Title 23: Division of Medicaid

Part 208: Home and Community Based Services (HCBS) Long Term Care

Part 208 Chapter 1: Home and Community-Based Services (HCBS) Elderly and Disabled Waiver

Rule 1.1: General

A. The Division of Medicaid covers certain home and community-based services as an alternative to institutionalization in a nursing facility through the Elderly and Disabled Waiver (E&D).

B. Persons enrolled in the E&D Waiver must reside in a private residence which is fully integrated with opportunities for full access to the greater community, and meet the requirements of a Home and Community-Based (HCB) setting.

C. The Division of Medicaid does not cover E&D 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).

D. The E&D Waiver is administered and operated by the Division of Medicaid.

Source: 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017.

Rule 1.2: Eligibility

A. Eligibility requirements for the Elderly & Disabled (E&D) Waiver Program include the following:

1. Persons must be twenty-one (21) years of age or older.

2. Persons must require nursing facility level of care as determined by a comprehensive long-term services and supports (LTSS) assessment.

3. Persons must meet the criteria in one (1) of the following Categories of Eligibility (COE):

a) Supplemental Security Income (SSI), or

b) An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an

Income Trust in order to qualify.

B. Persons enrolled in the E&D Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home and are prohibited from receiving additional Medicaid services through another waiver program.

C. Persons enrolled in the E&D Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 08/01/2016; Revised eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 1.3: Provider Enrollment

A. Providers of Elderly and Disabled (E&D) Waiver services must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Rule 4.8 in addition to the listed provider-type specific requirements and provide to the Division of Medicaid:

1. A National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. A copy of the provider's current license or permit, if applicable,

3. Verification of a social security number using a social security card, driver's license with a social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification document must match the name noted on the W-9, and

4. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

B To participate as a Home and Community-Based Services (HCBS) Elderly & Disabled (E&D) Waiver provider, the provider must:

1. Be approved by Division of Medicaid after attending mandatory orientation and submitting a completed proposal package to the Office of Long-Term Care.

2. Enter into a provider agreement with the Division of Medicaid within six (6) months of receiving an approved proposal package from the Office of Long-Term Care.

3. Have a duly constituted authority and a governing structure which assures responsibility

and requires accountability for performance.

4. Maintain responsible fiscal management and an established business line of credit for business operation from a reputable financial institution. The approval amount for the business line of credit must be enough to cover operational costs/expenditures for at least three (3) months at all branch locations.

5. Establish an office in the state of Mississippi with a physical address prior to enrollment and maintain the office's physical address until the provider agreement is terminated.

6. Successfully pass a facility inspection by the Division of Medicaid depending on the provider type.

7. Conduct a national criminal background check with fingerprints on all employees and volunteers prior to employment and every two (2) years thereafter, and maintain the record in the employee's personnel file.

8. Conduct registry checks, prior to employment and monthly thereafter, to ensure employees or volunteers are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record in the employee's personnel file.

9. Not have been, or employ individuals or volunteers who have been, convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f) , child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

10. Not apply for a Division of Medicaid provider number for the purpose of providing care to friends/family members.

11. Have written criteria for service provision, including procedures for dealing with emergency service requests.

12. Have responsible personnel management including:

    a) An appropriate process used in the recruitment, selection, retention, and termination of employees;

    b) Written personnel policies and job descriptions, and;

    c) Maintenance of a current training plan as a component of the policies/procedures documenting the method for the completion of required training. The training plan must require all employees to meet training requirements as designated by the

Division of Medicaid upon hire, and annually thereafter.

d) Maintenance of a personnel file on every employee and volunteer with the following required information including, but not limited to, credentialing documentation, training records, and performance reviews which must be made available to the Division of Medicaid upon request.

13. Maintain a roster of qualified personnel necessary to provide authorized services.

14. Be compliant with all federal and state regulations.

C. E&D providers must ensure all employees and volunteers:

1. Who have direct person contact receive an annual physical examination and have a negative Mantoux tuberculin skin test (TST) and

2. Are trained upon hire, and annually thereafter, as designated by the Division of Medicaid.

D. E&D providers must satisfy the following qualifications, as applicable, to render services.

1. Case Management providers must meet the following requirements:

a) Operate as a statewide network.

b) Be established as an agency and in business providing case management services for a minimum of one (1) year.

c) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

d) Have a two (2) person case management team which consists of and meets the following:

1) A Registered Nurse (RN) who must:

(a) Maintain an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, and

(b) Have a minimum of:

(1) Two (2) years of nursing experience with aged and/or disabled persons, or

(2) At least ninety (90) days of orientation regarding direction of E&D

Waiver services under the supervision of an established E&D Waiver case manager who has two (2) years of E&D Waiver experience.

(c) Be certified to complete the comprehensive long-term services & supports (LTSS) assessment.

2) A Licensed Social Worker (LSW) who must:

(a) Have a current and active social work license.

(b) Have a bachelor's degree in social work or other health related field.

(c) Have a minimum of:

(1) Two (2) years of experience in direct care services for the aged and/or disabled clients, or

(2) At least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

(3) Must be certified to complete the comprehensive long term services & supports (LTSS) assessment.

3) Each team must have an assigned case management supervisor. The case management supervisor cannot carry an active caseload of persons.

2. Adult day care providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid including, but not limited to, the following requirements:

a) Be established and in business as a provider of adult day care services for a minimum of one (1) year.

b) Provide written documentation to the Division of Medicaid stating how the required Quality Assurance Standards are to be met.

c) Serve counties no more than sixty (60) minutes from the facility.

d) Receive approval by the Division of Medicaid of the proposal packet and then meet the requirements of provider enrollment and receipt of a Mississippi Medicaid provider number. Once a provider number is issued any changes to the programming area/facility must be approved by the Division of Medicaid.

e) Be compliant with applicable state and local building restrictions as well as all zoning, fire, health codes and ordinances and meet the requirements of the Americans with Disabilities Act (ADA).

f) Have a sufficient number of employees, who must maintain current and active first aid and cardio pulmonary resuscitation (CPR) certification, with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver persons as follows:

1) There must be at least two (2) persons, with one (1) being a paid employee, at the adult day care center at all times when there are persons in attendance, and

2) The employee-to-persons ratio must be a minimum of one to six (1:6) in all programs except in programs serving a high percentage of persons who are severely impaired which must maintain an employee ratio of one to four (1:4).

g) Meet the physical and social needs of each waiver person and maintain compliance with state and federal guidelines regarding services provided

h) Have a facility which must have:

1) At least sixty (60) square feet of program space for multi-purpose use for each day service person,

2) At least one toilet for every ten (10) persons attending the ADC,

3) Sufficient, lighted parking available to accommodate family members, caregivers, visitors, employees and volunteers. A minimum of two (2) parking spaces must be identified as parking for those with a disability being at least thirteen (13) feet wide and located near the entrance door,

4) A rest area for persons,

5) Appropriate signage,

6) A locked, storage area for all toxic substances,

7) At least two (2) well-identified exits with doors opening to the outside (swings outward) or no more than ten (10) feet from an outside exit, and

8) A safe environment free from hazards including, but not limited to, weapons, high steps, steep grades, and exposed electrical cords.

9) Sufficient, safe seating available for all persons.

i) Have a governing body with full legal authority and judiciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements.

j) Have an advisory committee representative of the community and person population.

k) Have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

l) Have the following employees who must maintain current and active first aid and cardio pulmonary resuscitation (CPR) certification:

1) A qualified administrator, either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program who must have:

(a) A master's degree and one (1) year supervisory experience, either full-time or an equivalent, in a social or health service setting, or

(b) A bachelor's degree and three (3) years supervisory experience, either full-time or an equivalent, in a social or health service setting; or comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

2) A program director, either center manager, site manager, or center coordinator, responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program in accordance with the person's needs and any mandatory requirements.

(a) The program director must have:

(1) A bachelor's degree in health, social services, or a related field and one (1) year supervisory experience, either full-time or an equivalent, or

(2) Comparable technical and human services training with demonstrated competence and experience as a manager in a health or human services setting.

(b) The program director must be under the direction of the administrator.

3) A qualified social service employee on staff.

(a) The employee must be:

(1) A licensed social worker (LSW) with a master's degree in social work and at least one (1) year of professional work experience, either full-time or an equivalent, in a human services setting, or

(2) A bachelor's degree in social work and two (2) years of professional

work experience, either full-time or an equivalent in a human services setting, or

(3) A bachelor's degree in a health or social services related field and two (2) years' experience, either full-time or an equivalent, in a human services field.

(b) Social workers must comply with all licensure requirements set by the Mississippi State Board of Examiners for Social Workers and Marriage & Family Therapists. In lieu of a licensed social worker, the functions must be carried out by other health service professionals such as certified rehabilitation counselors, licensed gerontologists, licensed professional counselors, or licensed/certified mental health workers.

4) A registered nurse (RN) on staff if the facility provides nursing services. The RN must have a valid state license and a minimum of one (1) year applicable experience, either full-time or the equivalent. The RN must adhere to the scope of practice pursuant to the Nursing Practice Law and the rules and regulations of the Mississippi Board of Nursing.

5) An activities coordinator with a bachelor's degree and at least one (1) year of experience, either full-time or an equivalent, in developing and conducting activities for the type population to be served or an associate's degree in a related field and at least two (2) years of appropriate experience, either full-time or equivalent.

6) A program assistant with a high school diploma or the equivalent and at least one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served.

7) A food service director if the facility prepares food on site.

(a) The food service director must be a registered dietician (RD), dietetic technician registered (DTR), RD eligible, DTR eligible, or a four (4) year graduate of a baccalaureate program in nutrition/dietetics/food service. In addition, the food service director must have a minimum of one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting.

(b) If the food is not prepared on site, the facility must contract with a reputable food service provider/caterer.

8) A secretary/bookkeeper who has, at a minimum, a high school diploma or equivalent and the skills and training to carry out the responsibilities of the position.

9) A driver who:

(a) Maintains a valid state driver's license, a safe driving record, and training in first aid and cardiopulmonary resuscitation (CPR),

(b) Maintains compliance with all state requirements for licensure/certification, and

(c) Must be trained in basic transfer techniques and safe ambulation.

m) Must record volunteer hours and activities, if the facility utilizes volunteers, who:

1) Must be individuals or groups who desire to work with adult day service persons.

2) Must successfully complete an orientation/training program.

3) Have responsibilities that are mutually determined by the volunteers and employees and performed under the supervision of facility staff members.

4) Have duties that either supplement required employees in established activities or provide additional services for which the volunteer has special talent/training.

5) Cannot provide services in place of required employees and only be allowed on a periodic/temporary basis.

3. Personal care service providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid including, but not limited to, the following requirements:

a) Be established and in business providing personal care services for a minimum of one (1) year.

b) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

c) Serve counties no more than sixty (60) minutes from the physical office or if greater than sixty (60) minutes the provider must maintain a satellite office.

d) Employee qualified personal care attendants and qualified personal care service supervisors.

1) The personal care attendant must meet the following requirements:

(a) Be a high school graduate, have a GED or must demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits,

(b) Successfully complete a curriculum training course covering topics as defined by the Division of Medicaid and pass a scored examination upon hire prior to rendering services, and annually thereafter. All new hire training must include a hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

(c) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity and exhibit basic qualities of compassion and maturity and be able to respond to waiver persons and situations in a responsible manner,

(d) Be at least eighteen (18) years of age.

(e) Possess a valid state issued identification, and have access to reliable transportation,

(f) Be able to function independently without constant observation and supervision,

(g) Be physically and mentally able to perform the job tasks required including lifting and transferring and provide assurance that communicable diseases of major public health concern are not present, as verified by a physician,

(h) Have interest in, and empathy for, persons who are ill, elderly, or disabled,

(i) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people,

(j) Maintain current and active first aid and CPR certification,

(k) Be able to carry out and follow verbal and written instructions,

2) The personal care service supervisor must meet the following requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals and meet one (1) of the following requirements:

(1) A bachelor's degree in social work, home economics, or a related profession with one (1) year of direct experience working with aged and disabled persons,

(2) A licensed RN or Licensed Practical Nurse (LPN) with one (1) year of direct experience working with aged and disabled persons, or

(3) A high school diploma and four (4) years of direct experience working with aged and disabled persons.

3) Personal Care Service may be furnished by family members if they are not legally responsible for the person and they do not live with the person. Family members must be employed by a Medicaid approved agency that provides Personal Care Services, must meet provider standards, and must be deemed competent to perform the required tasks.

4. In-Home Respite providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid including, but not limited to, the following requirements:

a) Be established and in business providing in-home respite services for a minimum of one (1) year.

b) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

c) Serve counties no more than sixty (60) minutes from the physical office or if greater than sixty (60) minutes the provider must maintain a satellite office.

d) Employee qualified in-home respite employees and supervisors.

1) In-home respite employees must meet the following requirements:

(a) Be eighteen (18) years of age or older.

(b) Have a High school diploma or GED, and at least for (4) years, either full-time or an equivalent, experience as a direct care provider to the aged or disabled.

(c) Successfully complete a curriculum training course covering topics as defined by the Division of Medicaid and pass a scored examination upon hire prior to rendering services, and annually thereafter. All new hire training must include a hands-on skills assessment to ensure the trainees ability to provide the necessary care safely and appropriately.

(d) Maintain current and active first aid and CPR certification;

(e) Possess a valid state issued identification and have access to reliable transportation;

(f) Have the ability to function independently without constant supervision/observation.

(g) Must be physically and mentally able to perform the job tasks required

including lifting and transferring and provide assurance that communicable diseases of major public health concern are not present, as verified by a physician

(h) Have interest in, and empathy for, individuals who are ill, elderly, and/or disabled.

(i) Have emotional maturity and ability to respond to individuals and situations in a responsible manner.

(j) Have effective communication and interpersonal skills with the ability to deal effectively, assertively and cooperatively with a variety of people.

2) In-home respite supervisors must meet the following requirements:

(a) Have a bachelor's degree in social work or a related profession, and

(1) At least one (1) year experience, either full-time or an equivalent, working with aged and disabled persons, and

(2) Two (2) years supervisory experience, either full-time or an equivalent, or

(b) Be a licensed RN or LPN, and have

(1) One (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals, and

(2) Two (2) years supervisory experience, either full-time or an equivalent, or

(c) Have a high school diploma, and

(1) Four (4) years of experience, either full-time or an equivalent, working directly with aged and disabled individuals, and

(2) Two (2) years supervisory experience, either full-time or an equivalent.

5. Institutional Respite providers must be a Medicaid certified hospital, nursing facility or licensed swing bed facility.

6. Home Delivered Meal providers must meet the following requirements:

a) Be certified through the Mississippi State Department of Health (MSDH).

b) Have a person responsible for the day-to-day operation of the service.

c) Have an adequate number of employees to meet the purpose of the program.

d) Train all employees in the proper technique of preparing for and/or serving meals to aged and disabled persons including, but not limited to, sanitation procedures, proper cleaning of equipment and utensils, first aid and emergency procedures.

e) Provide in-service training for all employees.

f) Be established and in business for a minimum of one (1) year.

g) Submit written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into Mississippi provider agreement.

h) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

i) Provide delivery of meals at times coordinated with the person or their designated representative.

7. Extended Home Health providers must meet the following qualifications:

a) Be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid (DOM) with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its approved certificate of need (CON), if applicable, and

d) Execute a provider agreement with the Division of Medicaid, and

e) Ensure direct care providers have a current and active license and/or certification.

8. Physical therapy service providers must meet the following qualifications:

a) Be certified to participate as a Mississippi Medicaid enrolled home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable,

d) Execute a provider agreement with the Division of Medicaid, and

e) Employ qualified physical therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and Meet the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi:

9. Speech-Language Pathology providers must meet the following qualifications:

a) Be certified to participate as a Mississippi Medicaid home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid (DOM) with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable,

d) Execute a participation agreement with the Division of Medicaid, and

e) Employ qualified speech therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and Meet the state and federal licensing and/or certification requirements to perform speech-language therapy services in the State of Mississippi:.

10. Community Transition Service (CTS) providers must meet the following requirements:

a) Be established and in business for a minimum of one (1) year.

b) Provide documentation to the Division of Medicaid of successfully transitioning individuals into the community for a minimum of two (2) years, and/or working with individuals in the community for a minimum of eight (8) years. For those without two (2) years of successfully transitioning individuals into the community, experience will be considered on an individual basis.

c) Have documentation of attending the Division of Medicaid's approved person-centered training or another Division of Medicaid approved training relating to person-centered planning.

d) Attend all quarterly and annual trainings administered by the Division of Medicaid with a minimum of one (1) attendee from the provider.

e) Have written procedures for dealing with an after-hour crisis.

f) Each Community Transition Service provider must have qualified community navigators and qualified supervisors.

1) The community navigator must meet the following requirements:

(a) Be a(n):

(1) Licensed Social Worker (LSW) with valid Mississippi license and a minimum of one (1) year of relevant work experience,

(2) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),

(3) RN with a valid Mississippi license and a minimum of one (1) year of relevant work experience,

(4) Individual with relevant experience and training with a minimum of a bachelor's degree and (1) year of work experience in a social or health services setting, or

(5) Individual with comparable technical and human service training and five (5) years' experience will be considered and approved by the Division of Medicaid.

(b) Have documented experience and training in person-centered planning and a minimum of forty (40) hours of training which includes Profile Development training.

(c) Attend an eight (8) hour introductory course to CTS regardless of experience prior to beginning work that is administered by the Division of Medicaid, Office of Community Based Services.

(d) Complete a Person Centered Plan training course designated by the Division of Medicaid within the one (1) year prior to rendering services, unless otherwise excluded.

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity.

(f) Exhibit basic qualities of compassion/maturity and be able to respond to persons and situations in a responsible manner.

(g) Attend all quarterly and annual trainings administered by the Division of Medicaid, unless written exclusion to quarterly or annual training is provided by the Division of Medicaid.

(h) Possess a valid Mississippi driver's license.

(i) Be able to function independently without constant observation and supervision.

(j) Have interest in, and empathy for, people who are ill, elderly, and/or disabled.

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively and cooperatively with a variety of people.

(l) Be able to carry out and follow verbal and written instructions.

(m) Have training in current systems used by the Division of Medicaid including Long-Term Services and Supports (LTSS) and any other systems utilized for documentation purposes.

2) The community navigator supervisor must have a minimum of two (2) years of supervisory experience in programs dealing with elderly and disabled persons and meet one (1) of the following requirements:

(a) Have a bachelor's degree in Social Work, Psychology, or related profession with one (1) year of direct experience working with aged and disabled persons transitioning into the community,

(b) Be an RN with a current Mississippi license and two (2) years of direct experience working with aged and disabled persons transitioning into the community, or

(c) Have a high school diploma or GED with seven (7) years of direct experience working with aged and disabled persons with two (2) of the seven (7) years working directly with persons transitioning into the community.

E. The Division of Medicaid will suspend provider numbers for providers who have been inactive for a period exceeding one (1) year pending a review of provider qualifications.

1. If a provider's Medicaid provider number has been suspended for less than one (1) year, the provider must contact the Office of Long-Term Care and update any information that may have changed in order for their Medicaid provider number to be reinstated.

2. If the provider's Medicaid provider number has been suspended for more than one (1) year, their provider number will be terminated and the provider must re-enroll as a Medicaid provider.

F. The Division of Medicaid may suspend a provider immediately from providing E&D Waiver services if the provider is deemed to no longer meet, or be in violation of, the

defined requirements for waiver providers. Providers may be terminated from participation for failure to submit and implement a corrective action plan timely.

Source: 28 C.F.R. Part 36; 42 C.F.R. 455, Subpart E; 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 06/01/2013; Revised eff. 01/01/2013.

Rule 1.4: Freedom of Choice

A. Persons enrolled in a Medicaid Waiver have the right to freedom of choice of Medicaid providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. Each person found eligible for the Elderly and Disabled (E&D) Waiver must be given free choice of all qualified providers.

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).

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 431.51, 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2018; Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.5: Quality Management

A. Waiver providers must meet applicable service specifications as referenced in the Elderly and Disabled (E&D) Waiver approved by the Centers for Medicare and Medicaid Services (CMS).

B. Waiver providers must report:

1. Changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.

2. Critical incidences of abuse, neglect, and exploitation (including the unauthorized use of restraints, restrictive interventions, and/or seclusion) within twenty (24) hours of the occurrence or knowledge of the occurrence to the Division of Medicaid and other applicable agencies as required by law.

3. Any complaints not resolved within seven (7) days.

C. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to

Medicaid rules or regulations.

Source: 42 C.F.R. §§ 440.180; 441.302; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.6: Covered Services

A. The Division of Medicaid covers the following services through the Elderly and Disabled (E&D) Waiver:

1. Case Management (CM) - Case Management services include the identification of resources as well as the coordination and monitoring of services by case managers to ensure the health and social needs, preferences and goals of individuals are met throughout the person centered planning process and service provision.

   a) The case management team, consisting of a registered nurse (RN) and Licensed Social Worker (LSW), must conduct face-to-face visits together using the comprehensive long-term services and support (LTSS) assessment instrument at the time of admission and recertification.

      1) Additionally, the RN and LSW must visit the person together on a quarterly basis.

      2) Case management services may be provided at the Adult Day Care Facility at a maximum of one (1) visit per quarter. This visit cannot be the initial assessment, recertification assessment or quarterly visit.

   b) Each case management team must maintain no more than an average, active case load of one hundred (100) E&D Waiver persons.

      1) If a case management team maintains an average, active case load greater than one hundred (100), prior approval must be obtained by the Division of Medicaid.

      2) Approval will be considered based upon causation and duration of the increase.

2. Adult Day Care Services - Adult Day Care (ADC) services include community-based comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours.

   a) ADC services must meet the needs of aged and disabled persons through an individualized Plan of Services and Supports (PSS) that includes the following:

      1) Personal care and supervision,

2) Provide choices of food and drinks to persons at any time 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.

3) Provision of limited health care,

4) Transportation to and from the site and center-sponsored activities, with cost being included in the rate paid to providers, and

5) Social, health, and recreational activities which optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment and personal preferences and,

6) Provide information on, and referral to, vocational services.

b) The Division of Medicaid reimburses the ADC when the ADC:

1) Submits claims in fifteen (15) minute increments for the duration of time the services were provided and will be reimbursed by the Division of Medicaid the lessor of the maximum daily cap or the total amount of the fifteen (15) minute increment units billed.

(a) The duration of the service time must begin when the person enters the facility and ends upon their departure and does not include the time spent transporting the person to and from the facility.

(b) Claims must include separate line items for each day of service provision and cannot be span billed.

2) Provides services for at least eight (8) continuous hours per day, Monday through Friday.

c) ADC 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 engagement in community life, 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.

d) 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, 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, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

3. Personal Care Services - Personal Care Services (PCS) are non-medical support services provided in the home or community of eligible persons by trained personal care attendants to assist the waiver person in meeting daily living needs and ensure optimal functioning at home and/or in the community.

a) PCS:

1) Includes assistance to functionally impaired persons allowing them to remain in their home by providing assistance with activities of daily living, instrumental activities of daily living, and assistance in participating in community activities, and

2) Must be provided in accordance with a waiver person's PSS,

3) Are approved by the Division of Medicaid based upon assessed needs of the person with the person's involvement with sufficient documentation to substantiate the requested number of hours.

   (a) The frequency cannot duplicate hours rendered for respite care and/or home health aide services.

   (b) Any increase or decrease in the number of hours indicated on the PSS must be prior approved by the Division of Medicaid.

4) A personal care attendant (PCA) may accompany persons during community activities as a passenger in the vehicle.

   (a) The PCA cannot drive the vehicle.

   (b) If transportation is provided by a Medicaid Non-Emergency Transportation (NET) provider, there must be documentation that it is medically necessary for a PCA to accompany person.

b) PCA responsibilities include:

1) Assisting with personal care including, but not limited to:

   (a) Mouth and denture care,

   (b) Shaving,

   (c) Finger and toe nail care excluding the cutting of the nails,

   (d) Grooming hair to include shampooing, combing, and oiling,

   (e) Bathing in the tub or shower or a complete or partial bed bath,

   (f) Dressing,

   (g) Toileting including emptying and cleaning a bed pan, commode chair, or urinal,

   (h) Reminding person to take prescribed medication,

   (i) Eating,

   (j) Transferring or changing the person's body position, and

(k) Ambulation.

2) Performing housekeeping tasks including, but not limited to:

(a) Assuring rooms are clean and orderly, including sweeping, mopping and dusting,

(b) Preparing shopping lists,

(c) Purchasing and storing groceries,

(d) Preparing and serving meals,

(e) Laundering and ironing clothes,

(f) Running errands,

(g) Cleaning and operating equipment in the home such as the vacuum cleaner, stove, refrigerator, washer, dryer, and small appliances,

(h) Changing linen and making the bed, and

(i) Cleaning the kitchen, including washing dishes, pots, and pans.

3) Reporting to the PCS supervisor, PCS director, or the individual designated to supervise the PCS program.

c) PCA supervisor responsibilities include, but are not limited to:

1) Supervising no more than twenty (20) full-time PCAs,

2) Making home visits with PCAs to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

3) Reviewing and approving PCS duties on the approved service plans,

4) Receiving and processing requests for services,

5) Being accessible to PCAs for emergencies, case reviews, conferences, and problem solving,

6) Evaluating the work, skills, and job performance of the PCA,

7) Interpreting PCS agency policies and procedures relating to the PCS program,

8) Preparing, submitting, or maintaining appropriate records and reports,

9) Planning, coordinating, and recording ongoing in-service training for the PCA,

10) Performing supervised visits in the person's home and unsupervised visits which may be performed in the person's home or by phone, alternating on a biweekly basis to assure services and care are provided according to the PSS, and

11) Reporting directly to the PCS agency's Director and, in the absence of the Director, is responsible for the regular, routine activities of the PCS program.

d) Persons enrolled in the E&D Waiver who elect to receive PCS must allow providers to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system and must:

1) Not allow the one (1) time password (OTP) device to be removed from their home except by the Case Management Agency if an OTP is being utilized, and

2) Not submit service begin and end times on behalf of personal care provider.

4. In-Home or Institutional Respite Services - In-Home or Institutional Respite Services, either in an institutional or home setting, is covered for persons unable to care for themselves in the absence, or need for relief, of the person's primary full-time, live-in caregiver(s) on a short-term basis during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the person.

a) In-Home Respite Care Services are non-medical, unskilled services which are covered:

1) For the person who:

(a) Is home-bound due to physical or mental impairments and unable to leave home unassisted, and

(b) Requires twenty-four (24) hour assistance by the caregiver, and cannot be safely left alone and unattended for any period of time.

2) No more than sixty (60) hours per month are allowed. In-Home Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

3) When the person enrolled in the E&D Waiver who elects to receive In-Home Respite allows the provider to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system must:

(a) Not allow the one (1) time password (OTP) devices to be removed from their

home except by the Case Management Agency if an OTP is being utilized, and

(b) Not submit service begin and end times on behalf of the personal care provider.

b) Institutional Respite Care Services are covered only when provided in a Mississippi Medicaid enrolled Title XIX hospital, nursing facility, or licensed swing bed facility.

1) 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, and,

2) Are covered no more than thirty (30) calendar days per state fiscal year.

5. Home Delivered Meals are covered when the person is unable to leave home without assistance, unable to prepare their own meals, and/or have no responsible caregiver in the home and must meet the following requirements:

a) Persons must receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the person will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

b) Providers offering home delivered meals must adhere to the following requirements:

1) Ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health (MSDH) regulations governing food service sanitation.

2) Provide, at a minimum, the following service supplies with each individual meal:

(a) Straw which is six (6) inches individually wrapped (jumbo size),

(b) Napkin which is thirteen (13) inches by seventeen (17) inches,

(c) Flatware with each individually wrapped package to contain non-brittle medium weight plastic fork or spoon and serrated knife with handles at least three and one half ($3^{1/2}$) inches long,

(d) Carry-out tray which is Federal Drug Administration (FDA) approved compartment tray for hot foods.

(e) Condiments to include individual packets of iodized salt and pepper and when necessary to complete the menu other individually packed condiments, such as ketchup, mustard, mayonnaise, salad dressings, and tartar sauce.

(f) Cups which are four (4) ounce styrofoam, with covers for cold foods to accompany carry-out trays.

3) Use transporting equipment designed to protect the meal from potential contamination, and designed to hold the food at a temperature below forty-five (45) degrees Fahrenheit, or above one hundred forty (140) degrees Fahrenheit, as appropriate.

4) Have contingency plans to ensure that in the event of an emergency enrolled persons will have access to a nutritionally balanced meal.

5) Bring to the attention of the appropriate officials for follow-up any conditions or circumstances which place the person or the household in imminent danger.

6) Comply with all state and local health laws and ordinances concerning preparation, handling and service of food.

7) Must have available for use, upon request, appropriate food containers and utensils for blind and individuals with limited dexterity or mobility.

8) Must ensure all food preparation employees be under the supervision of an employee who will ensure the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must consult with the service provider dietitian for advice and consultation, as necessary.

9) May use various methods of delivery. However, all food preparation standards set forth in this section must be met.

10) Must ensure only one (1) hot meal is delivered per day and no more than fourteen (14) frozen meals per delivery.

11) Maintain documentation of delivered meals including the signature of the individual accepting delivery.

(a) If person, or designated caregiver, is not home at time of delivery, the meals must not be delivered.

(b) Meals delivered to anyone other than the person or their caregiver is not billable.

12) Establish procedures to be implemented by employees during an emergency (fire, disaster) and train employees in their assigned responsibilities. In emergency situations, such as under severe weather conditions, the provider may leave nonperishable meals or food items for a person, provided that proper storage and heating facilities are available in the home, and the person is able to prepare the meal with available assistance.

13) Forward billing information including the delivery documentation to the case manager on a monthly basis.

6. Extended Home Health Services, including skilled nursing and home health aide services, are covered when the following are met:

   a) When prior approved by the Division of Medicaid, additional home health visits after the initial twenty-five (25) State Plan home health visits have been exhausted.

   b) Home Health Agencies must follow all rules and regulations set forth in Miss. Admin. Code Part 215.

      1) The word "waiver" does not apply to anything other than Home Health visits with prior approval from the Division of Medicaid.

      2) Persons are subject to home health co-payment requirements through the twenty-fifth (25^{th}) visit of State Plan home health services.

      3) Beginning with the twenty-sixth (26^{th}) prior approved, waiver home health visit, within the state fiscal year, the person is exempt from home health co-payment requirements.

   c) The PCA and home health aide cannot be in the person's home at the same time and cannot perform the same duties. Exceptions to this rule must be based on medical justification and thoroughly documented.

7. Physical therapy services are covered when:

   a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a physical therapist who:

      1) Has a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi, and

      2) Meets the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

   b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

8. Speech therapy services are covered when:

   a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a speech therapist who:

      1) Has a non-restrictive current Mississippi license issued by the appropriate

licensing agency to practice in the State of Mississippi, and

2) Meets the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

9. Community Transition Services are covered for initial expenses required for setting up a household. The expenses must be included in the approved PSS and expenses are limited as designated by the Division of Medicaid.

a) Community Transition Services are covered when the person meets all of the following criteria:

1) Be in a long- term care (LTC) facility for greater than ninety (90) days in a long-term care service track with a minimum of one (1) day paid by Medicaid.

2) Have no other source to fund or attain the necessary items or support,

3) Be transitioning from a nursing facility where these covered items and services were provided, and transitioning to a residence where these covered items and services are not normally furnished.

4) Must meet the level of care criteria for a nursing facility and, if not for the provision of HCB long-term care services, the person would continue to require the level of care provided in the nursing facility.

5) Be transitioning to a qualified residence which must pass a U.S. Department of Housing and Urban Development (HUD) Housing Quality Standards inspection and be prior approved by the Division of Medicaid and meet one (1) of the following criteria:

(a) A home owned or leased by the transitioning person or the person's family member,

(b) An apartment with lockable access leased to the transitioning person which includes living, sleeping, bathing, and cooking areas over which the person or the person's family has domain and control, or

(c) A residence in a community-based residential setting in which no more than four (4) unrelated persons reside.

b) Community Transition Services include the following:

1) Security and Utility Deposits which:

(a) Has a limit of $1,000.00 per individual transitioning from the nursing facility back into the community.

(b) Must be required to occupy and use a community domicile.

(c) Only includes deposits for telephone, electricity, heating, and water.

(d) Includes payment of past due bills which inhibit the person's ability to transition from the nursing facility into the community when no other payment source is available.

(e) Must be listed on the PSS prior to transitioning from the facility.

2) Essential Household Furnishings which must be documented on the Division of Medicaid's required form and listed in the PSS prior to the person transitioning from the nursing facility and includes:

(a) Items required to occupy and use a community domicile, and

(b) Purchased items including furniture, window coverings, food preparation items, bed/bath items, one (1) time pantry stocking to ensure proper nutrition, and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the individuals' health and safety, which has a limit of two hundred and fifty dollars ($250.00) to ensure that all belongings from the institution of the person are able to be taken to the community residence.

4) Necessary Home Accessibility Adaptations (HAA) are covered for physical adaptations to the private residence of the person or the person's family, required by the person's Plan of Services and Supports (PSS), that are necessary to ensure the health, welfare, and their safety or that enable the person to function with greater independence in the residence.

(a) Covered HAA include:

(1) The installation of ramps and grab bars,

(2) Widening of doorways,

(3) Modification of bathroom facilities, and

(4) Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.

(b) Non-covered HAA include, but are not limited to:

(1) Those that are of general utility and are not of a direct medical or remedial benefit to the person, or

(2) Those that add to the total square footage of the home except when necessary to complete an adaptation to include improving entrance/egress to a home or configuring a bathroom to accommodate a wheelchair.

(c) HAA will be authorized for persons up to ninety (90) consecutive days prior to the transition of an institutionalized person to the community setting.

(d) HAAs begun while the person was institutionalized are not considered complete until the date the person transitions from the nursing facility and is admitted to the E&D Waiver, and cannot be billed to the Division of Medicaid until complete.

(e) A home inspection must be conducted to determine the needs for the person utilizing the Person-Centered Planning (PCP) process by the Community Transition Specialist and/or a contracted entity whose sole function is for conducting a home inspection.

(f) All providers/subcontracted entities rendering environmental accessibility adaptation services must:

(1) Meet all state or local requirements for licensure/certification including, but not limited to, building contractors, plumbers, electricians or engineers.

(2) Provide services in accordance with applicable state housing and local building codes.

(3) Ensure the quality of work provided meets standards identified below:

(i) All work must be done in a fashion that exhibits good craftsmanship.

(ii) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions.

(iii) The contractor must obtain all permits required by local governmental bodies.

(iv) All non-salvaged supplies and/or materials must be new and of best quality without defects.

(v) The contractor must remove all excess materials and trash, leaving the site clear of debris at completion of the project,

(vi) All work must be accomplished in compliance with applicable codes, ordinances, regulations and laws.

(vii) The specifications and drawings cannot be modified without a written change order from the case manager.

(viii) No accessibility barriers can be created by the modification and/or construction process.

5) Durable Medical Equipment (DME) is covered when:

(a) Required by the person's PSS,

(b) Required to ensure the health, welfare, and safety of the person, or

(c) It enables the person to function with greater independence in the home when no other payment source is available.

6) Community Navigation:

(a) Is defined as activities required to:

(1) Access, arrange for, and procure needed resources,

(2) Develop the person's profile to assist in the PSS development, including conducting person-centered planning meetings, discovery, identification of housing, and assistance with completion of applications for community resources and housing.

(b) Has a maximum unit allowance of two hundred (200) units or one hundred eighty (180) days.

(c) Is reimbursed per a 15 minute unit rate up to a hundred (100) units for a maximum of thirty (30) days post transition into the community.

c) Community Transition Services are furnished only to the extent that:

1) They are reasonable and necessary as determined through the service plan development process, and

(a) Clearly identified in the service plan, and

(b) The person is unable to pay for the expense or when the services cannot be obtained from other sources.

d) Community Transition Services do not include:

1) Monthly rental or mortgage expenses,

2) Regular utility charges,

3) Food except for the one time pantry stocking, and/or

4) Household appliances or items that are intended for purely diversional/recreational purposes.

e) Community Transition Services must be essential to:

1) Ensuring that the person is able to transition from the current nursing facility, and

2) Removing an identified barrier or risk to the success of the transition to a more independent setting.

Source: 42 C.F.R. §§ 431.53, 440.170, 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017; Revised eff. 01/01/2013.

Rule 1.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a person can receive services through the Elderly and Disabled (E&D) Waiver Program. To obtain approval, the waiver case management provider must complete and submit the following current Division of Medicaid approved forms as follows:

1. Long-Term Services and Supports (LTSS) Assessment,

2. Bill of Rights,

3. Plan of Services and Supports (PSS),

4. Emergency Preparedness Plan, and

5. Informed Choice.

B. An eligible person can only be enrolled in one (1) home and community-based waiver program at a time. Any request to add or increase services listed on the approved PSS must receive prior approval.

C. All requests for increases or decreases in service must be submitted to the Division of Medicaid and must include documentation to substantiate the need for the change.

Source: 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.8: Documentation/Record Maintenance

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the Elderly and Disabled (E&D) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3.]

Source: 42 C.F.R. §§ 440.180, 441.303; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121; 43-13-129.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.9: Person Cost Sharing

Persons enrolled in the Elderly and Disabled (E&D) waiver are exempt from cost-sharing for E&D Waiver services.

Source: 42 U.S.C. 1396(a); 42 C.F.R. §§ 440.180, 447.50 – 447.59; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.10: Reimbursement

A. Providers must bill for Elderly and Disabled (E&D) Waiver services no sooner than the first (1^{st}) day of the month following the month in which services were rendered for the following services:

    1. Case Management,

    2. Adult Day Care (ADC) Services,

    3. Institutional Respite, and

    4. Home delivered meals.

B. All E&D Waiver providers of Personal Care Services (PCS) and In-Home Respite must

utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system for the submission of claims. Requirements for the use of the EVV system include, but are not limited to:

1. Personal Care and In-Home Respite provider employees are prohibited from removing the one-time password (OTP) device from the home of the person if an OTP is being utilized.

    a) Removal of the OTP device from the person's home will result in the provider's inability to adequately substantiate the services billed, including the units of service; therefore the provider will not be reimbursed for services billed during the time period that the OTP device was removed from the person's home.

    b) If it is discovered, post-payment, that the OTP Device was being removed from the home, the provider will be required to refund the Division of Medicaid any money received from the Medicaid program for the time period that the OTP device was removed from the home [Refer to Miss. Admin. Code Part 305].

2. The provider's employee must obtain and document the OTP codes designating service start and end times while in the home of the person, if not utilizing the person's telephone land line to substantiate services billed including the units of service.

C. The Division of Medicaid reimburses for extended Home Health services, physical therapy services and speech therapy services in accordance with the State Plan.

Source: 42 C.F.R. §§ 440.180, 440.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

Rule 1.11: Due Process Protection

A. The Case Manager must provide written notice as specified in the Elderly and Disabled (E&D) Waiver to the person when any of the following occur:

    1. Services are reduced,

    2. Services for requested increases in services are denied, or

    3. Services are terminated.

B. The Elderly and Disabled (E&D) Waiver Notice of Action must contain the following information:

    1. The dates, type, and amount of services requested,

    2. A statement of the action to be taken,

    3. A statement of the reason for the action,

4. A specific regulation citation which supports the action,

5. A complete statement of the person/authorized representative's right to request a fair hearing,

6. The number of days and date by which the fair hearing must be requested,

7. The person's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesperson, and

8. The circumstances under which services may be continued if a hearing is requested.

C. Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the person 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.

D. In the event of imminent danger to the person, caregiver, or service provider, the person may be discharged from the waiver immediately.

Source: 42 C.F.R. 431, Subpart E; 42 C.F.R. §§ 431.210, 440.180, 441.301, 441.307; 42 CFR; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.12: Hearings and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the person/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 person receives all services that were in place prior to the notice of change.

Source: 42 C.F.R. 431, Subpart E; 42 C.F.R. §§ 440.180, 441.308; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.13: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning persons.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process which ensures the individual's rights to privacy, dignity, respect, and freedom from coercion and restraint..

8. Offer informed choices to the person regarding the services and supports they receive and from whom.

9. Include a method for the person to request updates to the PSS as needed.

10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to

the person with regard to preferences for the delivery of such services and supports and the level of need of the individual and must:

1. Reflect that the setting in which the person resides is:

    a) Chosen by the person and/or their representative,

    b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

        1) Seek employment and work in competitive integrated settings,

        2) Engage in community life,

        3) Control personal resources, and

        4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

E. All changes to the PSS require documented consent from the person either via current signature/date or via verbal consent with a witness's signature/date on a change request.

Source: 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; New rule eff. 01/01/2017.

Rule 1.14: Monitoring Safeguards

A. Case managers are required to provide each waiver person with written information regarding their rights as a waiver person during the initial assessment.

B. Case managers must provide the persons information during the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect or exploitation is alleged.

C. All E&D providers and their employees must immediately report in writing to the Division of Medicaid Office of Long-Term Care, the Mississippi Department of Human Services (MDHS), and any other entity required by federal or state law, all alleged or reported instances the following:

    1. Abuse,

    2. Neglect,

    3. Exploitation,

    4. Suspicious death, or

    5. Unauthorized use of restraints, seclusion or restrictive interventions.

Source: 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann §§ 43-13-117, 43-13-121, 43-47-1 - 43-47-39.

History: New to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018.