private telephone use must be reviewed daily (2) All actions regarding restrictions on outside communication must be documented in the case record (3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights. (b) Dating (Exception: Supported Living Services) (c) Off-site activities (Exception: Supported Living Services) (d) Household tasks (Exception: Supported Living Services)	*Single room occupancy - at least one hundred (100) square feet Multiple occupancy - at least eighty (80) square feet for each resident* *Resident bedrooms must be appropriately furnished with a minimum of a single bed, chest of drawers, appropriate lighting and adequate storage/closet space for each resident;* *H. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances.* *I. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used.* *Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.* *Individuals have the freedom to furnish and*

	(e) Curfew (Exception: Supported Living Services) (f) Use of alcohol, tobacco and other drugs (Use of alcohol and/or tobacco may not be prohibited unless covered in the individuals ISP or specifically precluded in a lease or similar legal document); (g) Respecting the rights of other residents' privacy, safety, health and choices. 5. Policy regarding the search of the individual's room, person and/or possessions (Exception: Unannounced searches may not be conducted in Supported Living and Host Home settings unless there is reason to believe that a crime has been committed), to include but not limited to; (a) Circumstances in which a search may occur; (b) Staff designated to authorize searches; (c) Documentation of searches; and (d) Consequences of discovery of prohibited items. 6. Policy regarding screening for prohibited/illegal substances (Exception: Staff may not screen for prohibited/illegal substances in Supported Living and Host Home settings unless there is reason to believe that a crime has been committed; in which case, law enforcement should be contacted immediately), to include but not limited to: (a) Circumstances in which screens may occur;	*decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.* *All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.* *All programs must ensure bathtubs and showers are equipped with:* *1. Soap dishes;* *2. Towel racks;* *3. Shower curtains or doors; and* *4. Grab bars (as needed by the residents).* *Each resident must be provided at least 2 sets of bath linens, including bath towels, hand towels, and wash cloths.* *All Supervised Living sites of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.*

	(b) Staff designated to authorize screening; (c) Documentation of screening; (d) Consequences of positive screening of prohibited substances; (e) Consequences of refusing to submit to a screening; and (f) Process for individuals to confidentially report the use of prohibited substances prior to being screened. 7. Orientation of the individual to Community Living Services, to include but not limited to: (a) Familiarization of the individual with the living arrangement and neighborhood; (b) Introduction to support staff and other residents (if appropriate) (c) Description of the written materials provided upon admission (i.e., handbook, etc.); and (d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission. 8. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care (Exception: Formal agreements described below may not be necessary or appropriate in Supported Living), to include but not limited to:	*Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.* *Residential programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.* *Each bedroom must have at least two means of escape.* *The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.* *Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.* *All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.*

	(a) Agreements with local physicians and dentists to provide routine care (b) Agreements with local physicians, hospitals and dentists to provide emergency care (c) Process for gaining permission from parent/guardian, if necessary.	*All sites must have separate storage areas for:* *1. Sanitary linen;* *2. Food (Food supplies cannot be stored on the floor.); and* *3. Cleaning supplies.*
	I. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights (Exception: This degree of staff responsibility may not be necessary in Supported Living); J. Determination of the need for and development, implementation and supervision of behavior change/management programs; K. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and, L. Criteria for termination\discharge from the Community Living Service. M. Providers of Supervised Living, must also address: 1. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared. Individuals must have access to food at any time, unless prohibited by his/her individual plan;	*All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.* *The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.* *There may be visiting hours that are mutually agreed upon by all people living in the residence. Visiting hours cannot be restricted unless mutually agreed upon by all people living in the dwelling.* *Providers must provide furnishings used in common areas (den, dining, and bathrooms) if:* *1. The individual does not have these items; or*

	2. Personal hygiene care and grooming, including any assistance that might be needed; 3. Medication management (including storing and dispensing); and, 4. Prevention of and protection from infection, including communicable diseases.	*2. These items are not provided through Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver.* *Individuals have choices about housemates and with whom they share a room. There must be documentation in each person's record of the person/people they chose to be their roommate.* *Individuals must have keys to their living unit if they so choose.* *The setting is selected by the individual from setting options including non-disability specific settings and the option of having a private unit, to the degree allowed by personal finances, in the residential setting. This must be documented in the record.* *Bedrooms must have lockable entrances with each person having a key to his/her bedroom and only appropriate staff having keys.* *Individuals share bedrooms based on their choices. No more than two individuals may share*

		a bedroom. If a person must share a bedroom, it must be prior approval from BIDD.
30.1	E. In living arrangements in which the residents pay rent or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following: 1. Procedures for setting and collecting fees (in accordance with Part 2: Chapter 10 Fiscal Management) 2. A detailed description of the basic charges agreed upon (e.g. rent, utilities, food, etc.) 3. The time period covered by each charge 4. The service(s) for which special charge(s) are made 5. The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed. 6. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. 7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to mitigate the likelihood that the individual will become homeless as a result of discharge/termination from the community living services.	In compliance with and supports 42 CFR § 441.301(c)(4)(vi) of the Final Rule with the following verbiage added effective July 1, 2016: *The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or collaborate with Support Coordination to arrange an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living provider.* *Individuals receiving ID/DD Waiver services must be 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).*

30.2	D. Supervised Living facilities must, to the maximum extent possible, duplicate a "home-like" environment. E. All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate. J. Individuals share residences based on their choices. K. Individuals have freedom and support to control their own schedules and activities.	In compliance with and supports 42 CFR § 441.301(c)(4)(vi) of the Final Rule.
30.2	A. All Supervised Living (all types) of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system; B. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas; C. Residential facilities using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas; D. Each bedroom must have at least two means of escape; E. The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit. F. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom; and,	Language will be added to the 6/1/2017 DMH Operational Standards to comply with 42 CFR § 441.301(c)(4)(i)-(vi) of the Final Rule: *G. Supervised Living services must be delivered in settings physically accessible to the person and must:* *1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.* *2) Be selected by the person from among setting options including non-disability specific*

		settings and an option for a private unit in a residential setting.—The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board. *3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.* *4) Optimize, but not regiment, 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.* *5) Facilitate individual choice regarding services and supports, and who provides them.* The language is silent on 42 CFR § 441.301(c)(5)(i)-(v) which will be added with the 6/1/2017 revision of DMH Operational Standards: *H. Supervised Living settings do not include the following:* *1) A nursing facility;*

		2) An institution for mental diseases; *3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID);* *4) A hospital; or* *5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.*
30.2	A. Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor if identified as a means of egress. All windows must be operable. B. Resident bedrooms must meet the following dimension requirements: 1. Single room occupancy - at least one hundred (100) square feet 2. Multiple occupancy - at least eighty (80) square feet for each resident	In compliance with and supports 42 CFR § 441.301(c)(4)(vi) of the Final Rule. *G. Individuals have the freedom to furnish and decorate their own rooms including the bedding listed in 32.3.F.* *H. Bedrooms must have lockable entrances with appropriate staff having keys as needed.*

	3. Children or youth group home – at least seventy-four (74) square feet for the initial occupant and an additional fifty (50) square feet for a second occupant. C. Resident bedrooms must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each resident; D. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances; E. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and F. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled. G. Individuals have the freedom to furnish and decorate their own rooms. H. Bedrooms must have lockable entrances with appropriate staff having keys. I. Individuals share bedrooms based on their choices.	
30.1.G	B. Supervised Living providers must have staff on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests/needs for assistance. A staff member must be designated as responsible for the program at all times. Apartment settings with an apartment manager with responsibilities related to collection of fees, maintenance,	In compliance with and supports 42 CFR § 441.301(c)(4)(v) of the Final Rule with 30.1.B. deleted and the following added effective July 1, 2016: *30.1.G*

	etc., must also have treatment/support staff in the required staff ratios in order to be considered Supervised Living. D. Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as a part of the Supervised Living program.	*There must be at least one staff person in the same dwelling as people receiving services at all times that is able to respond immediately to requests/needs for assistance from the individuals in the dwelling. Staff must be awake at all times.*
30.1	A. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. B. In addition to A, Supervised Living Services must include: 1. Direct personal care assistance activities such as: (a) Grooming (b) Eating (c) Bathing (d) Dressing (e) Personal hygiene 2. Instrumental activities of daily living which include: (a) Assistance with planning and preparing meals (b) Cleaning (c) Transportation or assistance with securing transportation	In compliance with and supports 42 CFR § 441.301(c)(4)(i) through (vi) of the Final Rule.

	(d) Assistance with ambulation and mobility (e) Supervision of the individual's safety and security (f) Banking (g) Shopping (h) Budgeting (i) Facilitation of the individual's inclusion in community activities (j) Use of natural supports and typical community services available to all people (k) Social interaction (l) Participation in leisure activities (m) Development of socially valued behaviors (n) Assistance with scheduling and attending appointments 3. Activities to promote independence as well as care and assistance with activities of daily living when the individual is dependent on others to ensure health and safety. 4. Assisting individuals in monitoring their health and/or physical condition and maintaining documentation of the following in each person's record. Such as: (a) Assistance with making doctor/dentist/optical appointments; (b) Transporting and accompanying individuals to such appointments; and (c) Conversations with the medical professional, if the individual gives consent. 5. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and	

	other sites as documented in the individual plan. 6. Accommodations must be made when an individual(s) wants to remain at home rather than joining group activities or if the individual is ill and must stay home from day activities. 7. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented. 8. Nursing services are considered a component of Supervised Living services and must be provided in accordance with the MS Nursing Practice Act.	

The Division of Medicaid filed an Administrative Code change to incorporate the requirements of the HCBS Final Rule into the necessary administrative code sections, effective January 1, 2017. Link to Administrative Code: Administrative Code | Mississippi Division of Medicaid (ms.gov)

The Division of Medicaid submitted:

- An Amendment to the 1915(c) Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver which added requirements to the HCBS final rule, effective May 1, 2017.
- A renewal for the 1915(c) E&D Waiver which added requirements pertaining to the HCBS final rule, effective July 1, 2017.
- A renewal for the 1915(c) ID/DD Waiver that incorporated the requirements of the HCBS Final Rule, effective July 1, 2018.
- A renewal for the 1915(c) Assisted Living Waiver that included updates to comply the HCBS Final rule, effective October 1, 2018.
- A 1915(i) renewal which added requirements pertaining to the HCBS Final Rule, effective November 1, 2018.
- An Amendment to the 1915(c) E&D Waiver which added open enrollment of case management with an effective date of October 1, 2019.
- A renewal for the 1915(c) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver that included updates to comply with the HCBS Final Rule, effective July 1, 2020.

Link to the State Plan: Mississippi Medicaid State Plan | Mississippi Division of Medicaid (ms.gov)

Link to 1915(c) Waivers: Waivers | Mississippi Division of Medicaid (ms.gov)

A new rule was added in Chapter 16 of the DMH Operational Standards to address specific HCBS setting requirements not already addressed in the above referenced rules effective 7/1/2016. A new rule was added in Chapter 30 of the DMH Operational Standards to address rental and/or lease agreements in addition to the already required fee agreements effective 7/1/2016. Additional revisions were made to the DMH Operational Standards effective 9/1/2020 as a result of validation assessments. These changes can be found at the Mississippi Secretary of State's Bulletin website at this link: 00024903b.pdf (ms.gov)

Identified DMH HCB setting requirements are located in the following documents and guidance contains specific qualities of home and community based settings at this link: http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf. A draft copy of the 2021 Record Guide is posted on the DMH website at the following link: http://www.dmh.ms.gov/provider-documents/

- Consent to Receive Services – Section B DMH Record Guide
- Rights of Individuals Receiving Services – Section B DMH Record Guide
- Consent to Obtain/Release Information – Section B DMH Record Guide
- Telephone/Visitation Agreement – Section D DMH Record Guide
- Plan of Services and Supports Guidance – Section I DMH Record Guide

Additional documents and guidance included in the comprehensive assessment are the Long Term Services and Supports Plan of Services and Supports (LTSS PSS) process, DOM Office of Performance Review process, and HCB settings monitoring procedures. The revisions to these documents were completed by the Division of Medicaid and other respective state agencies by January 1, 2017, to incorporate the Administrative Code changes listed above.

8. 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 and Department of Mental Health for residential and non-residential HCB settings based on the Exploratory Questions issued by CMS. Link to the assessment DOM assessment tools: HCBS Waiver Providers | Mississippi Division of Medicaid (ms.gov). Link to DMH assessment tools: http://www.dmh.ms.gov/iddd/

   The validation review included 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.

Provider Self-Assessments

The provider self-assessments were 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 helped providers and the Division of Medicaid and DMH determine the extent providers currently met 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 were compiled by the Division of Medicaid and DMH by June 30, 2015.

Validation of Self-Assessments

The Division of Medicaid received on May 6, 2016 a Geographical Information System (GIS) locator to determine setting sites that may require heightened scrutiny. After review of the GIS it was determined that the report did not completely identify site locations. Therefore, all 100% of settings received an onsite validation visit.

Each provider's self-assessment was 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 included an on-site validation visit of each provider's setting(s) and a "per setting" random sample of participant/beneficiary surveys during October 1, 2015, through December 31, 2017. For the Adult Day Care participant surveys, the random sample was selected on-site from those persons/beneficiaries attending the program when the validation process. For the Assisted Living, 100% of participants/beneficiaries were surveyed. The surveys were conducted in-person for these settings.

The Division of Medicaid prioritized site visits with those providers who self-identified as not meeting the requirements in the final rule.

During calendar year 2017, DMH staff visited 100% of the ID/DD Waiver and IDD Community Support Program 1915(i) service sites to validate the Provider Self-Assessments. However, the volume of sites and the number of DMH reviewers made it impossible to conduct complete observations of activities and interview a valid number of people receiving services and staff at each setting. Therefore, DMH contracted with an Independent Contractor to conduct Final Rule Assessment validations July 1, 2018 – November 30, 2018. The Independent Contractor and DMH staff developed the Final Rule Assessment validation tool using exploratory questions issued by CMS. All day program settings offering 1915(c) and 1915(i) Day Services Adult and Prevocational Services and 1915(c) Community Respite were assessed as well as all residential settings which included 1915(c) Supervised Living and Shared Supported Living sites. Due to CMS feedback concerning the initial STP approval, DMH staff assessed 1915(c) and 1915(i) Supported Living sites which were owned or controlled by the provider. Each setting assessment included observation of activities and interviews of a sample number of people receiving

services and at least one staff member. At least two Waiver beneficiaries were interviewed in person at each IDD setting in the initial on-site assessment and at least one Waiver beneficiary during the Validation virtual visit. In settings which provided multiple services, a person from each service was interviewed. Persons interviewed were chosen randomly on site by the surveyor. The number of consumer surveys were approximately 12% of persons receiving day program service(s) and 41% of the people receiving residential services.

Participant/beneficiary surveys were conducted in-person to a sample of persons/beneficiaries asking about their experiences in the HCB settings in order to validate provider self-assessments. The participant/beneficiary surveys were 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.

Participant/beneficiary surveys were conducted in-person to 100% of AL waiver participants. For ADC facilities, during the initial assessment period, two waiver beneficiaries were interviewed at each facility. Since the assessment period the majority of waiver beneficiaries are not utilizing ADC services in efforts to avoid congregate areas due to the pandemic. Ongoing monitoring for compliance will be conducted through the use of in-person and telephone interviews with a sampling of 30% of beneficiaries receiving ADC services.

The results of the validation review determined 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 determined what, if any, remediation strategies were needed to bring each provider into compliance. Providers were notified of their assigned category based on the completion of the validation review process by the Division of Medicaid and by DMH July through August 2019. New providers seeking to provide HCBS who do not meet the HCB setting requirements in the final rule have not been approved as a Medicaid provider or received DMH certification.

Validation Results

DOM and the DMH Independent Contractor developed a report to identify areas of non-compliance for each setting. Each report detailed information obtained from interviews with staff and people served, as well as observation of the physical setting, interaction between people and staff, and activities people were participating in. Each setting was assigned to one of four categories as designated by CMS after the validation results were compiled. There were a total of 185 settings that were validated by DOM and 264 settings by DMH with the following results:

E&D Waiver – there were 143 HCB setting sites validated:

Category I: 48 Settings - Full Compliance

Category II: 41 Settings - Needs Modifications

Category III: 54 Settings - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals

Category IV: 0 Settings - Requires Heightened Scrutiny

AL Waiver – there were 42 HCB setting sites validated:

Category I: 36 Settings - Full Compliance

Category II: 5 Settings - Needs Modifications

Category III: 1 Setting - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals

Category IV: 0 Settings - Requires Heightened Scrutiny

IDD Waiver / 1915(i) Settings: Total of 264 settings (83 Day Settings providing Day Services Adult, Prevocational Services and/or Community Respite; and 181 Residential Settings providing Supervised Living, Shared Supported Living and/or Supported Living)

Category I: 2 settings - Full Compliance
Day Settings – 0
Residential Settings - 2

Category II: 217 settings - Needs Modifications
Day Settings – 76
Residential settings - 141

Category III: 0 settings - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals

Category IV: 45 settings - Requires Heightened Scrutiny
Day Settings – 7
Residential Settings – 38

Technical Assistance

During April – June, 2019, the Independent Contractor conducted a series of webinars with DMH staff, DMH Certification staff, Division of Medicaid staff, Support Coordinators/Targeted Case Managers and IDD providers. The initial webinar reviewed the findings discovered through the HCBS Final Rule Assessments. The Independent Contractor also conducted three follow-up webinars on Protecting Rights, Achieving

Community Integration, and How to Achieve Compliance. The trainings emphasized the requirement that people must be provided the opportunity to participate in activities not solely designed for people with disabilities but rather in the broader community. Reverse integration, or a model of intentionally inviting individuals not receiving HCBS into a facility-based setting, in and of itself is not a sufficient strategy for settings to meet the integration requirements of the HCBS Final Rule. Webinars were made available on the DMH website for providers to review and use in training their staff. (ID/DD Services | Mississippi Department of Mental Health (ms.gov))

Support Coordinators for ID/DD Waiver and Targeted Case Managers for IDD Community Support Program (1915i) are required to complete a two-day intensive Person-Centered Thinking training using techniques from Michael Smull and Support Development Associates. IDD providers also participate in the two-day Person-Centered Thinking training offered throughout the year. Mississippi used the techniques to develop the Plan of Services and Supports (PSS), a detailed person-centered plan, which documents key components such as what is important to and important for the person, hopes and dreams, and abilities and risks. Any restriction or modification to any requirement of the HCBS Final Rule must be applied to an individual and must be based on the individual's specific assessed need(s) and documented in the Plan of Services and Supports.

Support Coordinators, Targeted Case Managers, providers, and individuals/families were trained in the person-centered approach in which the development of the person-centered plan is driven by the person to the maximum extent possible with the people the individual chooses. Support Coordinators/Targeted Case Managers provided participants/families a flyer concerning the HCBS Final Rule. A copy of the handout is available at the following link: http://www.dmh.ms.gov/wp-content/uploads/2019/07/CMS-HCBS-Final-Rule-Flyer.pdf

Currently, Support Coordinators/Targeted Case Managers schedule a Plan of Services and Supports (PSS) meeting initially and at least annually thereafter with the person and his/her support team. Support Coordinators/Targeted Case Managers assure each person is given a choice of services and providers, as well as non-disability specific alternatives. Rather than living with other people with disabilities in a congregate setting, other HCBS services are offered such as Supported Living, Home and Community Supports, In Home Respite and In Home Nursing Respite to provide support for the person to remain in the community or live independently. Likewise, rather than congregate day service settings each person has an opportunity to seek gainful employment with a job fully integrated in the community with assistance from MS Department of Rehabilitation Services or HCBS Supported Employment. Support Coordinators/Targeted Case Managers also inform people how to access other community resources such as HUD housing, YMCA activities, and other community supports based on the person's desires and support needs. The person's/legal representative's choice of services/providers is recorded on the Choice of Services Form, Choice of Provider Form, and in the Plan of Services and Supports. Individual rights and how the person may issue a complaint or grievance are also reviewed at least annually by Support Coordinators or Targeted Case Managers and each IDD provider. Each person

may request a change in his/her PSS at any time. 100% of initial PSS for enrollment, recertifications, and change requests PSS are reviewed by DMH staff to ensure the plan meets the HCBS requirements.

The Division of Medicaid's HCBS website outlines the requirements for enrollment as an HCBS E&D and AL provider at this link: HCBS Waiver Providers | Mississippi Division of Medicaid (ms.gov). This website includes, E&D providers, ADC Quality Assurance Standards, Individual Service Plan requirements, Standardized Progress Notes, and Facility Review Attestations for providers. For AL providers, the website has the AL Facility Walkthrough listing the HCB settings requirements. Any new provider desiring to become an AL provider must meet these requirements prior to the submittal of a MS Medicaid enrollment application. Additionally, training requirements for E&D and AL direct care staff are located on this website for providers as well as contact information for the MS Person Centered Practices Institute.

9. **Remediation/Revalidation**

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 or DMH Final Rule Assessment Validation. Non-compliance of HCB settings was determined during the validation of the provider self-assessment as described in #8 above. Providers determined to be non-compliant with the final rule received a Written Report of Findings (WRF) from the Division of Medicaid and/or DMH. The Division of Medicaid and DMH began the validation process on July 1, 2015, and completed each of the E&D and AL setting sites by December 31, 2017, totaling 185. Due to DMH contracting with an Independent Contractor, the IDD settings validation process was not complete until 11/30/2018, totaling 264. In all, there were 449 HCB setting sites validated.

For DOM, providers who received a WRF were required to submit of a POC to the Division of Medicaid detailing changes in HCB settings validated as non-compliant and the timelines the provider would be in full compliance with the final rule. Providers were required to have their completed POC submitted within forty five (45) days of receipt of the WRF unless an extension was granted on a case-by-case basis. The Division of Medicaid reviewed all submitted POCs for approval or request for additional information, if necessary, within forty five (45) days of receipt unless an extension on a case-by-case basis was required due to the volume of POCs received at one time. DOM provided technical assistance to providers to outline a path to comply with the final rule. All non-compliant Division of Medicaid providers were re-assessed through an on-site validation visit and a sample of participant/beneficiary re-surveys according to their submitted POC during the calendar years 2017 -2019 to determine if they have met the requirements of their POC (see below for DMH's process). If the provider was still assessed to be non-compliant the provider received another WRF. Another POC was completed and submitted to the Division of Medicaid within fifteen (15) days after the receipt of the WRF. A second on-site validation visit was conducted following receipt the receipt of the POC by the Division

of Medicaid's Office of Financial and Performance Review and completed by June 2021. There were no settings requiring heightened scrutiny in the AL or E&D Waiver.

For DMH, a copy of each setting's Final Rule Assessment validation identifying specific findings of noncompliance were sent to IDD Providers July – August 2019. Providers were given forty-five (45) days to submit a Plan of Compliance (POC) outlining strategies they would implement in order to become compliant and the DMH staff were given forty-five (45) days to work with the provider to accept the POC. DMH provided technical assistance to providers to develop an acceptable POC to outline a path to comply with the final rule. Some of the larger providers with numerous settings across the State were given more time due to the scale of the work. All settings POC were accepted by the end of February 2020. Providers were given three months from the acceptance of the POC to implement their plan and complete remediation strategies such as policy and procedure revision, staff training, installing bedroom door locks, etc. After the three-month implementation period, IC/DMH suspended the three-month implementation period of the Plan of Compliance (POC) to allow providers to focus on response to the COVID 19 pandemic.

On March 14, 2020, the Governor of Mississippi issued a proclamation declaring a State of Emergency as a result of the outbreak of COVID 19. The ID/DD Waiver Appendix K provided flexibilities to assist individuals continue HCB services to the fullest extent possible. The Appendix K allowed day services to be provided in person's homes and virtually/telephonically. Some providers altered their service delivery in this manner. Day program settings initially closed due to the Safer at Home executive order but gradually reopened serving about half of the number served pre-COVID. Some people and their families chose not to return to day program settings due to the risk of exposure or chose other options such as in-home supports. Likewise residential settings also made changes to service provision due to recommended safety protocols such as limiting visitors to the home and limiting community activities as did the broader community.

Validation of DMH Heightened Scrutiny Settings

DMH and the Independent Contractor developed a plan to resume assessment and validation of POC of HCBS settings in Heightened Scrutiny. DMH and the Independent Contractor first completed a desk audit of strategies outlined in each setting's approved POC beginning 5/1/2020. Types of evidence reviewed included revised policies and procedures, training records of staff and participants, photos of changes to physical settings such as door locks and secured areas, invoices or work orders, etc. DMH Independent Contractor conducted virtual validation visits to include a virtual tour of the setting and interview with staff per setting. Although personal experience could not be validated fully due to decreased community activities surrounding COVID, the provider had submitted evidence of understanding of HCBS requirements, had policies and procedures in place to comply with the Final Rule, and had trained staff and people receiving services concerning Final Rule requirements. People receiving services were being offered choices of activities at home and in the community to the same extent as other people without disabilities. The Independent Contractor concluded validation of settings in Heightened Scrutiny by 2/28/2021. All settings except two (2) supervised living settings were remediated and

determined compliant and therefore no longer under Heightened Scrutiny. The two (2) residential settings that have not been fully remediated will be sent to CMS for review at the end of the public comment period described in the Final Disposition section below. DMH will follow up with an on-site in-person survey with a random sample of persons in each of the forty-five (45) settings initially under Heightened Scrutiny by June 30, 2022 as outlined in the Ongoing Monitoring section. Any findings that are contrary to compliance with the Final Rule will result in a Written Report of Findings (WRF) and Plan of Compliance (POC).

Validation of DMH Settings that Needed Modification

DMH validated the remaining settings that needed modifications. Settings in this category had minor findings through the assessment process. DMH staff conducted desk audits of evidence submitted by providers that substantiated the provider had completed activities outlined in each settings POC. Desk audits included review of provider policies and procedures, training records for staff and persons served at the setting, written financial agreements, pictures of door locks or places to secure belongings, and other evidence specific to the setting. Virtual validations were postponed due to COVID-19 until 1/1/2021 to allow more settings to reopen and resume community activities with virtual validations completed by 6/30/2021. Virtual validation included a tour of the setting, observation of where individuals secure belongings, installation of key locks to home and bedroom and interview with a staff and a person receiving services at the setting. DMH staff used the same mitigation strategies during the validations of settings that needed modification as those described above for settings in Heightened Scrutiny.

Final Disposition

Below are the following number of HCB setting sites DOM validated and the categories assigned. There were a total of 185 settings that were validated by DOM.

E&D Waiver – there were 143 HCB setting sites validated:

Category I: 48 Settings - Full Compliance

Category II: 41 Settings - Needs Modifications
Disposition: All 41 settings made modifications according to the POC and have met compliance

Category III: 54 Settings - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals
Disposition: DOM inactivated providers of 4 settings, providers of 16 settings voluntarily terminated, and providers of 34 settings have been recommended for termination due to inactivity in the past year.

DOM was not involved with the transferring of beneficiaries to other settings that met compliance as the PDD case managers were responsible.

Category IV: 0 Settings - Requires Heightened Scrutiny

AL Waiver – there were 42 HCB setting sites validated:

Category I: 36 Settings - Full Compliance

Category II: 5 Settings - Needs Modifications

Disposition: All 5 settings made modifications according to the POC and have met compliance

Category III: 1 Setting - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals

Disposition: The setting was inside a nursing home. There were no Medicaid waiver persons in the AL facility to transfer. The provider voluntarily terminated their MS Medicaid provider number.

Category IV: 0 Settings - Requires Heightened Scrutiny

IDD Waiver / 1915(i) Settings: 264 settings initially assessed (83 Day Settings and 181 Residential Settings); Total validated – 248 settings validated (75 Day Settings and 173 Residential Settings); 16 settings closed prior to validation (8 Day Settings and 8 Residential Settings). Many settings provide multiple HCB Services. See a Summary of DMH Assessment Findings at the following link on the DMH website: http://www.dmh.ms.gov/wp-content/uploads/2021/11/SUMMARY-OF-FINAL-RULE-ASSESSMENTS.pdf

Category I: 2 settings - Full Compliance

Day Settings – 0
Residential Settings – 2

Category II: 217 settings - Needs Modifications

Day Settings – 76
Disposition: 68 settings made modifications according to the POC and have met compliance. 8 settings closed prior to the completion of the validation process. 1 day program setting lost certification by DMH/DOM and 7 voluntarily closed during the pandemic. Beneficiaries receiving services at all 8 settings were offered other providers and/or services by their Support Coordinators or Targeted Case Managers. NOTE: These 8 settings will be treated as new settings if they choose to reopen.

Residential Settings – 141

Disposition: 133 settings made modifications according to the POC and have met compliance. 8 residential settings closed prior to the completion of the validation process. All 8 settings voluntarily closed for various reasons. Beneficiaries receiving services at all 8 settings were offered other providers and/or services by their Support Coordinators or Targeted Case Managers. NOTE: These 8 settings will be treated as new settings if they choose to reopen.

Category III: 0 settings - Provider cannot meet the final rule requirements and requires removal from the program and/or relocation of individuals

Category IV: 45 settings - Requires Heightened Scrutiny

Day Settings Validated and determined Compliant– 7
Residential Settings Validated and determined Compliant – 36
Residential Settings Validated/Sent to CMS for Review – 2

Disposition:

Forty-three (43) settings – seven (7) Day Settings and thirty-six (36) Residential Settings were initially determined to meet Heightened Scrutiny criteria based on the effect of isolating individuals and/or having qualities of institutional care. DMH and the Independent Contractor developed key indicators for settings that isolate and/or have institutional qualities as follows: Settings which were large congregate settings or had multiple services/settings located in a single location, activities structured and regimented by staff with little input from individuals, community integration activities determined by the staff and conducted in groups with limited individualized planning, blanket rules around mealtimes or visitation policies rather than structuring services around the individual's support needs and abilities, and staff lacked an understanding of person-centered practices. DMH and the Independent Contractor concluded all settings in this category met compliance with the HCBS Final Rule following the remediation process prior to June 30, 2020. According to CMS Guidance for Heightened Scrutiny settings dated July 14, 2020, "if the state determines, through their assessment and validation activities, that a setting that isolates individuals from the broader community has implemented remediation strategies to bring the setting into compliance with the settings criteria by the new timeline of July 1, 2021, the setting will not need to be submitted to CMS for heightened scrutiny review."

Two (2) Supervised Living Residential Settings met the second prong of Heightened Scrutiny: one (1) was adjacent to a long-term nursing facility and (1) was adjacent to an ICF.

The setting adjacent to the long-term nursing facility had no connection to the facility. The nursing facility is in a residential neighborhood with homes

on both sides, across the street and behind the nursing facility. The validation process was concluded February 28, 2021. DMH is satisfied the HCBS Supervised Living setting demonstrates full compliance with HCBS Final Rule. However, due to the home's proximity to a nursing facility, DMH/DOM will submit an evidence package to CMS for review.

The setting adjacent to an ICF was owned by the same agency as the ICF and located across the street and two houses over from the ICF. DMH and the Independent Contractor considered the home to be adjacent to the ICF due to its proximity to the ICF campus. DMH discovered however in October 2021, the home is surrounded on each side by private ICF Group Homes owned by the same agency. There are five homes on the same street adjacent to the ICF campus – four homes are ICF Group Homes and one ID/DD Waiver Supervised Living program. The ICF and HCBS Services operate independently of each other, other than sharing Human Resources to conduct background checks for HCBS staff and the Business Office which bills Medicaid for HCBS Services. The setting completed the remediation process by June 30, 2021and demonstrated service provision meets compliance with the HCBS Final Rule. However, due to the home's location, the setting will be sent to CMS for review.

Both settings are fully certified by DMH and in good standing. Both settings completed the remediation process with DMH and determined compliant with the HCBS requirements concerning service provision. However, DMH/DOM will submit an evidentiary package to CMS for review due to their proximity to nursing facility and ICF. If either setting cannot meet full compliance with the HCBS Final Rule, DMH will work with the provider(s) and individuals living in the home to offer alternative HCBS settings/services.

All settings initially determined to be in Heightened Scrutiny will be posted on DOM website at Statewide Transition Plan | Mississippi Division of Medicaid (ms.gov).

Determination of Two (2) Settings in Heightened Scrutiny

No later than July 1, 2022, settings which do not meet the HCB settings requirements of the final rule will be notified of failure to meet HCB settings' requirements by the Division of Medicaid and that as of March 1, 2023, 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.

Persons/beneficiaries and/or their legal representatives will be notified by the Division of Medicaid in writing no later than July 1, 2022, 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 December 1, 2022. This will allow persons/beneficiaries 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.

By February 1, 2022, 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. Since all settings are compliant with the Final Rule there are no persons to be relocated.

10. **On-Going Monitoring**

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 On-Site Compliance Reviews (OSCR) as indicated, 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.
Ongoing monitoring is crucial to assure continued compliance with the HCBS Final Rule.

DOM will use the following strategies:

DOM requires case managers to provide a handout to currently enrolled persons 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 person's admission process.

E&D case managers are LSW or RNs employed by case management agencies and receive training upon hire and annually on the requirements of the HCB settings final rule as well as DOM's Administrative Code Part 208 which outlines the requirements for ADC providers. Case managers also must be certified on the completion of the interRAI within LTSS which includes the HCB settings requirements. These case managers perform monthly contacts with beneficiaries to assess for compliance with the HCB settings final rule and must report any unresolved concern to DOM within seven (7) days for intervention. Case managers do not provide services in the ADC setting nor do they monitor provider; however, they report issues to DOM that the beneficiaries report to them.

ADC compliance OSCRs are also performed if there are issues brought to the attention of DOM by beneficiaries, families or any other individual of non-compliance. At the completion of the OSCR, if there are deficiencies found, the provider will receive a Written Notice of Non-Compliance (WNN). The provider must respond with a CAP within 45 days of receipt of the WNN. A follow-up visit is then conducted by DOM's Office of LTC to ensure compliance with the CAP and HCB settings requirements.

The Office of Financial and Performance Review and Office of Long-Term Care are responsible for the ongoing auditing of the ADC providers which includes compliance with the HCB settings final rule.

For AL facilities case managers are LSWs employed by DOM. They receive training upon hire and annually on the requirements of the HCB settings final rule as well as DOM's Administrative Code Part 208 which outlines the requirements for AL providers. Case managers also must be certified on the completion of the interRAI within LTSS which includes the HCB settings requirements. Case managers perform monthly visits to assess for HCB settings compliance. If a noncompliant issue is found, the provider receives a CAP from DOM. The provider is allowed thirty (30) days to respond to the CAP with the case manager following up the next month. The Office of Financial and Performance Review conducts random audits and the AL facility is licensed by the Mississippi Department of Health and surveyed for compliance which includes several HCS settings requirements as well.

Any E&D or AL provider that fails to become compliant with deficiency findings following the issuance of a POC will begin the process of termination of their MS Medicaid provider agreement and provider number.

DOM staff will provide technical assistance and plan training opportunities based on results of Written Report of Findings, feedback from Case Managers, survey results, and requests from providers and/or stakeholders.

The waiver participants on the E&D, IL, and TBI/SCI waivers are not allowed to live in congregate living facilities, institutional settings or on or adjacent to the grounds of institutions. A person's home environment will continue to be assessed prior to admission to the waiver and contacts will continue to be made by the case managers that include home assessment. The State will continue to verify, through ongoing monitoring that all persons on these waivers reside in a private home of their choosing. The State will continue to conduct random home visits or telephone interviews throughout the year to ensure that the person's home continues to meet their health and safety needs as well as waiver requirements.

DMH will use the following strategies:

All newly certified settings since the 2018 validation assessments that are owned/operated by providers that have been through the remediation process must submit training records for staff/participants of each setting by September 30, 2021 showing all settings are using policies/procedures and HCBS Final Rule compliance required practices. Providers were required through the remediation process to include in policies and procedures that staff will be trained in the Final Rule requirements upon hire and at least annually thereafter.

Currently, DMH has identified eight (8) newly certified providers with thirteen (13) new settings since the 2018 validation assessments. All newly certified providers were certified under the revised 2016 DMH Operational Standards which included the HCBS Final Rule requirements and were informed during the application process. DMH certification staff provisionally certified all new settings prior to service delivery and fully certified settings within six months after beginning service provision. DMH will also conduct on-site Final Rule assessments to include interview with staff and random sample of at least two people served per setting by December 31, 2021 at all newly certified settings. Any areas of noncompliance will be identified through a Written Report of Findings. Providers are required to submit a Plan of Compliance within thirty (30) days of receipt of the WRF. The Plan of Compliance must address the corrective action by the provider, date of corrective action, timelines for completion of corrective action, and measures put in place to maintain compliance and prevent future occurrence. DMH staff will validate strategies toward compliance were implemented.

DMH Certification staff/programmatic staff will also provide ongoing monitoring of compliance with the HCBS Final Rule. DMH programmatic staff will review policies and procedures for compliance with DMH Operational Standards including Final Rule requirements of all applicants prior to certification. DMH Certification Team will conduct an on-site inspection of each new setting prior to service provision and again within six (6) months of beginning service provision. DMH programmatic 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 provider Plan of Compliance, and validation by DMH that strategies were implemented.

DMH Certification staff conducts on-site compliance reviews for one half of all current providers and 100% of their settings each year. Certification staff have been trained concerning HCBS Final Rule requirements and will monitor through observation of the physical setting and service provision and record review. On alternating years, the other half of providers are required to complete a self-assessment. HCBS providers will be required to submit a Final Rule self-assessment. Any areas of noncompliance in the on-site visit or self-assessment will result in a Written Report of Findings and subsequent remediation process. As per DMH Operational Standards, based on issues of noncompliance DMH may determine the need to take administrative action to suspend, revoke or terminate certification. DOM will be notified of any such administrative action.

Due to COVID restrictions/concerns, community access and participation has significantly decreased. As communities reopen, DMH will re-assess participants' community engagement. DMH will conduct a follow-up on-site visit with each of the forty-five (45) settings initially identified in Heightened Scrutiny by June 30, 2022 to interview participants and provide technical assistance and training as needed. Support Coordinators/Targeted Case Managers will also assess community engagement with participants through monthly telephone contact and quarterly face-to-face visits.

Support Coordinators/Targeted Case Managers will be trained concerning how to monitor and follow up on issues of noncompliance. Through observation and interview of the person receiving services, their family/caregiver, and support staff, Support Coordinators/Targeted Case Managers will assure people have freedom to control their schedules and engage in meaningful activities of their choice. Any issues with non-compliance with the Final Rule requirements will be reported to appropriate provider managers and documented in Service Notes how the issues are resolved. Any unresolved issues must be followed up on each month. Support Coordinators/Targeted Case Managers will consult with DMH as needed. Unresolved or egregious issues of noncompliance with HCBS requirements will be reported to DMH Certification and result in appropriate administrative action.

Support Coordinators/Targeted Case Managers will provide each participant/ family/caregiver a survey annually across all HCBS Services. The survey will allow the participant and/or family/caregiver an opportunity to comment on the specific components of the Final Rule such as freedom of choice.

DMH programmatic staff will provide technical assistance and plan training opportunities based on results of Written Report of Findings, feedback from Support Coordinators/Targeted Case Managers, survey results, and requests from providers and/or stakeholders.