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MISSISSIPPI DIVISION OF MEDICAID

Home & Community-Based Settings Final Rule
Compliance Update

States must ensure certain information is submitted to CMS to document state and provider compliance with HCBS regulatory criteria. The following summarizes Mississippi's methodologies for each of the required elements:

1. Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations.

   Nursing Facility (NF) Level of Care Waivers: There are four NF level of care waivers: Elderly and Disabled (E&D), Independent Living (IL), Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) and Assisted Living (AL). The State made the following modifications, pursuant to review and approval by the Mississippi Division of Medicaid:

   - DOM implemented language changes to administrative rules to incorporate HCBS requirements, all of which were finalized by July 1, 2017.
   - There are no provider owned or operated residential settings for the IL and TBI/SCI Waivers. Rather, services are delivered in the private dwellings of the waiver participants. Each participant's choice of dwelling, chosen by the individual through a person-centered planning process, is verified through a site visit prior to enrollment by an assigned Case Manager. Changes in residence are to be reported monthly by waiver case managers and are verified upon mandatory home visits. The State also modified the DOM Telephone Quality Interview form to ensure that DOM staff completing Quality interviews with members are evaluating compliance with the setting's requirements and are initiating remediation for any noted noncompliance.
   - For the E&D waiver, all home and community-based services except Adult Day Care, are delivered in the private dwellings of the waiver participants. Each participant's choice of dwelling, chosen by the individual through a person-centered planning process, is verified through a site visit prior to enrollment by an assigned Case Manager. Changes in residence are to be reported monthly by waiver case managers and are verified upon mandatory home visits. The State also modified the DOM Telephone Quality Interview form to ensure that DOM staff completing Quality interviews with members are evaluating compliance with the setting's requirements and are initiating remediation for any noted noncompliance. For Adult Day Care (ADC) services, DOM modified the audit tool and processes to assess HCBS compliance upon audit. The audit tool questions and protocols are designed to evaluate policies and procedures, as well as the actual experience of the individuals attending the program. As such, it allows the State to assess the current level of compliance, identify areas of

noncompliance that require remediation and offer opportunities for systemic and focused technical assistance. HCBS requirements are designated as mandatory, and any noncompliance with mandatory elements require a Corrective Action Plan (CAP).

- For the AL waiver, all services are rendered in a licensed residential facility setting (i.e. an assisted living facility). The facility setting is chosen by the individual through a person-centered planning process. Compliance with settings requirements are verified through a site visit prior to enrollment by an assigned Case Manager. Changes in residence are to be reported monthly by waiver case managers and are verified upon mandatory home visits. DOM also modified the audit tool and processes to assess HCBS compliance upon audit. The audit tool questions and protocols are designed to evaluate policies and procedures, as well as the actual experience of the individuals attending the program. As such, it allows the State to assess the current level of compliance, identify areas of noncompliance that require remediation and offer opportunities for systemic and focused technical assistance. HCBS requirements are designated as mandatory, and any noncompliance with mandatory elements require a Corrective Action Plan (CAP).
- All case managers must complete a DOM-sponsored training on Person- Centered Thinking.

Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) Level of Care Waiver: There is one ICF/IID level of care waiver: Intellectual Disabilities/Developmental Disabilities (ID/DD). The State made the following modifications for the ID/DD waiver, pursuant to review and approval by the Mississippi Division of Medicaid:

- DOM implemented language changes to administrative rules to incorporate HCBS requirements, all of which were finalized by July 1, 2017.
- A renewal for the 1915(c) ID/DD Waiver incorporated the requirements of the HCBS Final Rule, effective July 1, 2018.
- The operating agency, the Mississippi Department of Mental Health (DMH) modified existing operational standards to incorporate HCBS requirements. IDD certified providers were required to update their agency policies and procedures to comply with DMH Operational Standards.
- DMH modified both certification and monitoring tools to incorporate HCBS requirements.
- For the ID/DD waiver, all services except Day Services Adult, Community Respite, Prevocational services, Supervised Living, Shared Supported Living, and Supported Living (provided in a provider owned and/or controlled setting), are delivered in the private dwellings of the waiver participants. Each participant's choice of HCB services and supports are chosen by the individual through a person-centered planning process and verified by an assigned Support Coordinator. The Support Coordination Manual was revised to include HCBS settings regulations and Support Coordination monitoring processes. Support Coordinators monitor through monthly telephone contacts and quarterly face-to-face visits (alternating observation of each service and setting). Support Coordinators complete a Final Rule Monitoring Tool annually with each participant to submit with each person's recertification packet for DMH review.

- For Day Services Adult, Community Respite, Prevocational services, Supervised Living, Shared Supported Living, and Supported Living (provided in provider owned and/or controlled settings, DOM and DMH modified the audit/certifications tools and processes to assess HCBS compliance upon audit/certification review. These questions and protocols are designed to evaluate policies and procedures, as well as the actual experience of the individuals attending the program. As such, it allows the State to assess the current level of compliance, identify areas of noncompliance that require remediation and offer opportunities for systemic and focused technical assistance. HCBS requirements are designated as mandatory, and any noncompliance with mandatory elements require a Corrective Action Plan (CAP).
- All support coordinators must complete a DOM-sponsored training on Person-Centered Thinking.

State Plan HCBS Needs Based Eligibility Criteria: There is one State Plan HCBS Needs Based Eligibility Criteria: 1915(i) Community Support Program (CSP). The State made the following modifications for the CSP option, pursuant to review and approval by the Mississippi Division of Medicaid:

- DOM implemented language changes to administrative rules to incorporate HCBS requirements, all of which were finalized by July 1, 2017.
- A 1915(i) renewal added requirements pertaining to the HCBS Final Rule, effective November 1, 2018.
- The operating agency, the Mississippi Department of Mental Health (DMH) modified existing operational standards to incorporate HCBS requirements. IDD certified providers were required to update their agency policies and procedures to comply with DMH Operational Standards.
- DMH modified both certification and monitoring tools to incorporate HCBS requirements.
- For the CSP option, Day Services Adult, Prevocational services, and Supported Living (in provider owned and/or controlled settings) are delivered in DMH certified settings and must meet the HCBS settings requirements. Supported Living can be delivered in the private dwellings of the CSP participants. Supported Employment, services are provided in an integrated work setting which is fully integrated with opportunities for full access to the greater community and not in settings that group/cluster individuals. Each participant's choice of HCB services and supports are chosen by the individual through a person-centered planning process and verified by an assigned Targeted Case Manager. The Targeted Case Manager Manual was revised to include HCBS settings regulations and Targeted Case Manager monitoring processes. Targeted Case Managers monitor through at least monthly telephone contacts and quarterly face-to-face visits (alternating observation of each service and setting). Targeted Case Managers complete a Final Rule Monitoring Tool annually with each participant to submit with each person's recertification packet for DMH review.
- For Day Services Adult, Prevocational services, and Supported Living (in provider owned and/or controlled settings), DOM and DMH modified the audit/certifications tools and processes to assess HCBS compliance upon audit/certification review. These questions and protocols are designed to evaluate policies and procedures, as well as

the actual experience of the individuals attending the program. As such, it allows the State to assess the current level of compliance, identify areas of noncompliance that require remediation and offer opportunities for systemic and focused technical assistance. HCBS requirements are designated as mandatory, and any noncompliance with mandatory elements require a Corrective Action Plan (CAP).

- All targeted case managers must complete a DOM-sponsored training on Person-Centered Thinking.

This information is discussed in more detail within Mississippi's Statewide Transition Plan (STP) documents: https://medicaid.ms.gov/providers/1915c-and-1915i-home-and-community-based-hcb-setting-transition-plan/

2. Description of how the State assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.

NF Level of Care Waivers: For both initial and ongoing HCBS compliance, providers are assessed using the modified audit tool described above.

- For initial enrollments, prospective E&D ADC and AL providers must be found in compliance with all State and Federal waiver regulations before they provide direct services to clients. For this purpose, DOM completes a thorough enrollment review along with a site visit to all ADC and AL waiver settings. The purpose of this portion of the on-site review is to inspect the Facility to determine if waiver requirements and standards, including HCBS requirements, are in place to continue with the completion of the provider enrollment process. Providers only proceed in the enrollment process once review findings have been resolved. Once the new provider is approved to begin serving Medicaid waiver participants, DOM Office of Compliance staff complete post-payment audits as outlined in Appendix I of the CMS approved waiver applications to ensure that the actual experiences of Medicaid Waiver participants in the programs are fully consistent with the HCBS Final Settings Rule requirements. Compliance with these requirements is mandatory for continued approval of provider status.
- For post-payment audits, E&D ADC and AL providers must continue to be in compliance with all HCBS requirements, all of which are deemed mandatory. If any HCBS requirement is found to be noncompliant, an immediate CAP is required. No DOM provider may continue to provide waiver services if remediation is not fully completed and verified within the prescribed CAP timeframe.

ICF/IID Level of Care Waivers: For both initial and ongoing HCBS compliance, ID/DD providers are assessed using both the modified certification and monitoring tools.

- DMH Certification staff are responsible for ensuring initial HCBS compliance as well as providing an additional layer of ongoing compliance monitoring. Prospective provider agencies are provisionally certified initially and must be found in compliance with all State and Federal waiver regulations, including HCBS requirements, before they provide direct services to clients. This process includes policy and procedure reviews and onsite visits. Once the provider is approved to begin serving Medicaid waiver participants, within six (6) months of the new program's first admission of a Medicaid

Waiver participant, certification staff completes a follow-up on-site review to assess full compliance with DMH Operational Standards, including HCBS requirements. DMH staff also conduct an on-site HCBS Setting Assessment within the first year of service provision to ensure that the actual experiences of Medicaid Waiver participants in the program are fully consistent with the HCBS Final Settings Rule requirements. Compliance with these requirements is mandatory for continued approval of provider status.

- Existing providers are certified either annually or biennially. Settings must meet 100% of all Final Rule criteria during certification. Settings that fail to meet this standard must submit a Plan of Compliance (POC) to address the rules cited within 30 days. 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. Compliance with these requirements is mandatory for continued approval of provider status. The provider has the right to appeal DMH/DOMs actions.
- Support Coordinators monitor for compliance with HCBS regulations through observation and interview with the person, family/caregiver, and support staff. Any issues of 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 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.
- For post-payment audits, ID/DD providers must continue to be in compliance with all HCBS requirements, all of which are deemed mandatory. If any HCBS requirement is found to be noncompliant, an immediate CAP is required. No DOM provider may continue to provide waiver services if remediation is not fully completed and verified within the prescribed CAP timeframe.

State Plan HCBS Needs Based Eligibility Criteria: For both initial and ongoing HCBS compliance, CSP providers are assessed using both the modified certification and monitoring tools.

- DMH Certification staff are responsible for ensuring initial HCBS compliance as well as providing an additional layer of ongoing compliance monitoring. Prospective provider agencies are provisionally certified initially and must be found in compliance with all State and Federal waiver regulations, including HCBS requirements, before they provide direct services to clients. This process includes policy and procedure reviews and onsite visits. Once the provider is approved to begin serving CSP participants, within six (6) months the new program's first admission of a CSP participant, certification staff completes a follow-up on-site review to assess full compliance with DMH Operational Standards, including HCBS requirements. DMH staff also conduct an on-site HCBS Setting Assessment within the first year of service provision to ensure that the actual experiences of Medicaid Waiver participants in the program are fully consistent with the HCBS Final Settings Rule requirements. Compliance with these requirements is mandatory for continued approval of provider status.

- Existing providers are certified either annually or biennially. Settings must meet 100% of all Final Rule criteria during certification. Settings that fail to meet this standard must submit a Plan of Compliance (POC) to address the rules cited within 30 days. 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. Compliance with these requirements is mandatory for continued approval of provider status. The provider has the right to appeal DMH/DOMs actions.
- Targeted Case Managers monitor for compliance with HCBS regulations through observation and interview with the person, family/caregiver, and support staff. Any issues of 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. 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.

This information is discussed in more detail within Mississippi's Statewide Transition Plan (STP) documents: https://medicaid.ms.gov/providers/1915c-and-1915i-home-and-community-based-hcb-setting-transition-plan/

3. Description of a beneficiary's recourse to notify the State of provider non-compliance (grievance process, notification of case manager, etc.) and how the State will address beneficiary feedback.

NF Level of Care Waivers: For the NF Level of Care waivers, the State has in place a complaint and grievance process that is used by a beneficiary to notify the State of provider non-compliance. As a part of the processes that takes place at enrollment and at least annually, the waiver case manager provides each beneficiary with a description of the complaint and grievance procedures outlined in Appendix F of the CMS approved waiver applications, including rights delineated under the HCBS Final Settings Rule, and how/where to file a grievance and/or complaint. The beneficiary verifies that they were presented this information by signing the Bill of Rights.

As of May 2023, the State implemented a standardized DOM-designed HCBS Settings Rule flyer that is distributed to all of the beneficiaries enrolling in, or enrolled in, a NF Level of Care waiver to ensure that they have a full description of the HCBS requirements, as well as their recourse options if they feel a provider is noncompliant. The waiver case manager provides a physical copy of the HCBS Settings Rule Flyer and uses it as a guide to discuss the HCBS requirements and expectations with the beneficiary and/or their representative, including the participant's right to experience a fully HCBS compliant setting and the course of action to take if the participant and/or their representative feel that the setting is noncompliant. This includes notifying the case manager, and, if necessary, initiating the complaint and/or grievance process with DOM.

Final determinations regarding complaints and grievances, including any adverse findings, are reported to DOM. DOM has the final authority over any dispute. Quarterly, DOM reviews

all complaint and grievance data as a component of the Quality Improvement Strategies (QIS) process to identify any potential trends or issues, including HCBS noncompliance, and to determine/take needed systemic remediation.

ICF/IID Level of Care Waivers: For the ICF/IID Level of Care waiver, the State has in place a complaint and grievance process that is used by a beneficiary to notify the State of provider non-compliance. As a part of the processes that takes place at enrollment and at least annually, the Support Coordinator provides each beneficiary with a description of the complaint and grievance procedures outlined in Appendix F of the CMS approved waiver applications, including rights delineated under the HCBS Final Settings Rule, and how/where to file a grievance and/or complaint. The beneficiary verifies that they were presented this information by signing the Individual Rights Form.

The HCBS Settings Rule flyer was distributed to all beneficiaries currently enrolled in 2022. All newly enrolled beneficiaries and those that move from private dwelling or family home into an HCBS residential setting are provided a copy of the HCBS Settings Rule flyer to ensure they have a full description of the HCBS requirements, as well as their recourse options if they feel a provider is noncompliant. The Support Coordinator provides a physical copy of the HCBS Settings Rule Flyer and uses it as a guide to discuss the HCBS requirements and expectations with the beneficiary and/or their representative, including the participant's right to experience a fully HCBS compliant setting and the course of action to take if the participant and/or their representative feel that the setting is noncompliant. This includes notifying the Support Coordinator, and, if necessary, initiating the complaint and/or grievance process with DMH or DOM.

Final determinations regarding complaints and grievances, including any adverse findings, are reported to DOM. DOM has the final authority over any dispute. Quarterly, DOM reviews all complaint and grievance data as a component of the Quality Improvement Strategies (QIS) process to identify any potential trends or issues, including HCBS noncompliance, and to determine/take needed systemic remediation.

State Plan HCBS Needs Based Eligibility Criteria: For the State Plan HCBS program, the State has in place a complaint and grievance process that is used by a beneficiary to notify the State of provider non-compliance. As a part of the processes that takes place at enrollment and at least annually, the Support Coordinator provides each beneficiary with a description of the complaint and grievance procedures including rights delineated under the HCBS Final Settings Rule, and how/where to file a grievance and/or complaint. The beneficiary verifies that they were presented this information by signing the Individual Rights Form.

The HCBS Settings Rule flyer was distributed to all beneficiaries currently enrolled in 2022. All newly enrolled beneficiaries and those that move from private dwelling or family home into an HCBS residential setting are provided a copy of the HCBS Settings Rule flyer to ensure they have a full description of the HCBS requirements, as well as their recourse options if they feel a provider is noncompliant. The Targeted Case Manager provides a physical copy of the HCBS Settings Rule Flyer and uses it as a guide to discuss the HCBS requirements and expectations with the beneficiary and/or their representative, including the participant's

right to experience a fully HCBS compliant setting and the course of action to take if the participant and/or their representative feel that the setting is noncompliant. This includes notifying the Targeted Case Manager, and, if necessary, initiating the complaint and/or grievance process with DMH or DOM.

Final determinations regarding complaints and grievances, including any adverse findings, are reported to DOM. DOM has the final authority over any dispute. Quarterly, DOM reviews all complaint and grievance data as a component of the Quality Improvement Strategies (QIS) process to identify any potential trends or issues, including HCBS noncompliance, and to determine/take needed systemic remediation.