

# Mississippi Division of Medicaid

Effective March, 11, 2015

the Mississippi Division of Medicaid's Revised Statewide Transition Plan Summary and Timeline for 1915(c) and 1915(i) Home and Community-Based (HCB) programs compliance with HCB settings is available for review and comments.



MISSISSIPPI DIVISION OF  
**MEDICAID**

To request a copy of the statewide transition plan, please inquire at the front desk.



## 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 March 11, 2015**

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#### **Background**

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

#### **Overview of the Settings Provision**

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

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

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

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

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

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

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

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

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

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

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

#### **1. 1915(i) State Plan Services:**

The 1915(i) State Plan provides habilitation services in HCB settings to beneficiaries who do not meet the level of care for an Intermediate Care Facility for Individuals with Intellectual (ICF/IID) but who have intellectual and developmental disabilities (IDD) and meet two (2) of the five (5) needs-based criteria on a continuing or intermittent basis:

- Is unemployed or employed in a sheltered setting, or has markedly limited skills and a poor or non-existent work history,
- Shows severe inability to establish or maintain a beneficial, meaningful personal social support system,
- Requires help in basic Instrumental Activities of Daily Living (IADLs) such as money management, housekeeping, meal planning and preparation, shopping for food, clothing and other essential items, communicating by phone or other media, and traveling around and participating in the community,

- Exhibits inappropriate social behavior that results in the need for intervention, and
- Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.

Habilitation services include Day Services-Adult, Prevocational and Supported Employment services which allow individuals with IDD the ability to live more independently, to have increased access to community integration and to develop employment skills.

Beneficiaries must meet all the eligibility requirements for full Medicaid benefits to receive 1915(i) services and not be enrolled in any 1915(c) HCBS programs.

Providers certified by DMH to provide targeted case management for the IDD population coordinate the delivery of the following services:

- a. Day Services-Adult services provide beneficiaries with structured activities to enhance social development, allow greater independence and personal choice, and increase community integration,
- b. Prevocational services provide beneficiaries with learning and work experiences to develop skills and strengths that contribute to employability; and
- c. Supported Employment services provide beneficiaries with supports to successfully perform and maintain jobs and to be more competitive with employment.

## **2. 1915(c) Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver:**

The ID/DD waiver provides individualized supports and services to people who have the same support needs as someone living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The ID/DD waiver is operated by the Mississippi Department of Mental Health (DMH), Bureau of Intellectual and Developmental Disabilities (BIDD).

Participants in this waiver must qualify for one (1) of the following eligibility categories:

- Supplemental Security Income (SSI),
- Temporary Assistance for Needy Families (TANF),
- Disabled Child Living at Home, or
- Income up to 300% of the SSI federal benefit rate.

DMH, through its regional centers and assessment process, provides support coordination and makes referrals for the following services:

- Behavior Support
- Day Services-Adult
- Home and Community Supports
- Occupational Therapy
- Physical Therapy

- Speech Therapy
- Supervised Living
- Community Respite
- Host Homes
- Crisis Support
- Crisis Intervention
- In-Home Nursing Respite
- Support Living
- Transition Assistance
- Support Coordination
- Supported Employment
- Prevocational Services
- Job Discovery
- Specialized Medical Supplies

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

The E&D waiver provides individualized supports and services to people who have the same support needs as someone living in a nursing facility. Individuals must be twenty one (21) years of age and older. The E&D waiver is administered and operated by the Division of Medicaid.

Participants in this waiver must qualify for one (1) of the following eligibility categories:

- Supplemental Security Income (SSI), or
- Income up to 300% of the SSI federal benefit rate.

Services provided through the E&D waiver include:

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

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

The AL waiver provides individualized supports and services to people who have the same support needs as someone living in a nursing facility. Participants reside in a Personal Care Home-Assisted Living (PCH-AL) facility licensed by the Mississippi State Department of Health (MSDH). The Division of Medicaid reimburses for the services received in the PCH-AL facility. Individuals must be twenty one (21) years of age and older. The AL waiver is administered and operated by the division of Medicaid.

Participants in the AL waiver must qualify for one (1) of the following eligibility categories:

- Supplemental Security Income (SSI), or
- Income up to 300% of the SSI federal benefit rate.

Services provided through the AL waiver 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 participants reside in private home dwellings located in the community. The TBI/SCI waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

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

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

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

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

2. Two (2) Public Hearings held on September 26, 2014, at the Woolfolk Building in Jackson, MS, with teleconference, and October 3, 2014, at the War Memorial Building in Jackson, MS,
3. Comments received during the thirty (30) day comment period September 17 – October 17, 2014 were:

- The Arc of Mississippi requested the Personal Outcome Measures as either a substitute for or accompaniment to the NCI for data collection for measuring quality.

*DOM Comment: 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 DOM is using the NCT performance measure for the IDD population. To use the POM would be a duplication of efforts. DOM 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.

*DOM Comment: Ms. Porter was referred to the Division of Medicaid's website and the location of the transition plans as well as instructed her to contact the Division of Medicaid to obtain a copy of the transition plan if unable to download and print.*

- Beth Porter with Disability Rights Mississippi commented “Under Section 3, Quality Management Provider Monitoring it doesn't look like you're doing any changes. It just says annually. You're just going to leave it annually instead of changing any of that? I think that should be changed -- well, that's my comment. I think that should be changed to quarterly. Thank you.”

*DOM Comment: DOM and DMH presently do not have the staffing capacity to perform quarterly monitoring. However, a committee consisting of stakeholders will be formed 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, 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.

*DOM Comment: 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.

*DOM Comment: 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 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](http://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](mailto: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:
  - a. Disability Rights of Mississippi,
  - b. The Arc of Mississippi,
  - c. Mississippi Council for Developmental Disabilities,
  - d. The Five DMH Regional Centers,
  - e. The Ten Planning and Development Districts (PDDs),
  - f. DMH, and
  - g. Mississippi Access to Care (MAC) stakeholders.

3. 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](mailto:Margaret.Wilson@medicaid.ms.gov).
4. A review of state standards, rules, regulations and other requirements to determine whether they align or do not align with federal regulations. A review of the Miss. Admin. Code Title 23: Division of Medicaid, Part 208: Home and Community-Based Services, Chapter 2: Elderly and Disabled Waiver, Chapter 3: Assisted Living Waiver, Chapter 5: Individuals with Intellectual/Developmental Disabilities Waiver and Chapter 7: 1915 (i) State Plan Services will be conducted to determine compliance with the HCB settings final rule by April 1, 2016. The Division of Medicaid will then propose and final file the Administrative Code any changes necessary to comply with the final rule on HCB settings with the Mississippi Secretary of State's office according to the Administrative Procedures Act by June 1, 2016. A review of the Provider Reference Guide, On-Site Compliance Review (OSCR) processes, the DMH Record Guide, and HCB settings monitoring procedures will also be conducted. The review and changes to these documents will be completed by the Division of Medicaid and other respective state agencies between April 1, 2015 and April 1, 2016.
5. A sequential timeline which includes the completion and validation of the provider self-assessment tool. The provider self-assessment tool was developed by the Division of Medicaid for residential and non-residential HCB settings based on the Exploratory Questions issued by CMS.

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

Each provider's self-assessment will be checked for validity by the validation review committee which consists of the Division of Medicaid, Offices of Long-Term Care and Mental Health, and DMH. The validation process will include an on-site validation visit of each provider's setting(s) and a random sample of participant/beneficiary surveys during June 1, 2015, through December 31, 2016.

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

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

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

6. The process for non-compliant providers to submit a written Plan of Compliance (POC) based on results of the validation of the provider self-assessment. Non-compliance of HCB settings is determined during the validation of the provider self-assessment as described in #5 above. Providers determined to be non-compliant with the final rule will receive a Written Report of Findings (WRF) from the Division of Medicaid and/or DMH within forty five (45) days of the completion of the on-site validation visit beginning July 1, 2015.

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

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

Participants/beneficiaries and/or their legal representatives will be notified by the Division of Medicaid in writing no later than March 1, 2018, if the participant/beneficiary receives HCBS in HCB settings not in compliance with the federal regulations. The participant/beneficiary will be required to choose an alternative HCB setting which meets federal regulations to receive their HCBS before March 1, 2019. This will allow participants/beneficiaries one (1) years' time to make an informed choice of alternate HCB settings and HCBSs which are in compliance with the federal rule. The notification will include the Division of Medicaid's appeal process according to Miss. Admin. Code Title 23, Part 300 and for IDD individuals will also include the appeals process for DMH. The participant/beneficiary's case manager 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 in available in advance and at the time of the transition, including ID/DD Support Coordinator, Targeted Case Manager, family, natural supports, and
- Timeline for the relocation or change of provider and/or services.

During calendar years 2015 and 2016, non-compliant providers will receive ongoing technical assistance, training and follow-up on-site validation visits to determine progress toward meeting their POC. The Division of Medicaid, with guidance from CMS, will train state level and field staff of the Division of Medicaid and DMH, as well as families and other stakeholders about the requirements of the final rule to correct non-compliance issues. During Calendar Year 2017, the Division of Medicaid will conduct follow-up on-site validation visits for those providers determined to continue to be non-compliant of the final rule. This timeline allows providers two (2) years to meet the HCB setting requirements of the final rule.

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

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

The National Core Indicators (NCI) will be used to assess the satisfaction of people receiving services and supports and to determine the effectiveness of the HCB settings final rule in participant/beneficiary's day-to-day lives for the 1915(c) and 1915(i) HCBS programs. Currently data is collected for the IDD population and is being expanded to include the Aged

and Disabled population. A random sample of participants/beneficiaries will be interviewed using the NCI Survey. Data gathered from surveys conducted in 2017 will be compared to data from previous years to determine the result of the implementation of the HCB setting requirements in the final rule. Areas identified as deficient will be reviewed and strategies will be developed to remediate the issues.

**Mississippi Division of Medicaid  
Revised Statewide Transition Plan Timeline  
1915(c) and 1915(i) Home and Community-Based (HCB) Programs  
Compliance with HCB Settings  
March 11, 2015**

	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
	<b>Section 1: Assessment</b>					
1.	Provider residential and non-residential settings self-assessment tool development	DOM develops provider self-assessment tool for residential and non-residential settings based on federal requirements for meeting HCB setting	DOM/DMH staff	12/1/14	02/15/15	Complete
2.	Provider meeting	Meet with providers to provide training to conduct the self- assessment tool	DOM/DMH staff, providers, key stakeholders	12/15/14	12/31/14	Complete
4.	Providers conduct self-assessment	Provider self-assessments of residential and non-residential settings must be completed and submitted to DOM or DMH if services for IID. Provider's Quality Management Committees must review assessments of all settings before submission to DMH.	All Providers	1/1/15	04/15/15	
5.	Administrative Code and Reference Guide review	Revision of DOMs Miss. Admin. Code Part 208, Chapters 2, 3, 5, and 7 and DMH's Record Guide, Medicaid's Provider Reference Guide, On-Site Compliance Review processes, and HCB settings monitoring procedures	DOM/DMH staff, key stakeholders	4/1/15	4/1/16	
6.	Compilation of results of self-assessments	Self-assessment data is compiled to determine providers category I-IV	DOM/DMH staff	5/1/15	6/30/15	
7.	Participant/legal representative Survey	Surveys by e-mail, Survey Monkey, hard copy mailings and phone surveys to a sample of participants inquiring about the HCB settings they receive HCBS to validate provider self-assessments	DOM/DMH and a representative sample size of participants	6/1/15	12/31/15	

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	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
8.	On-site Validation and Re-Validation Visits	Validate each providers self-assessment of each HCB setting site	DOM/DMH staff	7/1/15	12/31/17	
9.	Provider Category Assigned	The state will identify the provider category I-IV based on the validation of the provider self-assessment	DOM/DMH staff	9/1/15	12/31/17	
10.	Provider Notification of Assigned Category	DOM/DMH will notify providers of their assigned category. If provider is a Category II or III refer to Remedial Strategies	DOM/DMH	9/1/15	12/31/17	
11.	DOM/DMH monitoring processes and procedures	Review and revise as appropriate ongoing monitoring processes for HCB setting requirements	DOM/DMH staff	1/1/16	On-going	
12.	Miss. Admin. Code Secretary of State filings	Proposed and final filing Administrative Code changes with the for Secretary of State according to the Administrative Procedures Act	DOM/DMH staff	4/1/16	6/30/16	
13.	Amended Statewide Transition Plan	Amended Statewide Transition Plan submitted to CMS that includes an estimate of the number of settings within each category I-IV	DOM	4/1/17	4/1/17	
	<b>Section 2: Remedial Strategies</b>					
1.	Written Report of Findings (WFR)	DOM notifies providers of non-compliance through a WFR	DOM/DMH	8/1/15	12/31/17	
2.	Plan of Compliance (POC)	Non-compliant providers must submit POC to DOM/DMH within 45 days of receipt of WFR	Non-compliant Providers	9/15/15	12/31/17	
3.	Review of POC	DOM/DMH staff reviews all provider POCs to determine compliance to HCB settings requirements	DOM/DMH	11/1/15	12/31/17	
4.	Follow-up On-site	DOM/DMH staff conducts an on-site	DOM/DMH	12/1/15	2/1/18	

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	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
	Validation Visit	validation visit for compliance with POC				
5.	Provider Notification of Non-Compliance	DOM/DMH notifies the provider that they are non-compliant with HCB settings final rule and will no longer be an approved Medicare provider or DMH certified.	DOM/DMH	2/1/18	2/1/18	
6.	Participant Relocation Notification	DOM/DMH notifies the participant that the provider does not meet the HCB settings as required in the final rule and the participant must choose another provider for the HCBS service they are receiving.	DOM/DMH	3/1/18	3/1/18	
7.	Relocation plans	Providers that do not/cannot comply with the HCB settings final rule requirements must submit to DOM/DMH a transition plan for each participant outlining the relocating process to an appropriate residential or non-residential HCB compliant setting through a person-centered plan.	DOM/DMH, providers	3/1/18	11/1/18	
8.	Relocation	Relocation of each participant to a HCB setting in compliance of the final rule of the participant's choosing.	DMH, providers	11/1/18	3/1/19	
<b>Section 3: Quality Management</b>						
1.	NCI Committee	A committee will be formed to evaluate the feasibility of conducting NCI quality monitoring quarterly or bi-annually for the IDD population in HCB resident and non-resident settings.	DOM, DMH, Stakeholders	10/1/15	12/31/15	
2.	Provider Monitoring for HCB settings for IDD	Compare previous NCI data with NCI data gathered after implementation of the rule to determine changes in individual responses	DOM/DMH staff, key stakeholders	2/1/15	On-going	

**Mississippi Division of Medicaid  
Revised Statewide Transition Plan Timeline  
1915(c) and 1915(i) Home and Community-Based (HCB) Programs  
Compliance with HCB Settings  
March 11, 2015**

	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
		based on implementation of the HCB setting requirements for the IDD population.				
3.	Provider Monitoring for E&D and AL waiver	Data for E&D and AL waiver participants will be included in the NCI monitoring process to evaluate HCB settings	DOM	4/1/15	Annually	
4.	On-going Monitoring	Provider compliance monitoring includes certification reviews by the State's licensing agencies for residential and non-residential settings. Monitoring also encompasses reviews On-Site Compliance Reviews (OSCR) of on-site investigations, waiver participant/legal representative survey results, provider records, participant records, staff licensing requirements and qualifications, and case management/support coordination visit reports.	DOM/DMH	Annually	On-going	
<b>Section 4: Public Input</b>						
1.	Tribal notice	The Tribe is notified by letter of the intent to submit the transition plan.	DOM	8/22/14	8/22/14	Complete
2.	Public notice to newspaper	DOM publishes public notice in newspaper	DOM	9/17/14	9/17/14	Complete
3.	Transition Plan posted on DOM website	DOM/DMH begins collection of public comments through multiple methods including public hearings and web postings and an email address specifically for comments regarding the Transition Plan	DOM	9/17/14	9/17/14	Complete
4.	Public Hearings	DOM conducts public hearings to gather input regarding Transition Plan – written as well as oral comments will be accepted	DOM/DMH	9/26/14 and 10/3/14	9/26/14 and 10/3/14	Complete

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	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
5.	CMS Review	CMS requires revision of the Transitions Plans submitted	CMS	2/6/15	4/22/15	
6.	Public Notice	DOM publishes public notice in newspaper and allows the public the opportunity to send questions and/or comments via email or standard mail.	DOM	3/11/15 and 3/15/15	3/11/15	
7.	Thirty (30) Day Comment Period	DOM posts a link that takes the user directly to the Revised Statewide Transition Plan on the main page of the DOM website during the thirty (30) day comment period	DOM	3/11/15 – 4/10/15		
8.	Public Hearings for Revised Statewide Transition Plan	DOM will hold three (3) public hearings regarding the Revised Statewide Transition Plan at the Jackson Regional Office, the Hattiesburg Regional Office and the Grenada Regional Office. The public hearings will allow DOM to gather input regarding the Statewide Transition Plan – written as well as oral comments will be accepted	DOM	Jackson: 3/26/15  Hattiesburg: 3/29/2015  Grenada: 3/24/15		
9.	State Responses to Comments	DOM/DMH will retain public comments and state responses for CMS and general public review	DOM/DMH staff	4/22/15		
10.	Implementation of Revised Transition Plan	DOM/DMH will work with various stakeholder groups to periodically present and seek feedback on the implementation of the Statewide Transition Plan, including status reports, results of surveys, revisions to the Transition Plan, revisions to DOM/DMH Administrative Code, and amendments to 1915(c) waivers and/or 1915(i) State Plan services	DOM/DMH staff, key stakeholders	4/22/15	On-Going	

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	<b>Action item</b>	<b>Description</b>	<b>Who</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress</b>
11.	Stakeholder Training and Education	DOM/DMH will design, schedule and conduct multiple trainings for people receiving supports, their families, and other stakeholders; changes they can expect to see which could affect their services.	DOM/DMH staff	7/1/15	On-going	