



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 208
Home and Community Based Services
(HCBS), Long Term Care

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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 (NPES),
 - 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.

- 1) 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 lesser 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.

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 (25th) visit of State Plan home health services.
 - 3) Beginning with the twenty-sixth (26th) 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 (1st) 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.

Part 208 Chapter 2: Home and Community-Based Services (HCBS) Independent Living Waiver

Rule 2.1: General

- A. The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.
 1. Waiver participants must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.
 2. The Division of Medicaid does not cover IL waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).
- B. The IL Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitative Services (MDRS).
- C. The Division of Medicaid maintains responsibility for the administration of the waiver and formulates policies, rules, and regulations. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. MDRS is responsible for operational functions and maintaining a current Medicaid provider number.

- D. The average cost for a waiver applicant/participant must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicaid and Medicare Services (CMS) for the current waiver year. The State may refuse entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the facility and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State.

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

History: Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.2: Eligibility

- A. Eligibility is limited to individuals age sixteen (16) or older who:

1. Exhibit severe orthopedic and/or neurological impairments that render the individual dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living.
2. Are able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants (PCAs), counselors, case managers or others involved in their care.
3. Are certified as medically stable by their physician. The Division of Medicaid defines medical stability as the absence of all of the following:
 - a) An active, life-threatening condition requiring systematic therapeutic measures,
 - b) Intravenous drip to control or support blood pressure, and
 - c) Intracranial pressure or arterial monitoring.

- B. Clinical eligibility for waiver services is determined through a comprehensive Pre-Admission Screening (PAS) tool that includes, but is not limited to, the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services.

- C. Pre-admission screening data, entered into a scoring algorithm generating a numerical score, is compared to a set numerical threshold and determines clinical eligibility.

- D. Individuals must qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):

1. Supplemental Security Income (SSI),
2. Parents and Other Caretaker Relatives Program,

3. Disabled Child Living at Home,
4. Children under age nineteen (19) who meet the applicable income requirements,
5. Disabled Adult Child,
6. Protected Foster Care Adolescents,
7. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,
8. IV-E Foster Children and Adoption Assistance Children,
9. 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, or
10. Working Disabled.

E. Persons enrolled in the Independent Living 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 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 2.2.E. eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 2.3: Covered Services

The Division of Medicaid covers the following Independent Living Waiver services:

- A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities:
 1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs, preferences, and goals.
 2. Must assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.
 3. Are responsible for ongoing monitoring of the provision of services included in the

participant's plan of care.

4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required. More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.
 5. Are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).
- B. Case Management must be provided by Registered Nurses (RN) and Rehabilitation Counselors who must meet the following qualifications:
1. The Registered Nurse must:
 - a) Have a current and active unencumbered Registered Nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license; and
 - b) Have at least one (1) year of experience with the aged and/or individuals with disabilities; and
 - c) Not have a history of a criminal offense which precludes him/her from working with the vulnerable population; and
 - d) Not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion list.
 2. The Rehabilitation Counselor must:
 - a) Possess at a minimum a Bachelor's degree in Rehabilitation Counseling or other related field; and
 - b) Have one (1) year of experience working with individuals with disabilities; and
 - c) Be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population; and
 - d) Not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.
 3. Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating

qualifications of the Registered Nurse and Rehabilitation Counselor. MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

4. MDRS must verify provider qualifications upon hire and at least annually.
- C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.
1. PCA services must be provided in accordance with the approved plan of care, cannot be purely diversional in nature, and must include:
 - a) Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living.
 - b) Food shopping and assistance with preparation of meals, but not the cost of the meals.
 - c) Housekeeping chores essential to the health of the beneficiary, when specified in the approved plan of care.
 - d) Support for community participation by accompanying and assisting the participant as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.
 2. A personal care attendant must be chosen by the participant as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified personal care attendants. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS Rehabilitation Counselors and Registered Nurses must certify and document that the PCA meets the requirements.
 3. A personal care provider must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The educational program must be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants cannot be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the participant and Rehabilitation Counselor/Registered Nurse prior to rendering any waived services. In addition to the technical skills required, the personal care provider must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and Rehabilitation Counselor/Registered Nurse to be adequate in fulfilling the responsibilities of personal care. The training, to be conducted by the participant/caregiver and the Rehabilitation Counselor/Registered Nurse, or an agency

permitted by law to train nurse aides, must include:

- a) The purpose and philosophy of self-directed services by the disabled,
 - b) Disability awareness,
 - c) Employee-employer relationships and the need for respect for the participant's privacy and property.
 - d) Basic elements of body functions,
 - e) Infection control procedures,
 - f) Maintaining a clean and safe environment,
 - g) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.
 - h) Meal preparation and menus that provide a balanced, nutritional diet.
4. The individual who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements. Competency certification for these personal care providers by the participant and Rehabilitation Counselor/Registered Nurse is required. A personal care attendant that has satisfactorily provided personal care attendant service for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.
5. Personal care services can be furnished by family members provided they are not the spouse or the parent or step-parent of a minor child. Only qualified family members not legally responsible for the waiver participant can be employed as the personal care attendant. Family members must meet provider standards and be certified competent to perform the required tasks by the participant and the Rehabilitation Counselor/Registered Nurse. There must be adequate justification for the family member to function as the attendant such as lack of other qualified attendants in the remote area.
6. Minimum requirements include:
- a) Must be at least 18 years of age;
 - b) Must be a high school graduate, have a GED or demonstrates the ability to read and write to complete required forms and reports of visits;

- c) Must be able to follow verbal and written instructions;
 - d) Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;
 - e) Must be certified as meeting the training and competence requirement by the participant and the Rehabilitation Counselor/Registered Nurse;
 - f) Must be able to communicate effectively and carry out directions;
 - g) Must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, 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.
 - h) Must receive training in the areas of the Vulnerable Person's Act, care giver boundaries and dealing with difficult patients upon hire and annually thereafter.
7. MDRS must verify the competency for all personal care attendant as needed.
 8. If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six (6) consecutive months, the participant is reevaluated for the need for waiver services to determine if the waiver can meet the needs of this participant.
 9. MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants for employment decisions and/or actions and service provision to consumers of the department's services. MDRS must verify that any potential personal care attendant is not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.
 10. If a waiver participant chooses the Participant Directed Care Service option for managing personal care attendants, the Financial Management Service provider is responsible for obtaining the criminal background check. The FMS provider must verify that the personal care attendants employed by the waiver participant are not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.
- D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
1. The need for use of such items must be documented in the assessment/case file and

approved on the plan of care.

2. Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. Items not of direct medical or remedial benefit to the participant are excluded.
 3. Specialized medical equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS must certify and document that providers meet the criteria/standards in the waiver document.
 4. Requests for specialized medical equipment and supplies must be evaluated by the MDRS counselor or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for specialized medical equipment and/or supplies for approval.
 5. Medicaid waiver funds are utilized as the payor of last resort.
- E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the Independent Living Waiver program.
1. Transition Assistance services include the following:
 - a) Security deposits required to obtain a lease on an apartment or home.
 - b) Essential furnishings required to occupy and use a community domicile. Televisions or cable TV access are not essential furnishings.
 - c) Moving expenses.
 - d) Fees/deposits for utilities and service access for a telephone.
 - e) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.
 2. Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars (\$800.00) per lifetime. These expenses must be included in the approved plan of care.
 3. To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:
 - a) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid;

- b) Have no other source to fund or obtain the necessary items/supports;
 - c) Be moving from a nursing facility where these items/services were provided;
 - d) Be moving to a residence where these items/services are not normally furnished.
4. Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.
 5. Transition Assistance must be completed by the day the participant relocates from the institution.
 6. Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.
 7. Transition Assistance services must be provided by a Registered Nurse and/or a Rehabilitation Counselor.
- F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.
1. Environmental accessibility adaptations must be included in the approved plan of care.
 2. Environmental accessibility adaptations include the following:
 - a) Installation of ramps and grab bars.
 - b) Widening of doorways.
 - c) Modification of bathroom facilities.
 - d) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.
 3. Environmental accessibility adaptations exclude the following:
 - a) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.
 - b) Adaptations which add to the square footage of the home.
 4. Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for environmental accessibility adaptation.

5. Providers rendering environmental accessibility adaptation services must:
 - a) Meet all state or local requirements for licensure/certification including, but not limited to, building contractors, plumbers, electricians or engineers.
 - b) Provide services in accordance with applicable state housing and local building codes.
 - c) Ensure the quality of work provided meets standards identified below:
 - 1) All work must be done in a fashion that exhibits good craftsmanship.
 - 2) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions.
 - 3) The contractor must obtain all permits required by local governmental bodies.
 - 4) All non-salvaged supplies and/or materials must be new and of best quality, without defects.
 - 5) The contractor must remove all excess materials and trash, leaving the site clear of debris at completion of the project,
 - 6) All work must be accomplished in compliance with applicable codes, ordinances, regulations and laws.
 - 7) The specifications and drawings cannot be modified without a written change order from the case manager.
 - 8) No accessibility barriers can be created by the modification and/or construction process.
6. MDRS must certify and document that providers meet the criteria/standards in the waiver.

G. Financial Management Service (FMS):

1. FMS is a support service to assist the waiver participant who chooses the Participant-Directed Personal Care service. Participant-Directed Personal Care service recognizes the waiver participant as the employer of record.
2. The waiver participant performs budgetary and employer functions and has the ability to negotiate salaries and benefits with the personal care attendants.
3. The FMS agent assists the waiver participant with employer and budget authority by ensuring federal, state and local employment taxes and labor and worker's compensation

insurance rules related to household employment and payroll are implemented in an accurate and timely manner as related to the personal care attendant.

4. The FMS agent ensures that the necessary employer related duties and tasks, including payroll, are carried out. The service must ensure initial orientation and ongoing training is provided related to responsibilities of being an employer and adhering to legal requirements for employers.
5. The FMS provider must:
 - a) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS related responsibilities on behalf of the participant.
 - b) Provide assistance determining personal care attendant wages and benefits.
 - c) Provide assistance in hiring by verifying employees' citizenship status, conducting criminal background checks, and verifying the employee is not on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion lists.
 - d) Verify and maintain documentation of employee qualifications, citizenship status, and documentation of services delivered.
 - e) Provide education on recruiting, hiring and terminating employees as well as identifying the need for special skills and determining duties and schedules.
 - f) Ensure appropriate payment by:
 - 1) Collecting timesheets,
 - 2) Processing timesheets,
 - 3) Processing payroll and payables, and
 - 4) Making withholdings for and payment of applicable and federal, state and local employment related taxes.
 - g) Provide quarterly written reports to the waiver participant of all expenditures and the status of the waiver participant's budget.
 - h) Maintain a separate account for each waiver participant.
 - i) Make services available only to those persons deemed eligible and referred by MDRS,
 - j) Establish contact with the participant within five (5) working days of the referral from MDRS,

- k) Conduct a face-to-face visit to initiate the FMS process within five (5) working days of establishing contact with the participant,
- l) Conduct at least one (1) face-to-face meeting annually with each participant to review and update the overall function of the FMS,
- m) Ensure Division of Medicaid (DOM) access to the participant's case files.
- n) Employ staff members with knowledge, experience and abilities to sufficiently carry out the FMS component of service.
- o) Have Medicaid provider agreements with the Division of Medicaid with the following requirements.
 - 1) Have a minimum of five (5) years of billing and payroll experience relevant to participant-directed medical care,
 - 2) Have a working knowledge of disability etiquette, psychology, and social aspects of disability, vulnerable persons act including reporting requirements, HCBS waivers, especially the plans of care, and W-2 employee tax reporting requirements. If the FMS lacks a working knowledge of disability etiquette, psychology and social aspects of disability, vulnerable person's act and home and community based waivers, training must be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.
- p) Develop and maintain policies and procedures for the delivery of Financial Management Services.
- q) Have qualifications verified by DOM initially and monitored annually or more frequently as indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §440.180; 43-13-117(15); CFR §440.180(b)(9);Section 37-33-157 of the Mississippi code of 1972 ; CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.4: Prior Approval/Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility requiring the beneficiary meet nursing facility (NF) level of care.
- B. Clinical eligibility for waiver services is determined through the utilization of a

comprehensive Pre-Admission Screening.

- C. The physician must certify the participant is appropriate for Medicaid long term care services.
- D. The plan of care is the fundamental tool which ensures the health and welfare of participants in the Independent Living Waiver.
 - 1. A participant's plan of care must be based on a comprehensive preadmission screening process and is developed based on the waiver participant's goals, preferences and needs.
 - 2. The case manager/counselor must engage the participant and other interested parties as requested by the participant in developing the plan of care that best meets the needs of the participant.
 - 3. Plans of care must be approved by a Medicaid Program Nurse prior to services being provided.
 - 4. Development of the plan of care must include an emergency preparedness plan.
 - 5. The Plan of Care must be developed at the time of the PAS, updated quarterly, annually and as needed.
 - 6. The Pre-Admission Screening (PAS) and the Plan of Care must be completed jointly by the Rehabilitation Counselor and Registered Nurse on initial certifications.
 - 7. The PAS and the Plan of Care must be completed by the Rehabilitation Counselor or a combination of the Rehabilitation Counselor and the Registered Nurse at re-certification.
- E. The application along with the Plan of Care must be submitted to the Division of Medicaid for approval after the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS.
- F. A participant can only be enrolled in one (1) HCBS waiver program at a time.
- G. Added services must be prior approved by the Division of Medicaid.
- H. MDRS is responsible for implementation of the plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for plan of care implementation. Monitoring the implementation of the plan of care includes on site review activity, record reviews, annual recertification reviews, participant phone calls from the Medicaid agency, and other strategies as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §441.301(b)(1)(i)

History: Revised - 01/01/2013

Rule 2.5: Freedom of Choice

- A. Division of Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.
- B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.
- C. Beneficiaries must be:
 - 1. Informed of any feasible alternatives under the waiver,
 - 2. Given the choice of either institutional or home and community-based services, and
 - 3. Provided a choice among providers or settings in which to receive home and community-based services (HCBS) including non-disability specific setting options.

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

History: Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.6: Quality Management

- A. Providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services (CMS).
- B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.
- C. All reports of abuse, neglect or exploitation, as defined below, must be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS and the Department of Human Services (DHS). The potential abuse, neglect, or exploitation must be reported to the Division of Medicaid/Long Term Care within twenty-four (24) hours.
 - 1. Abuse (A) is defined as willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.
 - 2. Neglect (N) includes, but is not limited to, a single incident of the inability of a vulnerable person living alone to provide for himself and/or failure of a caretaker to

provide what a reasonably prudent person would do.

3. Exploitation (E) is the illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person and includes acts committed pursuant to a power of attorney and can include but is not limited to a single incident.
- D. The Department of Human Services (DHS), Division of Aging and Adult Services is responsible for investigating allegations of Abuse, Neglect and Exploitation. The Division of Medicaid and DHS have a Memorandum of Understanding (MOU) allowing a free flow of information between the two (2) agencies to ensure the health and welfare of waiver participants.
- E. Quality Management Strategy for the waiver includes the following:
1. Level of care determination consistent with the need for institutionalization,
 2. Plan of care consistent with the participant's needs,
 3. Providers must meet the provider specifications of the CMS approved waiver, including licensure/certification requirements,
 4. Critical event/incident reporting mechanism for participants and caregivers to report concerns/incidents of abuse, neglect, and exploitation,
 5. Division of Medicaid retention of administrative authority over the waiver program,
 6. Division of Medicaid retention of financial accountability for the waiver program.
- F. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.

Source: Miss. Code Ann. §43-13-117; §43-13-121; 42 CFR 441.302; Social Security Act 1915(c)

History: Revised – 01/01/2013

Rule 2.7: Participant Direction of Services

- A. Participants are encouraged to make choices in regards to participant needs, goals, preferences and desires with all aspects of the services provided.
- B. Participants have the choice of two (2) options for personal care service:
 1. Co-Participant personal care service, the traditional personal care services, is a viable choice for participants who do not desire to be become the employer of record with

budgetary control. Mississippi Department of Rehabilitation Services is recognized as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority, excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance.

2. Participant-Directed personal care service allows the participant to exercise employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant has the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues.
 - a) The FMS provides assistance to the participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS must submit claims for attendant services to the Division of Medicaid for payment and is responsible for assisting with, including but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. The participant must be given detailed information about all providers except Personal Care Service, and the participant has the opportunity and is encouraged to choose the provider they feel most comfortable and can best meet their needs.
 - b) The FMS must:
 - 1) Provide support for financial management when the participant is the employer of the personal care attendant.
 - 2) Assist participant in verifying personal care attendant citizenship status.
 - 3) Collect and process timesheets of personal care attendants.
 - 4) Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
 - 5) Verify the personal care attendant is not listed on the Mississippi Nurse Aide Abuse Registry.
 - 6) Verify the personal care attendant is not listed on the Office of Inspector General (OIG) exclusion list.
 - 7) Ensure the participant receives initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for

employers.

- 8) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant.
 - 9) Provide assistance determining employee wages and benefits.
 - 10) Verify and maintain documentation of employee qualifications and documentation of services delivered.
 - 11) Conduct criminal background checks on personal care attendants.
 - 12) Assist the participant with recruitment of personal care attendants.
 - 13) Maintain a separate account for each participant's participant-directed budget.
 - 14) Track and report participant funds, disbursements and the balance of participant funds.
 - 15) Process and pay invoices for personal care attendant services approved in the service plan.
 - 16) Provide participant with periodic reports of expenditures and the status of the participant directed budget.
- c) FMS providers must have a Medicaid provider agreement with the Division of Medicaid. The Division of Medicaid is responsible for oversight of the FMS entities by compliance reviews conducted on an annual basis or more often if needed. Reviews are instigated in the event of a complaint regarding management of funds. Any participant under-utilization or over-utilization of services must be reported to the Division of Medicaid.
- d) Waiver participant's failure to comply with participant directed service guidelines will result in a corrective action plan. Repetitive non-compliance disqualifies a waiver participant for the Participant-Directed Service option.
- e) A waiver participant can change from the Participant-Directed Personal Care service to the Co-Participant Directed Personal Care service at any time at their request.
- f) Immediate termination of the Participant-Directed personal care service option occurs if the following circumstances arise, including, but not limited to:
- 1) The participant's/employer's health or welfare is immediately jeopardized,
 - 2) The personal care attendant is convicted of criminal offenses precluding him/her from working with the vulnerable population,

- 3) The participant/employer has not implemented an acceptable corrective action plan as required to continue Participant-Direction,
- 4) The waiver participant declines to the degree he/she is no longer able to express his/her ideas and wants verbally or nonverbally,
- 5) The waiver participant fails to provide adequate justification for underutilizing or over utilizing personal care services,
- 6) Fraud and/or abuse of funds, or
- 7) Unsafe environment for care providers.

Source: CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.8: Monitoring Safeguards

- A. MDRS case managers are required to provide each waiver participant with written information regarding their rights as a waiver participant at the initial assessment.
- B. Case managers must provide the participants information at 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.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.9: Additional Dispute Resolution Process

- A. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.
- B. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services.
- C. MDRS must inform the participant at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes.
- D. MDRS must inform the participant of their rights which address disputes, complaints/grievances and hearings.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.10: Financial Accountability

- A. Claims for waiver services are based on state payment for waiver services that have been rendered to waiver participants as authorized by the plan of care, accurately billed by qualified waiver providers, and in accordance with the approved waiver.
- B. The DOM conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.
- C. DOM denies payment for services when a waiver participant or applicant is not Medicaid eligible on the date of service.
- D. DOM conducts post utilization reviews to ensure the services provided were on the participant's approved plan of care.
- E. Records documenting the provision of services must be maintained by the operating agency (if applicable) and providers of waiver services for a minimum of three (3) years.
- F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

Source: 45 CFR § 92.42, Miss Code 43-13-121

History: Revised 01/01/2013

Rule 2.11: Hearing and Appeals

- A. The Division of Medicaid provides an opportunity to request a Fair Hearing to individuals:
 - 1. Who are not given the choice of home and community-based services as an alternative to the institutional care,
 - 2. Who are denied the service(s) of their choice or the provider(s) of their choice, or
 - 3. Whose services are denied, suspended, reduced, or terminated.
- B. MDRS must provide the individual with a Notice of Action (NOA) via certified mail as required in 42 CFR §431.210.
- C. The NOA must include:

1. A description of the action the provider has taken or intends to take,
 2. An explanation for the action,
 3. Notification that the participant has the right to file an appeal,
 4. Procedures for filing an appeal,
 5. Notification of participant's right to request a Fair Hearing,
 6. Notice the participant has the right to have benefits continued pending the resolution of the appeal, and
 7. The specific regulations or the change in Federal or State law that supports or requires the action.
- D. The waiver participant or his/her representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. The request for a local or state hearing must be made in writing by the participant or his/her legal representative.
- E. The waiver participant may be represented by anyone he/she designates. If the participant elects to be represented by someone other than a legal representative, he/she must designate the person in writing.
- F. The participant has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period is extended if the participant can show good cause for not filing within (30) days.
- G. A hearing cannot be scheduled until a written request is received by either the MDRS or the State DOM office. If the written request is not received within the thirty (30) days of the NOA, services will be discontinued.
- H. At the local hearing level, MDRS issues a determination within thirty (30) days of the date of the initial request for a hearing.
- I. The participant has the right to appeal a local hearing decision by requesting a State hearing; A State hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.
- J. At the State hearing level, DOM issues a determination within ninety (90) days of the date of the initial request for a hearing.
- K. The waiver participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record.
 2. The right to have legal representation at the hearing and to bring witnesses.
 3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
 4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.
- L. Services must remain in place during any appeal process, except when there is a threat of harm of the participant or the service provider.

Source: 42 CFR Part 431, Subpart E Item 1-F; 42 CFR §431.210, Miss Code 43-13-121

History: Revised 01/01/2013

Rule 2.12: 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 participants.
 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.

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,
 - 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.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 3: Home and Community-Based Services (HCBS) Assisted Living Waiver

Rule 3.1: General

- A. The Division of Medicaid covers certain Home and Community Based Services (HCBS) services as an alternative to institutional care in a nursing facility through the Assisted Living (AL) Waiver.
- B. The AL Waiver is administered and operated by the Division of Medicaid.

Source: Social Security Act 1915(c); 42 CFR § 440.180; Miss. Ann. Code § 43-13-117.

Rule 3.2: Eligibility

- A. To be eligible for the Assisted Living Waiver Program a waiver participant must:
 1. Be twenty-one (21) years of age or older,
 2. Require nursing facility level of care as determined by a standardized comprehensive preadmission screening, and
 3. Be in the Supplemental Security Income (SSI) Category of Eligibility (COE) or 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. To be eligible for care in a Traumatic Brain Injury Residential facility a participant must:
 1. Meet all the requirements in Miss. Admin. Code Part 208, Rule 3.2.A.,
 2. Have a diagnosis of an acquired traumatic brain injury defined by the Division of Medicaid as a non-degenerative structural brain damage excluding a brain injury that is congenital or due to injuries induced by birth trauma,

3. Have completed acute rehabilitation treatment,
4. Be in a crisis/high stress environment with behavioral needs which place the participant at high risk for institutionalization,
5. Have documentation as to why the services could not be provided inside the State of Mississippi, and
6. Have an Executive Director's Letter of Approval for Out-of-State Placement.

C. Persons enrolled in the Assisted Living 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 USC § 1396n; 42 CFR §§ 435.217, 440.180 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.C. eff. 06/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.B. to correspond with the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.3: Provider Enrollment

To become an HCBS/AL Waiver provider, the prospective provider must:

- A. Submit a provider enrollment packet complete with all necessary information.
- B. Submit a copy of the current and active license/certification to function as a Personal Care Home – Assisted Living Facility (PCH-AL) or meet licensure requirements deemed acceptable by the Division of Medicaid to meet minimum requirements specific for a Traumatic Brain Injury Residential facility.
- C. Successfully pass a facility inspection by a Division of Medicaid inspector.
- D. Satisfy all criteria and requirements for enrollment as a Medicaid provider in accordance with Miss. Admin. Code Part 208, Chapter 1, Rule 1.1, upon completion of items A., B. and C. in Miss. Admin. Code Part 208, Rule 3.3.

Source: 42 CFR Part 455, Subpart E; Miss. Code Ann. §§ 43-13-5; 43-11-13; 43-11-121.

History: Revised Miss. Admin. Code, Part 208, Rule 3.3.B. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.4: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of approved Medicaid providers

for services as outlined in Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.

- B. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).

Source: 42 U.S.C. § 1396a; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 3.5: Prior Approval/Physician Certification

- A. Prior approval must be obtained from the Division of Medicaid before an individual can receive services through the Home and Community-Based Waiver Program.
- B. Functional eligibility for waiver services is determined through a comprehensive Pre-Admission Screening.
 - 1. The physician must certify that the individual meets nursing home level of care.
 - 2. Clinical eligibility must be determined annually using the pre-admission screening for continued AL Waiver services.
- C. The Plan of Care must be developed that:
 - 1. Is person-centered,
 - 2. Involves collaboration between the case manager and the participant and/or their designated representative or responsible party,
 - 3. Is all inclusive to meet the needs, desires and goals, including personal goals, for the participant, and
 - 4. Is approved by the Division of Medicaid prior to enrollment into waiver services.
- D. A waiver participant shall be locked into only one (1) waiver program at a time.

Source: 42 CFR § 441.301 (b)(1)(i); Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code, Part 208, Rule 3.5.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.6: Covered Services

- A. The Assisted Living (AL) Waiver covers Case Management Services provided by a social worker licensed to practice in the State of Mississippi with at least two (2) years of full-time

experience in direct services to elderly and disabled individuals.

B. AL Services include the following:

1. Personal care services rendered by personnel of the licensed facility,
2. Homemaker services,
3. Attendant care services,
4. Medication oversight/administration with personnel operating within the scope of applicable licenses and/or certifications,
5. Therapeutic, social, and recreational programming services,
6. Intermittent skilled nursing services and interventions ordered by the physician and provided:
 - a. At least eight (8) hours a day, including weekends and holidays, to assess and assist the waiver person with services including, but not limited to, medication administration and oversight, and
 - b. By a nurse with an active and unencumbered license acting within their scope of practice. If the facility employs a Licensed Practical Nurse (LPN), the LPN must have supervision by either a Registered Nurse (RN), nurse practitioner, or a physician.
7. Transportation services must be provided by the AL Waiver provider or through the Division of Medicaid's Non-Emergency Transportation (NET) program if the waiver person has not reached the maximum NET service limits.
8. An electronic emergency attendant call system in each Personal Care Home-Assisted Living (PCH-AL) facility which:
 - a) Is available to waiver persons who are:
 - 1) At risk of falling,
 - 2) At risk of becoming disoriented, or
 - 3) Experiencing some disorder placing them in physical, mental or emotional jeopardy.
 - b) Includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides for supervision, safety and security.

9. Provision of normal, daily personal hygiene items including, at a minimum, deodorant, soap, shampoo, toilet paper, facial tissue, laundry soap and dental hygiene products.

C. AL Waiver providers must provide:

1. A setting physically accessible to the person but not located in:
 - a) A nursing facility,
 - b) An institution for mental diseases,
 - c) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
 - d) A hospital providing long-term care services, or
 - e) Any other location that has qualities of an institutional setting, as determined by the Division of Medicaid including, but not limited to, any setting:
 - 1) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
 - 2) Located in a building on the grounds of or immediately adjacent to a public institution, or
 - 3) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).
2. A private, home-like living quarter with a bathroom consisting of a toilet and sink and must:
 - a) Be a unit or room in a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the waiver person, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the Division of Medicaid must ensure that:
 - (1) A lease, residency agreement or other form of written agreement will be in place for each HCBS person, and
 - (2) That the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - b) Provide each waiver person privacy in their sleeping or living unit with:
 - 1) Lockable entrance doors with only appropriate staff having keys to doors, and

- 2) The option to share living units only at the choice of the person.
3. A setting which integrates and facilitates the person's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals without disabilities,
4. A setting selected by the person from among all available alternatives and is identified in the person-centered Plan of Services and Supports (PSS),
5. Protection of a person's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint,
6. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact,
7. Individual choice regarding services and supports, and who provides them,
8. An assessment of safety needs of a person with cognitive impairment supported by a specific assessed need and addressed in the PSS,
9. Freedom and support of persons to control their own schedules and activities and have access to food at any time,
10. Freedom to have visitors of their choosing at any time,
11. A living environment supportive of the person to exercise their rights to:
 - a. Attend religious and other activities of their choice,
 - b. Manage their own personal financial affairs or receive a quarterly accounting of financial transactions made on their behalf,
 - c. Not be required to perform services for the facility,
 - d. Receive mail unopened or in compliance with the facility policy,
 - e. Be treated with consideration, kindness, respect and full recognition of their dignity and individuality,
 - f. Retain and use personal clothing and possessions as space permits,
 - g. Voice grievances and recommend changes in licensed facility policies and services,
 - h. Not be confined to the licensed facility against their will and allowed to move about

- in the community at liberty,
- i. Free from physical and/or chemical restraints,
 - j. Allowed to choose a pharmacy or pharmacist provider in accordance with State law,
 - k. Decide when to go to bed and get up in the morning,
 - l. Furnish and decorate their sleeping or living space within the lease or other agreement,
 - m. Allows the person to decide when to eat his or her meals,
 - n. Have nutritious snacks available at all times, and
 - o. Use the dining room for congregate meals and socialization.

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

History: Revised eff. 01/01/2017; Revised Miss. Admin. Code Part 208, Rule 3.6.B. and added Miss. Admin. Code Part 208, Rule 3.6.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.7: Quality Management

- A. AL Waiver providers must meet applicable service specifications. Refer to the Miss. Admin. Code, Part 208, Chapter 1.
- B. AL Waiver providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to Division of Medicaid.
- C. Providers must maintain compliance with all current waiver requirements, regulatory rules and regulations and administrative codes as specified by the licensing agency.
 1. If an AL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the AL Waiver provider demonstrates compliance with the regulatory agency.
 2. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the Division of Medicaid.
- D. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: 42 CFR § 441.302; Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 208, Rule 3.7.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.8: Documentation and Record Maintenance Requirements

A. Providers participating in the HCBS/AL Waiver program are required to:

1. Maintain legible, accurate, and complete records.
2. Document the services rendered and billed under the program including when a participant is out of the facility and the reason why.
3. Make records available immediately, upon request, to representatives of the Division of Medicaid in substantiation of any and all claims.
4. Maintain records for a minimum of six (6) years or until resolution of any pending investigation, audit or litigation.
5. Maintain statistical and financial data supporting a cost report for at least five (5) years from the date of the cost report, or amended cost report or appeals submitted to the Division of Medicaid.
6. Identify and maintain records of medication allergies of waiver participants.
7. Maintain a current, signed and dated copy of the Division of Medicaid approved admission agreement for each waiver participant which includes, at a minimum:
 - a) Basic charges agreed upon separating costs for room & board and personal care services,
 - b) Period to be covered,
 - c) List of itemized charges, and
 - d) Agreement regarding refunds for payments.

B. Providers must satisfy all requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Chapter 1, Rule 1.3.

C. AL Waiver providers are required to submit copies of all service logs/documentation along with a copy of their billing for each waiver participant served, to the individual's case manager no later than the fifteenth (15th) of the following month in which the service was rendered.

Source: Miss. Code Ann. § 43-13-117; 43-13-118; 43-13-121; 43-13-129.

History: Added Miss. Admin. Code Part 208, Rule 3.8.A.6 and 3.8.A.7 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.9: Beneficiary Cost Sharing

For waiver participants in a Home and Community-Based Service Waiver, the co-payment is exempt if the service is being paid through the Waiver. If services are being paid through regular Mississippi Medicaid, the co-payment is applicable unless exempt by one (1) of the beneficiary groups or services stated in Miss. Admin. Code Part 200, Chapter 3, Rule 3.7.

Source: Social Security Act 1902 (a)(14); 42 CFR § 447.50 – 447.59; Miss. Code Ann. § 43-13-121.

Rule 3.10: Reimbursement

- A. Reimbursement for AL Waiver provider services cannot be requested earlier than the first (1st) day of the month following the month in which services were rendered.
- B. Reimbursement for AL Waiver provider services is only for those services provided within the facility. The Division of Medicaid does not reimburse for room and board.
- C. Transportation is an integral part of AL Waiver provider services and is not reimbursed separately.

Source: Miss. Code Ann. § 43-13-17, 121.

Rule 3.11: Hearings and Appeals for Denied/Terminated Services

- A. Decisions made by the Division of Medicaid that result in services being denied, reduced or terminated, may be appealed in accordance with Part 300 of the Miss. Admin. Code.
- B. The waiver participant/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

Rule 3.12: Education, Training and Supervision

- A. All AL Waiver providers must have policies and procedures assuring safeguards to protect the safety, health and well-being of all waiver participants which must include:
 - 1. Definitions of abuse, neglect and exploitation,
 - 2. Education for employees in detection of abuse, neglect and exploitation,
 - 3. Guidance for facility staff to prevent abuse, neglect and exploitation, and

4. Reporting requirements for abuse, neglect, exploitation and critical incidents.
- B. AL Waiver providers must provide all staff with training upon hire and annually thereafter in the following areas:
1. Vulnerable Persons Act regarding prevention of abuse, neglect and exploitation,
 2. Resident Rights and Dignity,
 3. Care of an Alzheimer's resident,
 4. Care of residents with mental illness, and
 5. How to deal with difficult residents.
- C. The AL Waiver provider must maintain evidence of the training listed in the Miss. Admin. Code, Part 208, Rule 3.12.B. on file and easily accessible upon request of the Division of Medicaid.
- D. The AL Waiver provider must assure:
1. Each direct care staff successfully completes forty (40) hours of course curriculum as identified by the State,
 2. The training is provided prior to providing care to a waiver participant,
 3. Documentation of completion of this course work be maintained at the facility and made available to the Division of Medicaid upon request.
- E. AL Waiver providers must submit an acceptable plan of correction if all training requirements in the Miss. Admin. Code, Part 208, Rule 3.12 are not met continued noncompliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.
- F. TBI Residential Waiver providers must train all staff upon hire in the following areas including, but not limited to:
1. Identifying, preventing and reporting abuse, neglect and exploitation,
 2. Rights and dignity,
 3. Crisis prevention and intervention,
 4. Caring for individuals with cognitive impairments,

5. Assisting with activities of daily living,
6. HIPAA Compliance,
7. Stress reduction,
8. Behavior programs,
9. Recognition and care of individuals with seizures,
10. Rational/behavioral therapy,
11. Elopement risks,
12. Safe operation and care of individuals with assistive devices,
13. Caring for individuals with disabilities,
14. Safety, and
15. Training in CPR and first aid.

G. All program managers employed by a TBI residential provider must be nationally certified as a Brain Injury Specialist.

Source: 42 CFR §§ 431.210; 441.308; 441.307; Miss. Code Ann. § 43-13-121;

History: Added Miss. Admin. Code Part 208, Rule 3.14 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.13: Background Checks

AL Waiver providers must:

- A. Conduct a search of the Mississippi Nurse Aide abuse registry prior to hiring an individual who will provide care to waiver participants including, but not limited to:
 1. Any individual providing direct care or supervision to the residents,
 2. Owners,
 3. Operators, and
 4. Transportation drivers.

- B. Maintain documented evidence in the personnel file of each employee to demonstrate to the Division of Medicaid that the Mississippi Nurse Aide Abuse Registry has been searched.
- C. Conduct a disciplinary search with the professional licensing agency, if any, for each employee to determine if any disciplinary actions have been taken against the employee by the agency.
- D. Conduct a National Criminal Background Check by submitting fingerprints to the licensing agency to be electronically submitted to the Federal Bureau of Investigations and the Mississippi Criminal Information Center as specified in the Minimum Standards For Personal Care Homes Assisted Living, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification.
- E. Deny or terminate employment of any applicant/employee with a felony conviction, a guilty plea, and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which have not been reversed on appeal, or for which a pardon has not been granted:
 - 1. Possession or sale of drugs,
 - 2. Murder,
 - 3. Manslaughter,
 - 4. Armed robbery,
 - 5. Rape,
 - 6. Sexual battery,
 - 7. Sex offense listed in Section 45-33-23 (g), Mississippi Code of 1972,
 - 8. Child abuse,
 - 9. Arson,
 - 10. Grand larceny,
 - 11. Burglary,
 - 12. Gratification of lust,
 - 13. Aggravated assault, or
 - 14. Felonious abuse and/or battery of vulnerable adult.

- F. AL Waiver providers cannot grant a waiver for employment of any employee or applicant with offenses listed in Miss. Admin. Code Part 208, Rule 3.13 E.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 208, Rule 3.13 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.14: Disaster Preparedness

- A. AL Waiver providers must have disaster preparedness and management procedures to ensure that waiver participant's care, safety, and well-being are maintained during and following instances of natural disasters, disease outbreaks, or similar situations.
- B. In the event of termination of an AL Waiver provider agreement, the Division of Medicaid, the participants and their designated representatives, and the licensing agency will work collaboratively to arrange for appropriate transfer of waiver participants to other Medicaid approved providers.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 208, Rule 3.14 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.15: 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 participants.
 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.
 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,
 - 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.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 4: Home and Community-Based Services (HCBS) Traumatic Brain Injury/Spinal Cord Injury Waiver

Rule 4.1: General

- A. The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. Waiver services are available statewide.
1. Persons enrolled in the TBI/SCI Waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.
 2. The Division of Medicaid does not cover TBI/SCI waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).
- B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitative Services (MDRS).

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

History: Revised eff. 01/01/2017.

Rule 4.2: Eligibility

- A. Eligibility is limited to individuals with the following disease(s) or condition(s):
1. Traumatic brain injury which the Division of Medicaid defines as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of

consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

2. Spinal cord injury which the Division of Medicaid defines as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two (2) of the above three (3) deficits.
- B. The extent of injury must be certified by the physician.
- C. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.
- D. Individuals must be certified as medically stable by their physician. The Division of Medicaid defines medically stable as the absence of all of the following:
1. An active, life threatening condition requiring systematic therapeutic measures.
 2. Intravenous drip to control or support blood pressure.
 3. Intracranial pressure or arterial monitoring.
- E. Individuals must qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):
1. Supplemental Security Income (SSI),
 2. Parents and Other Caretaker Relatives Program,
 3. Disabled Child Living at home program,
 4. Working Disabled,
 5. Infants and Children under age nineteen (19) who meet the applicable income requirements,
 6. Disabled Adult Child,
 7. Protected Foster Care Adolescents,
 8. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,
 9. IV-E Foster Children and Adoption Assistance Children, or
 10. 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.

- F. Persons enrolled in the TBI/SCI 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 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 4.2.F. eff. 06/01/2016.

Rule 4.3: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
- B. Personal care services may be furnished by family members provided they are not legally responsible for the individual.
 - 1. The Division of Medicaid defines a person legally responsible for an individual as the parent, or step-parent, of a minor child or an individual's spouse.
 - 2. Family members must meet provider standards and must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.
 - 3. There must be adequate justification for the family member to function as the attendant.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

Rule 4.4: Quality Assurance Standards

- A. Waiver providers must meet applicable quality assurance standards.
- B. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: Miss. Code Ann. § 43-13-121; §43-13-117; §1915(c) of the Social Security Act; 42 CFR 441.302

Rule 4.5: Covered Services

- A. The Division of Medicaid covers the following traumatic brain injury/spinal cord injury (TBI/SCI) Waiver services:
 - 1. Case Management services are defined as services assisting beneficiaries in accessing

needed waiver and other services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.

- a) Case Management services must be provided by Mississippi Department of Rehabilitation Services (MDRS) TBI/SCI counselors/registered nurses who meet minimum qualifications listed in the waiver.
 - b) Responsibilities include, but are not limited to, the following:
 - 1) Initiate and oversee the process of assessment and reassessment of the person's level of care.
 - 2) Provide ongoing monitoring of the services included in the person's plan of care.
 - 3) Develop, review, and revise the plan of care at intervals specified in the waiver.
 - 4) Conduct monthly contact and quarterly face-to-face visits with the person.
 - 5) Document all contacts, progress, needs, and activities carried out on behalf of the person.
2. Attendant Care services are defined as support services provided to assist the person in meeting daily living needs and to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.
- a) Attendant Care is non-medical, hands-on care of both a supportive and health related nature and does not entail hands-on nursing care.
 - b) Services must be provided in accordance with the approved plan of care and is not purely diversional in nature.
 - c) Services may include, but are not limited to the following:
 - 1) Assistance with activities of daily living defined as assistance with eating, bathing, dressing, and personal hygiene.
 - 2) Assistance with preparation of meals, but not the cost of the meals.
 - 3) Housekeeping chores essential to the health of the person including changing bed linens, cleaning the person's medical equipment and doing the person's laundry.
 - 4) Assistance with community related activities including escorting the person to appointments, shopping facilities and recreational activities. The cost of activities or transportation is excluded.
 - d) Attendant Care providers must meet minimum requirements as specified in the

- waiver. MDRS TBI/SCI counselors and registered nurses are responsible for certifying and documenting that the provider meets the training and competency requirements as specified in the current waiver document.
- e) Attendant Care services may be furnished by family members provided they are not legally responsible for the individual.
 - 1) The Division of Medicaid defines legally responsible for an individual as the parent (or step-parent) of a minor child or an individual's spouse.
 - 2) Family members must meet provider standards and they must be certified competent to perform the required tasks by the person and the TBI/SCI counselor/registered nurse.
 - 3) There must be documented justification for the relative to function as the attendant.
 - 3. Respite services are defined as services to assistance beneficiaries unable to care for themselves because of the absence of, or the need to provide relief to the primary caregiver. Institutional Respite is limited to thirty (30) days or less annually. In-home Companion and Nursing respite is limited to sixty (60) hours per month.
 - a) Services must be provided in the person's home, foster home, group home, or in a Medicaid certified hospital, nursing facility, or licensed respite care facility.
 - b) All respite providers must be certified by the Mississippi Department of Rehabilitation Services (MDRS).
 - 4. Specialized medical equipment and supplies are defined as devices, controls, or appliances that will enhance the person's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.
 - a) The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.
 - b) Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under Medicaid.
 - c) Items not of direct medical or remedial benefit to the person are excluded.
 - d) Equipment and supplies must meet the applicable standards of manufacture, design, and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

5. Environmental Accessibility Adaptation is defined as those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the person, or which enable the person to function with greater independence, and without which, the person would require institutionalization.
 - a) The need for these adaptations must be identified in the approved plan of care.
 - b) Environmental accessibility adaptations include the following:
 - 1) Installation of ramps and grab bars the widening of doorways.
 - 2) Modification of bathroom facilities.
 - 3) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.
 - c) Environmental accessibility adaptations exclude the following:
 - 1) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the person.
 - 2) Adaptations which add to the square footage of the home.
 - d) Providers rendering environmental accessibility adaptations must:
 - 1) Meet all state or local requirements for licensure of certification.
 - 2) Provide services in accordance with applicable state housing and local building codes.
 - 3) Ensure the quality of work meets standards identified in the waiver.
 - e) MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.
6. Transition Assistance services are defined as services provided to a person currently residing in a nursing facility who wishes to transition from the nursing facility to the TBI/SCI Waiver program.
 - a) Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars (\$800.00) for the one (1) time initial expense per lifetime. The expenses must be included in the approved plan of care.
 - b) To be eligible for Transition Services, the person must meet all of the following criteria:

- 1) Be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid.
 - 2) Have no other source to fund or attain the necessary items/support.
 - 3) Be moving from a nursing facility where these items/services were provided.
 - 4) Be moving to a residence where these items/services are not normally furnished.
- c) Transition Assistance Services include the following:
- 1) Security deposits required to obtain a lease on an apartment or home.
 - 2) Essential furnishings defined as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Televisions and cable TV access are not essential furnishings.
 - 3) Moving expenses.
 - 4) Fees/deposits for utilities and service access for a telephone.
 - 5) Health and safety assurances defined as pest eradication, allergen control, or one-time cleaning prior to occupancy.
- d) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

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

History: Revised eff. 01/01/2017.

Rule 4.6: Prior Approval/Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility.
- B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.
- C. The physician must certify the level of care.
- D. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. A brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

- E. The Plan of Care must be developed by the case manager and, in conjunction with the Pre-Admission Screening, should contain objectives, types of services to be furnished, and frequency of services.
- F. After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, the application along with the Plan of Care (POC) must be submitted to the Division of Medicaid for approval.
- G. At the time of the initial certification, the Pre-Admission Screening and the Plan of Care must be completed jointly by the TBI/SCI counselor and registered nurse.
- H. At the time of recertification, the Plan of Care must be completed by the IL counselor or the registered nurse.
- I. A beneficiary can only be enrolled in one HCBS waiver program at a time.
- J. Request to add or change services listed on the approved plan of care requires prior approval.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.301 (b)(1)

Rule 4.7: Documentation and Record Keeping

- A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth for applicable waiver quality assurance standards. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.
- B. Waiver providers must submit copies of all service logs/documentation of visits.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 4.8: Beneficiary Cost Sharing

- A. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver.
- B. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(14)

Rule 4.9: Reimbursement

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Due Process Protection

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

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.210

Rule 4.11: Hearings and Appeals

- A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed.
 - 1. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.
 - 2. All appeals must be in writing.
- B. The beneficiary/legal representative is entitled to initially appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor.
- C. If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid no later than five (5) days after notification of the state level appeal.
- D. The Division of Medicaid must assign a hearing officer.
- E. The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case and the beneficiary/legal representative will receive written notification of the decision.
- F. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations, or sexual harassment by the service providers. The TBI/SCI counselor/registered nurse is responsible for ensuring that the beneficiary, receive all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.210; 42 CFR 441.307; 42 CFR 441.308

Rule 4.12: 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 participants.
 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.
 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,
 - 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.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 5: Home and Community-Based Services (HCBS) Intellectual Disabilities/Developmental Disabilities Waiver

Rule 5.1: Eligibility

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services are services covered by the Division of Medicaid as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) which:

1. Are operated jointly with the Mississippi Department of Mental Health (DMH). The Division of Medicaid is the single state Medicaid agency having administrative responsibility in the administration and supervision of the ID/DD Waiver. DMH is responsible for the daily operation of the ID/DD Waiver,
 2. Are available statewide, and
 3. Carry no age restrictions for eligibility.
- B. All of the following eligibility requirements must be met to receive ID/DD Waiver services:
1. Applicant must require a level of care (LOC) found in an ICF/IID.
 2. Applicant must qualify for full Medicaid benefits in one (1) of the following eligibility categories:
 - a) Supplemental Security Income (SSI),
 - b) Parents and Other Caretaker Relatives Program,
 - c) Disabled Child Living at Home Program,
 - d) Working Disabled,
 - e) Infants and Children Under Age Nineteen (19) who meet the applicable income requirements,
 - f) Protected Foster Care Adolescents,
 - g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,
 - h) Title IV-E Foster Children and Adoption Assistance Children,
 - i) Disabled Adult Child,
 - j) 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.
 3. Applicant must have one (1) of the following:
 - a) An intellectual disability based on the following criteria:
 - 1) An IQ score of approximately seventy (70) or below,
 - 2) A determination of deficits in adaptive behavior, and

- 3) Disability which manifested prior to the age of eighteen (18).
- b) A developmental disability, defined by the Division of Medicaid as a severe, chronic disability attributable to a mental or physical impairment including, but not limited to, cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability that results in impairments requiring similar treatment or services. A developmental disability must:
 - 1) Have manifested prior to age twenty-two (22) and be likely to continue indefinitely,
 - 2) Result in substantial functional limitations in three (3) or more of the following major life activities:
 - (a) Self-care,
 - (b) Understanding and use of language,
 - (c) Learning,
 - (d) Mobility,
 - (e) Self-direction, or
 - (f) Capacity for independent living.
 - 3) Include individuals with a developmental delay, specific congenital or acquired condition from birth to age nine (9) that does not result in functional limitations in three (3) or more major life activities, but without services and supports would have a high probability of having three (3) or more functional limitations later in life, and
 - 4) Require a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.
 - c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
- C. Persons enrolled in the ID/DD Waiver can only be enrolled in one (1) home and community-based services (HCBS) waiver program at a time and must receive at least one (1) service a month to remain eligible for the ID/DD Waiver, and the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan.

D. Persons enrolled in the ID/DD 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 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 5.1.D. eff. 06/01/2016; Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.2: Provider Enrollment

A. The Division of Medicaid Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver providers must be certified by the Department of Mental Health (DMH) except for the providers listed below:

1. Occupational therapists,
2. Speech-language pathologists,
3. Physical therapists, and
4. Providers of specialized medical supplies.

B. The provider's listed in Miss. Admin. Code Part 208, Rule 5.2.A.1-4 must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the ID/DD Waiver services and have a current Mississippi Medicaid provider number.

C. All providers must comply with the Centers for Medicare and Medicaid Services (CMS) regulations for home and community-based services (HCBS) and the ID/DD Waiver.

Source: 42 CFR § 455, Subpart E; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.3: Freedom of Choice

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver persons have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. The person and/or guardian or legal representative must be informed of alternatives available through the ID/DD Waiver, and given the option of choosing either institutional or home and

community-based services (HCBS) once eligibility requirements for the ID/DD Waiver have been met.

- C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings and an option for a private unit in a residential setting with identified resources available for room and board. The setting options must be selected by the person and identified and documented in the plan of services and supports.
- D. The choice made by the person and/or guardian or legal representative must be documented and signed by the person and/or guardian or legal representative and maintained in the ID/DD Waiver case record.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 431.51, 441.301, 441.302; Miss. Code Ann. § 43-13-121.

History: Revised 01/01/2017. Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.4: Evaluation/Reevaluation of Level of Care (LOC)

A. A participant's level of care (LOC) is determined by an initial evaluation and required reevaluations to assess the needs for services through the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

- 1. All LOC initial evaluations and required reevaluations must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the Department of Mental Health's (DMH's) five (5) comprehensive regional programs.
- 2. The specific battery of standardized diagnostic and assessment instruments must accurately assess the individual's level of function in all areas of development and serve as a baseline for future reassessments.
- 3. There is not a single instrument/tool required to determine LOC eligibility requirements for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

B. Initial LOC evaluations must:

- 1. Be conducted in an interdisciplinary team format that includes, at a minimum, a psychologist and social worker with other disciplines participating, as needed, based on the applicant's needs.
- 2. Be administered by evaluators:
 - a) Whose educational/professional qualifications are the same as evaluators of ID/DD Waiver and ICF/IID services, and

- b) Who are appropriately licensed/certified under state law for their respective disciplines.
3. Include an ID/DD Waiver LOC reevaluation tool to establish a baseline for future assessments.

C. Reevaluations of LOC must be:

1. Conducted at least annually or when a significant change occurs which is defined as a decline or improvement in a participant's status including, but not limited to, a change:
 - a) In mental or physical status that will not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions,
 - b) That is not self-limiting for declines only,
 - c) That impacts more than one area of the participant's health status,
 - d) Which requires interdisciplinary review and/or revision of the Plan of Services and Supports (PSS),
2. Administered by ID/DD Waiver support coordinators,
3. Reviewed by Master's level staff before submission to DMH,
4. Reviewed by the Diagnostic and Evaluation (D&E) team if a significant change occurred since the baseline LOC assessment, and
5. Reviewed by DMH.

D. All participants must be initially certified by DMH as needing ICF/IID LOC before services provided through the ID/DD Waiver can begin.

Source: 42 USC § 1396n; 42 CFR §§ 440.180, 441.302, 483.20; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.5: Covered Services

- A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services must only be provided to persons when approved by the Department of Mental Health (DMH) and authorized by the ID/DD Waiver support coordinator as part of the approved Plan of Services and Supports (PSS).
- B. All providers must follow DMH Operational Standards regarding criminal background checks, valid driver's license and current vehicle insurance.

C. The ID/DD Waiver services include the following:

1. Support Coordination is defined by the Division of Medicaid as the monitoring and coordinating of all person services, regardless of funding source, to ensure the person's health and welfare needs are met.
 - a) Support Coordination activities must include:
 - 1) Developing, reviewing, revising and ongoing monitoring and assessing of each person's PSS which must include,
 - (a) Information on the person's health and welfare, including any changes in health status,
 - (b) Information about the person's satisfaction with current service(s) and provider(s) (ID/DD Waiver and others),
 - (c) Information addressing the need for any new ID/DD Waiver or other services based upon expressed needs or concerns and/or changing circumstances and actions taken to address the need(s),
 - (d) Information addressing whether the amount/frequency of service(s) listed on the PSS remains appropriate,
 - (e) A review of individual plans developed by agencies which provide ID/DD Waiver services to the person, and
 - (f) Ensuring all services a person receives, regardless of funding source, are coordinated to maximize the benefit for the person.
 - 2) Informing each person about all services offered by certified providers on the person's PSS.
 - 3) Submitting all required information for review, approval, or denial to DMH.
 - 4) Notifying each person and/or guardian or legal representative of:
 - (a) Approval or denial of initial enrollment,
 - (b) Approval or denial of requests for recertification,
 - (c) Approval or denial of requests for readmission,
 - (d) Changes in service amounts or types,

- (e) Discharge from the ID/DD Waiver, and
 - (f) Procedures for appealing the denial, reduction or termination of ID/DD Waiver services as well as providing a written copy of the appeals process.
- 5) Sending service authorizations to providers upon receipt of approval from DMH.
- b) Support coordinators must:
- 1) Monitor implementation of the PSS, the person's health and welfare, and effectiveness of the back-up plan at least monthly,
 - 2) Speak with the person and/or guardian, or legal representative:
 - (a) Face-to-face at least every three (3) months which must include rotation of service settings and communicating with staff, and
 - (b) At least one (1) time per month in the months when a face-to-face visit is not required,
 - 3) Determine if necessary services and supports in the PSS have been provided,
 - 4) Review implementation of strategies, guidelines, and action plans to ensure specified need, preferences, and desired outcomes are being met,
 - 5) Review the person's progress and accomplishments,
 - 6) Review the person's satisfaction with services and providers,
 - 7) Identify any changes to the person's needs, preferences, desired outcomes, or health status,
 - 8) Identify the need to change the amount or type of services and supports or to access new ID/DD Waiver or non-waiver services,
 - 9) Identify the need to update the PSS,
 - 10) Maintain detailed documentation of all contacts made with the person and/or guardian or legal representative in the ID/DD Waiver support coordination service notes,
 - 11) Inquire and document about each person's health care needs and changes during monthly and quarterly contacts,
 - 12) Perform all necessary functions for the person's annual recertification of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

level of care (LOC),

- 13) Educate families on the person's rights and the procedures for reporting instances of abuse, neglect, and exploitation, and
 - 14) Complete the Risk Assessment Tool for the PSS for inclusion in the PSS and to be included in each provider's plan for the person.
2. In-Home Nursing Respite is defined by the Division of Medicaid as services provided in the person's family's home to provide temporary, periodic relief to the primary caregivers of eligible persons who are unable to care for themselves.
- a) In-Home Nursing Respite services:
- 1) Must be provided by a registered nurse or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations and employed by a DMH certified ID/DD Waiver provider,
 - 2) Must be billed separately for services provided to more than one (1) person in the same residence that are related as defined by the Division of Medicaid as siblings or parents/siblings,
 - 3) Must be ordered by a physician, nurse practitioner or a physician assistant and include:
 - (a) Medications, treatments and other procedures the person needs in the absence of the primary caregiver, and
 - (b) Time-frames for medication administration, treatments and other procedures.
 - 4) Are provided when the primary caregiver is absent or incapacitated due to hospitalization, illness, injury, or death,
 - 5) Are provided on a short-term basis,
 - 6) Allows the person to be accompanied on short outings,
 - 7) May be provided on the same day as the following ID/DD Waiver services, but not during the same time period:
 - (a) Day Services-Adults,
 - (b) Prevocational services,
 - (c) Supported Employment,

- (d) Home and Community Supports,
 - (e) Therapy services, and
 - (f) Behavior Support services.
 - b) In-Home Nursing Respite services are not allowed:
 - 1) To be performed in the home of the respite worker,
 - 2) To comingle with personal errands of the respite worker, or
 - 3) To be provided at the same time on the same day as private duty nursing through EPSDT.
 - c) In-Home Nursing Respite services are not covered for persons:
 - 1) Living alone, in group homes or staffed residences,
 - 2) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance, or
 - 3) Receiving:
 - (a) Supported Living ,
 - (b) Supervised Living,
 - (c) Host Home services, or
 - (d) Shared Supported Living.
 - d) Persons enrolled in the ID/DD Waiver who elect to receive In-Home Nursing Respite services must allow providers to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) MediKey system.
- 3. Community Respite is defined by the Division of Medicaid as services provided generally in the afternoon, early evening, and on weekends in a DMH certified community setting to give periodic support and relief to the person's primary caregiver and promote the health and socialization of the person through scheduled activities.
 - a) Community Respite service providers must:
 - 1) Provide the person with assistance in toileting and other hygiene needs,
 - 2) Offer persons a choice of snacks and drinks, and

- 3) Have meals available if services are provided during normal meal time.
- b) Community Respite services are not provided:
- 1) To persons overnight,
 - 2) To persons receiving:
 - (a) Supervised Living services,
 - (b) Host Home services, or
 - (c) Supported Living services.
 - 3) In place of regularly scheduled day activities including, but not limited to:
 - (a) Supported Employment,
 - (b) Day Services-Adult,
 - (c) Prevocational services, or
 - (d) Services provided through a school system.
- c) Community Respite service settings must be physically accessible to the person and must:
- 1) Be integrated in and support full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
 - 2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
 - 3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - 4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

- 5) Facilitate individual choice regarding services and supports, and who provides them.
- d) Community Respite settings do not include the following:
- 1) A nursing facility,
 - 2) An institution for mental diseases,
 - 3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
 - 4) A hospital, or
 - 5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, 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).
4. Supervised Living services are defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community inclusion, transportation and leisure skill development. Supervised living, learning and instruction include elements of support, supervision and engaging participation to reflect that of daily living in settings owned or leased by a provider agency or by participants.
- a) Supervised Living providers must:
- 1) Have staff available on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests or needs of assistance and must not sleep during billable hours.
 - 2) Provide an appropriate level of services and supports twenty-four (24) hours a day during the hours the person is not receiving day services or is not at work.
 - 3) Oversee the person's health care needs by assisting with:

- (a) Scheduling medical appointments,
 - (b) Transporting and accompanying the person to appointments, and
 - (c) Communicating with medical professionals if the person gives permission to do so.
- 4) Provide furnishings used in the following areas if items have not been obtained from other sources including, but not limited to:
- (a) Den,
 - (b) Dining,
 - (c) Bathrooms, and
 - (d) Bedrooms such as:
 - (1) Bed frame,
 - (2) Mattress and box springs,
 - (3) Chest,
 - (4) Night stand, and
 - (5) Lamp.
- 5) Provide the following supplies:
- (a) Kitchen supplies including, but not limited to:
 - (1) Refrigerator,
 - (2) Cooking appliance, or
 - (3) Eating and food preparation utensils,
 - (b) Two (2) sets of linens:
 - (1) Bath towel,
 - (2) Hand towel, and
 - (3) Wash cloth,

- (c) Cleaning supplies.
- 6) Train staff regarding the person's PSS prior to beginning work with the person.
- 7) Provide nursing services as a component in accordance with the Mississippi Nurse Practice Act.
- b) Supervised Living providers cannot:
 - 1) Receive or disburse funds on the part of the person unless authorized by the Social Security Administration,
 - 2) Bill for the cost of room and board, building maintenance, upkeep, or improvement, or
 - 3) Bill for services provided by a family member of any degree.
- c) Supervised Living is available to persons who are at least eighteen (18) years of age.
- d) Supervised Living services cannot be provided to persons receiving:
 - 1) Home and Community Supports,
 - 2) Supported Living,
 - 3) In-Home Nursing Respite,
 - 4) Community Respite, or
 - 5) Host Home services.
- e) The cost to transport persons to work or day programs, social events or community activities when public transportation is not available is included in the payments made to the Supervised Living providers. Supervised Living providers may transport persons in their own vehicles as an incidental component of this service and must have a valid driver's license, current automobile insurance and registration.
- f) Nursing services are also a component of Supervised Living services and must be provided in accordance with the Mississippi Nurse Practice Act.
- g) Supervised Living settings must be physically accessible to the person and must:
 - 1) Be integrated in and support full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as

individuals not receiving Medicaid HCBS.

- 2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
 - 3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - 4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
 - 5) Facilitate individual choice regarding services and supports, and who provides them.
- h) Supervised Living services may be provided in settings owned or leased by a provider agency or settings owned or leased by persons.
- 1) The setting can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services which the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
 - 2) If the landlord tenant laws do not apply to the setting, the DMH must ensure:
 - (a) A lease, residency agreement or other form of written agreement is in place for each person, and
 - (b) The agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - 3) Each person must have privacy in their sleeping or living unit which includes:
 - (a) Entrance doors lockable by the person with only appropriate staff having keys to doors,
 - (b) A choice of roommates if individuals are sharing units, and
 - (c) The freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - 4) Persons must have the freedom and support to control their own schedules and

activities, and have access to food at any time.

- 5) Persons are able to have visitors of their choosing at any time.
 - 6) The setting is physically accessible to the person.
 - i) Supervised Living settings do not include the following:
 - 1) A nursing facility,
 - 2) An institution for mental diseases,
 - 3) An intermediate care facility for individuals with intellectual disabilities (ICF/IDD),
 - 4) A hospital or
 - 5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.
 - j) Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.
 - 1) Each person must have access to food at any time, unless prohibited by his/her individual plan.
 - 2) Each person must have choices of the food they eat.
 - 3) Each person must have choices about when and with whom they eat.
 - k) Supervised Living sites must duplicate a "home-like" environment.
5. Day Services-Adult is defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies included on the PSS. Activities include environments designed to foster the acquisition and maintenance of skills, build positive social behavior and

interpersonal competence which foster the acquisition of skills, greater independence and personal choice.

a) Day Services-Adult must:

- 1) Take place in a non-residential setting, separate from the home or facility in which the person resides,
- 2) Be physically accessible to the person and must:
 - (a) Be integrated in and support full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.
 - (b) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,
 - (c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - (d) Optimize, but not regiment, 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
 - (e) Facilitate individual choice regarding services and supports, and who provides them.
 - (f) Allow persons to have visitors of their choosing at any time they are receiving Day Services-Adult services.
- 3) Have a community integration component that meets each person's need for community integration and participation in activities which may be:
 - (a) Provided at a DMH certified day program site or in the community, or
 - (b) Offered individually or in groups of up to three (3) people when provided in the community.

b) Day Services-Adult 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).
- c) Day Services-Adult providers must:
- 1) Not exceed one hundred thirty-eight (138) service hours in a month with twenty-three (23) working days or one hundred thirty-two (132) service hours in a month with twenty-two (22) working days.
 - 2) Provide assistance with personal toileting and hygiene needs during the day as well as a private changing/dressing area.
 - 3) Provide each person assistance with eating/drinking as needed and as indicated in each person's PSS.
 - 4) Provide choices of food and drinks to persons at any time during the day which includes, at a minimum:
 - (a) A mid-morning snack,
 - (b) A noon meal, and
 - (c) An afternoon snack.
 - 5) Provide transportation as a component part of Day Services-Adult.
 - (a) The cost for transportation is included in the rate paid to the provider.
 - (b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.
 - (c) Transportation for community outings can be counted in the total number of service hours provided per day.

- d) Day Services-Adult persons:
 - 1) Must be at least eighteen (18) years old.
 - 2) Can receive services that include supports designed to maintain skills and prevent or slow regression for persons with degenerative conditions and/or those who are retired.
 - 3) Can also receive Supported Employment, Prevocational services, and Job Discovery, but not during the same time on the same day.
 - 4) Can also receive Crisis Intervention services on same day at the same time.
- 6. Prevocational services are defined by the Division of Medicaid as services intended to develop and teach a participant general skills that contribute to paid employment in an integrated community setting. These services cannot otherwise be available under a program funded under the Rehabilitation Act of 1973, 29 U.S.C. § 110 or IDEA, 20 U.S.C. § 1400-01.
 - a) Prevocational services must:
 - 1) Be physically accessible to the person and must:
 - (a) Be integrated in and support full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
 - (b) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.
 - (c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - (d) Optimize, but not regiment, 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.
 - (e) Facilitate individual choice regarding services and supports, and who provides them.
 - 2) Be reflected in the person's PSS and be related to habilitative rather than explicit

employment objectives.

- 3) Not exceed one hundred thirty-eight (138) hours per month in a month which has twenty-three (23) working days or one hundred thirty-two (132) hours per month in a month which has twenty-two (22) working days.
 - 4) Provide choices of food and drinks to persons who do not bring their own at any time during the day which includes, at a minimum:
 - (a) A mid-morning snack,
 - (b) A noon meal, and
 - (c) An afternoon snack.
 - 5) Include personal care/assistance but cannot comprise the entirety of the service; however, participants cannot be denied Prevocational services because they require the staff's assistance with toileting and/or personal hygiene.
 - 6) Include a review with staff and the ID/DD Waiver support coordinator for the necessity and appropriateness of the services, when a person earns more than fifty percent (50%) of the minimum wage.
 - 7) Be furnished in a variety of locations in the community and are not limited to fixed program locations.
- b) Prevocational service providers must:
- 1) Provide transportation as a component part of Prevocational services.
 - (a) The cost for transportation is included in the rate paid to the provider.
 - (b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.
 - (c) Transportation to and from the program for the purpose of training may be included in the number of hours of services provided per day for the period of time specified in the PSS.
 - 2) Conduct an orientation annually informing persons about Supported Employment and other competitive employment opportunities in the community.
 - 3) Offer community job exploration to persons monthly.
 - 4) Bill only for actual amount of services provided:

- (a) Bill for a maximum of one hundred thirty-eight (138) hours per month for a person who attends twenty-three (23) working days in a month, or
 - (b) Bill for a maximum of one hundred thirty-two (132) hours per month for a person who attends twenty-two (22) working days in a month.
- c) Prevocational service persons:
- 1) Must be at least eighteen (18) years of age or older to participate.
 - 2) May be compensated in accordance with applicable Federal Laws.
 - 3) May pursue employment opportunities at any time to enter the general work force.
 - 4) May also receive the following ID/DD Waiver services but not during the same time on the same day:
 - (a) Day Services-Adult,
 - (b) Job Discovery, and
 - (c) Supported Employment.
- d) Prevocational service settings do not include the following:
- 1) A nursing facility,
 - 2) An institution for mental diseases,
 - 3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
 - 4) A hospital, or
 - 5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, 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).

- e) The amount of staff supervision someone receives is based upon tiered levels of support determined by a person's score on the Inventory for Client and Agency Planning (ICAP).
7. Supported Employment services are defined by the Division of Medicaid as ongoing support enabling persons to obtain and maintain competitive employment. These services cannot otherwise be available under the Rehabilitation Act of 1973, 29 U.S.C. § 110 or IDEA, 20 U.S.C. § 1400-01.
- a) Supported Employment services include:
 - 1) Activities needed to sustain paid work by persons including:
 - (a) Job analysis,
 - (b) Job development and placement,
 - (c) Job training,
 - (d) Negotiation with prospective employers, and
 - (e) On-going job support and monitoring.
 - 2) Services and supports to assist the person in achieving self-employment, but does not pay for expenses associated with starting up or operating a business, including the following:
 - (a) Aiding the person in identifying potential business opportunities,
 - (b) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business,
 - (c) Identifying supports necessary for the person to successfully operate the business, and
 - (d) On-going assistance, counseling and guidance once the business has launched.
 - 3) Services provided at work sites where persons without disabilities are employed. Payment is made only for the adaptations, supervision, and training required by persons receiving ID/DD Waiver services.
 - 4) Personal care/assistance as a component of Supported Employment, but it must not comprise the entirety of the service.
 - 5) The ability for persons to receive other services in addition to Supported

Employment if included in the approved PSS which include educational, Prevocational, Day Services-Adult, In-home Nursing Respite, Community Respite, ICF/IID Respite, Crisis Support, Home and Community Supports, Behavior Support/Intervention services, and/or physical therapy, occupational therapy or speech therapy. Persons can receive multiple services on the same day but not during the same time period except for Behavior Support or Crisis Intervention services which can be provided simultaneously with Supported Employment.

- 6) Providing transportation between the person's residence and/or other habilitation sites and the employment site as a component part.
 - (a) The cost of transportation is included in the rate paid to the provider and covers transportation between the person's residence and job site and between habilitation sites.
 - (b) Providers cannot bill separately for transportation services and cannot charge persons for these services.
- b) Supported Employment services do not include:
 - 1) Sheltered workshops or other similar types of vocational services furnished in specialized facilities,
 - 2) Volunteer work,
 - 3) Payment for the supervisory activities rendered as a normal part of the business setting, or
 - 4) Facility based or other types of services furnished in a specialized facility that are not part of the general workforce.
- c) Supported Employment providers must:
 - 1) Notify the person's ID/DD Waiver support coordinator of any changes affecting the person's income, and
 - 2) Collaborate with the person's support coordinator to maintain eligibility under the ID/DD Waiver and health and income benefits through the Social Security Administration.
- d) Employment must be in an integrated work setting in the general workforce where a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities.

- e) A person cannot receive Supported Employment services during the Job Discovery process.
8. Home and Community Supports (HCS) are defined by the Division of Medicaid as a range of services provided to persons that live in the family home and need assistance with activities of daily living, instrumental activities of daily living, and inclusion in the community and may be shared by up to three (3) persons who have a common direct service provider agency. Services ensure the person can function adequately both in the home and in the community. Services must also provide safe access to the community. HCS must be provided in a person's private residence and/or community settings.

a) HCS services include:

- 1) Accompanying and assisting the person in accessing community resources and participating in community activities.
- 2) Supervision and monitoring of the person in the home, during transportation, and in the community.
- 3) Assistance with housekeeping directly related to the person's disability and is necessary for the health and well-being of the person. This cannot comprise the entirety of the service.
- 4) Assistance with money management, but not receiving or disbursing funds on behalf of the person.
- 5) Grocery shopping, meal preparation and assistance with feeding, not to include the cost of the groceries.
- 6) Transportation as an incidental component, which is included in the rate paid to the provider. Providers must possess a valid driver's license and current insurance, and must follow DMH Operational Standards regarding criminal background checks.

b) HCS services cannot:

- 1) Be provided in a school setting or in lieu of school services or other available day services.
- 2) Be provided by someone who:
 - (a) Lives in the same home as the person,
 - (b) Is the parent/step-parent of the person,
 - (c) Is a spouse,

- (d) Legal guardian/representative, or
 - (e) Anyone else who is normally expected to provide care for the person.
- 3) Exceed one hundred seventy-two (172) hours per month when provided by a DMH approved family member.
 - 4) Be provided to persons:
 - (a) Living in a residential setting, or any other type of staffed residence,
 - (b) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility if the facility is billing Medicaid, Medicare, and/or private insurance, or
 - (c) Receiving the following ID/DD Waiver services:
 - (1) Supported Living,
 - (2) Supervised Living, or
 - (3) Host Home services.
 - c) HCS providers seeking approval for family members excluding those listed in Miss. Admin. Code Part 208, Rule 5.5.B.8. to provide HCS services must obtain prior approval from DMH.
 - d) Persons enrolled in the ID/DD Waiver who elect to receive HCS services must allow providers to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) MediKey system.
9. Behavior Support services are defined by the Division of Medicaid as services providing systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for persons whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration and/or are at risk for being placed in a more restrictive setting. This service also includes consultation and training provided to families and staff living with the person. The desired outcome of the service is long term behavior change. Behavior Support services cannot replace educationally related services available under IDEA, 20 U.S.C. § 1401 or covered under an individualized family service plan (IFSP) through First Steps. Early and Periodic Screening Diagnosis and Treatment (EPSDT) services must be exhausted before ID/DD Waiver services can be provided.
- a) Behavior Support service providers:
 - 1) Must provide services in the following settings:

- (a) Home,
 - (b) Habilitation setting, or
 - (c) Provider's office.
- 2) Cannot provide services in a public school setting. The provider may observe the person in the school setting to gather information, but may not function as an assistant in the classroom by providing direct services.
- b) Behavior Support services include the following:
- 1) Assessing the person's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for those behaviors, and how those particular behaviors impact the person's environment and life.
 - 2) Developing a behavior support plan, implementing the plan, collecting the data measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan.
 - 3) Providing therapy services to the persons to assist him/her in becoming more effective in controlling his/her own behavior, either through counseling or by implementing the behavior support plan.
 - 4) Communicating with medical and ancillary therapy providers to promote coherent and coordinated services addressing behavioral issues in order to limit the need for psychotherapeutic medications.
10. Therapy Services are defined by the Division of Medicaid as physical therapy, occupational therapy, and speech-language pathology services used for the purpose of maintaining a person's skill, range of motion, and function rather than for rehabilitative reasons.
- a) Therapy services:
- 1) Are provided through the ID/DD Waiver after the termination of State Plan therapy services,
 - 2) Must be on the person's approved PSS,
 - 3) Are only available under the ID/DD Waiver when not available through the IDEA, 20 U.S.C. § 1401 or through EPSDT/Expanded EPSDT.
- b) Therapy services are limited to a:

- 1) Maximum of three (3) hours per week for speech-language pathology,
 - 2) Maximum of three (3) hours per week for physical therapy, and
 - 3) Maximum of two (2) hours per week for occupational therapy.
11. Specialized Medical Supplies are defined by the Division of Medicaid as those supplies in excess of those covered in the Medicaid State Plan. These supplies which must be included on the person's PSS include:
- a) Specified types of catheters,
 - b) Diapers, and
 - c) Blue pads.
12. Supported Living is defined by the Division of Medicaid as services to assist participants with ADLs and IADLs who reside in their own residences (leased or owned) for the purpose of facilitating independent living in their home or community.
- a) Supported Living provides assistance with the following:
 - 1) Grooming,
 - 2) Eating,
 - 3) Bathing,
 - 4) Dressing,
 - 5) Personal care needs,
 - 6) Planning and preparing meals,
 - 7) Cleaning,
 - 8) Transportation or assistance with securing transportation,
 - 9) Assistance with ambulation and mobility,
 - 10) Supervision of person's safety and security,
 - 11) Assistance with banking, budgeting, and shopping,
 - 12) Facilitation of person's inclusion in community activities, and.

13) Use of natural supports.

b) Supported Living providers must:

- 1) Be on call twenty-four (24) hours a day seven (7) days a week to respond to emergencies via phone or to return to the program site depending on the type of emergency.
- 2) Provide transportation when necessary and have documentation of:
 - (a) A valid driver's license,
 - (b) Vehicle registration,
 - (c) Current insurance, and
 - (d) Must follow DMH Operational Standards regarding criminal background checks.
- 3) Not sleep during billable hours, and
- 4) Develop methods, procedures, and activities to provide meaningful days and independent living choices about activities/services/staff for people served in the community.

c) Supported Living participants:

- 1) May share Supported Living services with up to three (3) persons who may or may not live together and who have a common direct service provider agency.
- 2) May share Supported Living staff when:
 - (a) Agreed upon by the person, and
 - (b) Health and welfare can be assured for each person.
- 3) Must be at least eighteen (18) years of age to receive Supported Living services.
- 4) Cannot receive Supported Living services if they are currently:
 - (a) An inpatient of a:
 - (1) Hospital,
 - (2) Nursing Facility,

- (3) ICF/IID, or
 - (4) Any type of rehabilitation facility.
- (b) Receiving the following ID/DD Waiver services:
 - (1) Supervised Living,
 - (2) Host Home services,
 - (3) In-Home Nursing Respite,
 - (4) Home and Community Supports, or
 - (5) Community Respite.
- 13. Crisis Intervention is defined by the Division of Medicaid as immediate therapeutic intervention services available twenty-four (24) hours a day that are designed to stabilize the participant in crisis, prevent further deterioration of the participant, restore the participant to the level of functioning before the crisis, and provide immediate treatment in the least restrictive setting, including, but not limited to a participant's home, alternate community living setting, and/or a participant's day setting.
 - a) Crisis Intervention services, regardless of setting, must be delivered in a way to maintain the person's normal routine to the maximum extent possible and may be billed at the same time on the same day as:
 - 1) Day Services-Adult,
 - 2) Prevocational services, or
 - 3) Supported Employment.
 - b) Crisis intervention must include consultations with family members, providers and other caregivers to design and implement individualized Crisis Intervention plans and provide additional services as needed to stabilize the situation.
 - c) Crisis intervention is authorized up to twenty-four (24) hours per day in seven (7) day segments with the goal to phase out the support as the person becomes able to function appropriately in his/her daily routines/environments and is able to return to his/her home or to Supervised Living or Supported Living.
- 14. Crisis Support is defined by the Division of Medicaid as time-limited services provided in a Division of Medicaid licensed and certified facility when a person's behavior, or family/primary caregiver's situation regarding behavior, warrants a need for immediate

specialized services that exceed the capacity of Crisis Intervention or Behavior Support services.

a) Crisis Support services:

- 1) Provide the person with behavioral and emotional support necessary to allow the person to return to his/her living arrangement.
- 2) Cannot exceed the maximum of thirty (30) days per stay, unless prior authorization is obtained from DMH.

b) A person has to receive prior approval from DMH before admission to an ICF/IID program for crisis support.

15. Host Home services is defined by the Division of Medicaid as services in private homes where a person lives with and family and receives personal care and supportive services through a family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the person's physical, social, and emotional well-being and growth in a family environment. Host Home agencies must take into account compatibility with the Host Home family member(s) including age, support needs and privacy needs. The person receiving Host Home services must have his/her own bedroom.

a) Host Home services are limited to one (1) person per Host Home and include assistance with:

- 1) Personal care,
- 2) Leisure activities,
- 3) Social development,
- 4) Family inclusion, and
- 5) Access to medical services.

b) Host Home agencies must:

- 1) Ensure availability, quality, and continuity of Host Home services,
- 2) Recruit, train, and oversee the Host Home family,
- 3) Be available twenty-four (24) hours a day to provide back-up staffing for scheduled and unscheduled absences of the Host Home family, which includes back-up staffing for scheduled and unscheduled absences of the Host Home family, and

- 4) Ensure the person has basic bedroom furnishings if furnishings are not available from another source.
- c) The Host Home family must:
- 1) Attend PSS meeting and participate in the development of the PSS,
 - 2) Follow all aspects of the PSS,
 - 3) Provide transportation,
 - 4) Assist the person with attending appointments,
 - 5) Meet all staffing requirements as outlined in the DMH Operational Standards, and
 - 6) Participate in training provided by the Host Home agency.
- d) Host Home families are not eligible for:
- 1) Room and board payment, or
 - 2) Maintenance or improvement of Host Home family's residence.
- e) Host Home persons must be
- 1) At least eighteen (18) years of age, and
 - 2) Able to self-administer their medications.
- f) Host Home persons are not eligible for the following ID/DD Waiver services:
- 1) Home and Community Supports,
 - 2) Supported Living,
 - 3) Supervised Living,
 - 4) In-Home Nursing Respite, or
 - 5) Community Respite.
16. Job Discovery is defined by the Division of Medicaid as time-limited services used to develop a person's person-centered career profile and employment goals or career plan
- a) Job Discovery services include, but are not limited to, the following:

- 1) Assisting the person with volunteerism,
 - 2) Self-determination and self-advocacy,
 - 3) Identifying wants and needs for supports,
 - 4) Developing a plan for achieving integrated employment,
 - 5) Job exploration,
 - 6) Job shadowing,
 - 7) Informational interviewing,
 - 8) Labor market research,
 - 9) Job and task analysis activities,
 - 10) Employment preparation, and
 - 11) Business plan development for self-employment.
- b) Job Discovery persons must be:
- 1) At least eighteen (18) years of age, and
 - 2) Unemployed.
- c) Staff must receive or participate in at least eight (8) hours of training on Customized Employment before providing Job Discovery services.
- d) Job Discovery cannot exceed twenty (20) hours over a three (3) month period and must result in the development of a career profile and employment goals or career path.
- e) Job Discovery persons are not eligible for the following ID/DD Waiver services during the same time on the same day:
- 1) Prevocational services, or
 - 2) Day Services-Adult.
17. Transition Assistance is defined by the Division of Medicaid as a one-time, setup expense for persons who transition from an institution (ICF/IID or a Title XIX Nursing Home) to a less restrictive community living arrangement. These funds cannot be used if the person is using transitional funds from other sources.

- a) Persons are eligible for transition assistance if:
 - 1) There is no other funding source to attain essential furnishings to establish basic living arrangements,
 - 2) The person is transitioning from a setting where essential furnishings were provided, and
 - 3) The person is moving to a residence where essential furnishings are not normally provided.

- b) Transition Assistance can only be used once and is a life-time maximum allowance of eight hundred dollars (\$800.00) used to establish the person's basic living arrangement and must be on the person's PSS which may include the following:
 - 1) Expenses to transport furnishings and personal possessions from the facility to the new residence,
 - 2) Security deposits that are required to obtain a lease on an apartment or home that do not constitute paying for housing rent,
 - 3) Utility set-up fees or deposits for utility or service access,
 - 4) Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy,
 - 5) Initial stocking of pantry with basic food items,
 - 6) Cleaning supplies,
 - 7) Towels and linens,
 - 8) Bed,
 - 9) Table,
 - 10) Chairs,
 - 11) Window blinds, and
 - 12) Eating utensils.

- c) Transition Assistance does not include the following:
 - 1) Monthly rental or mortgage expenses,

- 2) Monthly utility charges, or
- 3) Household appliances, items, or services that are intended purely for diversional or recreational activities.
- d) Items purchased with these funds are for the persons use and are property of the person.

Source: 20 U.S.C. § 1401; 42 U.S.C. § 1396n; 42 C.F.R. §§ 431.53, 440.170, 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2017; Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.6: [Reserved]

Rule 5.7: Reimbursement

A. Providers cannot bill the Division of Medicaid for Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services until the first (1st) day of the month after the services were rendered for the following services:

1. Support Coordination,
2. Community Respite,
3. Supervised Living,
4. Day Services-Adult,
5. Prevocational services,
6. Supported Employment,
7. Behavior Support,
8. Therapy services,
9. Specialized Medical Supplies,
10. Supported Living,
11. Crisis Intervention,
12. Crisis Support,

- 13. Host Home,
 - 14. Job Discovery, and
 - 15. Transition Assistance.
- B. The Division of Medicaid reimburses for services provided to persons when authorized by the ID/DD Waiver support coordinator as part of the approved PSS.
 - C. All ID/DD Waiver providers must be enrolled as a Mississippi Medicaid Provider and must maintain an active provider number.
 - D. All ID/DD Waiver providers must be certified by DMH, except providers of Therapy services and Specialized Medical Supplies.
 - E. All ID/DD Waiver providers must utilize the Mississippi Medicaid Electronic Visit Verification (EVV) MediKey for the following services:
 - 1. Home and Community Supports (HCS), and
 - 2. In-Home Nursing Respite.

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

History: Revised eff. 12/01/2017. Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.8: Serious Events/Incidents and Abuse/Neglect/Exploitation

- A. Department of Mental Health (DMH) certified providers must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:
 - 1. Education as to what constitutes possible abuse/neglect/exploitation,
 - 2. Abuse/neglect/exploitation reporting requirements and procedures, and
 - 3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.
- B. All service providers must provide to the person and/or guardian or legal representative upon admission and annually thereafter, oral and written communication of:
 - 1. DMH's program procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse and how to report any suspected violation of rights and/or grievances to DMH, and
 - 2. The person's rights which must:

- a) Provide information on how to report:
 - 1) Violation of rights,
 - 2) Grievances, and
 - 3) Abuse, neglect, or exploitation.
 - b) Be explained in a way that is understandable to the person and/or his/her guardian or legal representative.
 - c) Include a signed form that states the person and/or guardian or legal representative understood their rights.
 - d) Include the DMH toll-free Helpline phone number.
- C. All providers must post the DMH toll-free Helpline phone number in a prominent place throughout each program site. The toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week.
- D. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:
1. A written description of events/incidents and actions,
 2. All written reports, including outcomes, and
 3. A record of telephone calls to DMH.
- E. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the guardian or legal representative as identified by the person receiving services. Incident reports regarding the serious event/incident must be completed and maintained in a central file on site that is not the person's case record. A description of the event/incident must be documented in the person's case record.
- F. Death of a person on provider property, participating in a provider-sponsored event or during an unexplained absence from a residential program site, being served through a certified community living program, or during an unexplained absence of the person from a community living residential program must be reported verbally to DMH within eight (8) hours of discovery with a subsequent written report within twenty-four (24) hours.
- G. The following serious events/incidents must be reported to DMH as outlined in the DMH Operational Standards including, but not limited to:

1. Suicide attempts on provider property or at a provider-sponsored event,
 2. Suspected abuse/neglect/exploitation,
 3. Unexplained absence of any length from a community living or day program,
 4. Emergency hospitalization or treatment of a person receiving Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services,
 5. Accidents associated with suspected abuse or neglect, or in which the cause is unknown or unusual,
 6. Disasters including, but not limited to, fires, floods, tornadoes, hurricanes, earthquakes and disease outbreaks,
 7. Use of seclusion or restraints, either mechanical or chemical. Providers are prohibited from the use of:
 - a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,
 - b) Seclusion,
 - c) Time-out, and
 - d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,
 8. Incidents involving person injury while on provider property or at a provider-sponsored event, and
 9. Medication errors.
- H. If an ID/DD Waiver provider has a question of whether or not an event/incident should be reported, the provider must contact DMH.
- I. Suspected abuse/neglect/exploitation must also be reported to the appropriate authorities according to state law including, but not limited to, the Vulnerable Persons Unit (VPU) at the Attorney General's Office, and the Division of Family and Children Services (DFCS) and the Adult Protective Services (APS) at the Mississippi Department of Human Services (DHS), dependent upon the type of event.
- J. If the alleged perpetrator of abuse/neglect/exploitation carries a professional license or

certificate, a report must be made to the entity that governs their license or certificate.

- K. Disease outbreaks at a provider site must be reported to the Mississippi State Department of Health (MSDH).

Source: 42 U.S.C. § 1396n; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.9: Medication Management and Medical Treatment

- A. Nurses employed by an agency enrolled as an Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver provider must practice within the current guidelines outlined in the Mississippi Nurse Practice Act and applicable state and federal laws and regulations, regardless of the setting.
 - 1. A registered nurse (RN) and/or licensed practical nurse (LPN) must be supervised by appropriately qualified staff through a home health agency or other entity allowed by state and federal laws and regulations.
 - 2. RNs and LPNs must be employed by a Medicaid provider and work under the direction of physician, physician assistant or nurse practitioner.
 - 3. If a participant cannot self-administer medications and the guardian or legal representative is unavailable, only a licensed nurse, nurse practitioner, physician, physician assistant or dentist may administer or oversee administration of medications at ID/DD Waiver program sites in the community or in the home setting.
- B. The following practices must be in place to protect the health and safety of a participant who requires medications or medical procedures/treatments:
 - 1. Medications must be stored appropriately in their original containers if a licensed nurse is to administer them.
 - 2. Licensed nurses may not prepare medications in a medication planner for a non-licensed provider(s) to dispense in his/her absence.
 - 3. All medications must be documented in the participant's record by the appropriately licensed medical professional administering them.
 - 4. Documentation must reflect whether the guardian or legal representative administers the participant's medications or if a participant self-administers his/her medications.
 - 5. RNs must assess the participant for medication side effects and report any suspected side effects or untoward effects to the practitioner who prescribed them. Suspected side effects or potential health issues noted by an LPN must be reported promptly to an RN or

appropriately qualified staff.

6. The first-line responsibility for monitoring a participant's medication regimen lies with the licensed medical professional who prescribes the medication. A licensed medical professional is defined by the Division of Medicaid as a physician, physician assistant, certified nurse practitioner, or licensed dentist who meets the state and federal licensing and/or certification requirements.
 7. Second-line monitoring must be provided by the staff in the supervised living setting which focuses on areas of concern identified by the physician and/or pharmacist.
- C. Supervised Living providers must make arrangements for a licensed nurse to administer medication(s) if a participant who requires medication cannot self-administer while receiving services. With the participant's permission, the licensed nurse or employing agency may accompany the participant to physician visits and/or communicate with the participant's physician. After communicating with the physician, the licensed nurse employed by the Supervised Living provider or employing agency, must document the following:
1. Physician visits including the reason for the visit,
 2. Physician instructions/orders,
 3. New prescriptions including any detailed pharmacy information supplied with the prescription, and
 4. Any pertinent information regarding the participant's medical status.
- D. All medical treatments prescribed by a physician, physician assistant, or nurse practitioner must be provided or administered by a licensed nurse.
1. Documentation must contain an assessment of the treatment and the name of the healthcare professional, including credentials, who performed the required medical treatment.
 2. If the physician, physician assistant, or nurse practitioner orders the participant and/or guardian or legal representative be taught to provide or administer treatments, only an RN may provide this service in accordance with current Mississippi nursing laws, rules and regulations.
- E. Providers must have policies and procedures for the frequency of monitoring behavior, medication administration, side effects and adverse reactions.

Source: Miss. Code Ann. §§ 43-13-121, 73-15-1 to -35.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.10: Documentation and Record Maintenance

- A. Documentation of each Intellectual Disabilities/Developmental Disabilities (ID/DD) service provided must be in the case record. [Refer to Miss. Admin. Code, Part 200, Rule 1.3.]
- B. The entry or clinical note must include all of the following documentation:
 - 1. Date of service,
 - 2. Type of service provided,
 - 3. Time service began and time service ended,
 - 4. Length of time spent delivering service,
 - 5. Identification of participant(s) receiving or participating in the service,
 - 6. Summary of what transpired during delivery of the service,
 - 7. Evidence that the service is appropriate and approved on the PSS, and
 - 8. Name, title, and signature of individual providing the service.
- C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:
 - 1. Documentation requirements in the Centers for Medicare and Medicaid Services (CMS) approved ID/DD Waiver,
 - 2. DMH Operational Standards,
 - 3. Evidence that the service is appropriate and approved on the PSS, and
 - 4. Documentation requirements in the DMH Record Guide.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.11: Beneficiary Cost Sharing

- A. For beneficiaries covered under a HCBS waiver, the co-payment is exempt if the service is being paid through the waiver.
- B. If services are being paid through Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Miss.

Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-.52; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.12: Grievances and Complaints

- A. The Department of Mental Health (DMH) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. Grievances may be made via phone, written letter format or email.
- B. Personnel issues are not within the purview of DMH.
- C. A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.
- D. Providers of waiver services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.
- E. All grievances must be resolved within thirty (30) days of receipt by DMH unless additional time is required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from DMH of the resolution and all activities performed in order to reach the resolution.
- F. Providers must ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.13: Reconsiderations, Appeals, and Hearings

- A. If it is determined that an applicant does not meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care (LOC) at the completion of an initial evaluation by the Diagnostic and Evaluation (D&E) team, the applicant and/or guardian or legal representative may request reconsideration from DMH.
- B. Decisions that result in services being denied, terminated, or reduced may be appealed according to DMH appeal procedures.
 - 1. If the participant and/or guardian or legal representative disagrees with the decision made by DMH regarding services being denied, terminated, or reduced, a written request to

appeal the decision may then be made to the Executive Director of the Division of Medicaid. [Refer to Miss. Admin. Code, Part 300.]

2. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations or sexual harassment of the service providers. The ID/DD Waiver support coordinator is responsible for ensuring that the beneficiary continues to receive all services that were in place prior to the notice of change.

Source: 42 CFR Part 431, Subpart E; Miss. Code Ann. §§ 41-4-7, 43-13-116, 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.14: 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 participants.
 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.

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,
 - 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.

Source: 42 C.F.R. § 441.301.

New rule eff. 01/01/2017.

Part 208 Chapter 6: Bridge to Independence (B2I)

Rule 6.1: General

- A. Bridge to Independence (B2I), Mississippi's Money Follows the Person (MFP) initiative, is a six (6) year federal demonstration grant that was awarded to the Division of Medicaid on April 1, 2011, and is funded by the United States Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS).
- B. The purpose of B2I is to establish a person-driven and sustainable home and community-based long-term care system offering choice and access to quality services in the community for institutionalized individuals:
 1. With a physical disability,
 2. With a mental illness,
 3. With an intellectual or developmental disability, or
 4. Sixty-five (65) years of age or older.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.2: Eligibility

- A. To participate in the Bridge to Independence (B2I) demonstration project, the person:
 1. Must reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or a nursing facility for at least ninety (90) consecutive days with at least one (1) day of the stay reimbursed by Medicaid.
 2. Cannot have received short-term rehabilitation services reimbursed under Medicare during the ninety (90) day stay requirement.
 3. Must be eligible for one (1) of the following Medicaid Home and Community-Based Services (HCBS):

- a) Assisted Living (AL) Waiver,
 - b) Elderly and Disabled (E&D) Waiver,
 - c) Independent Living (IL) Waiver,
 - d) Intellectual Disability/Developmental Disability (ID/DD) Waiver,
 - e) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, and/or
 - f) Community Mental Health Center (CMHC) Services/Rehabilitation option of the State Plan.
4. Must meet the level of care criteria for an ICF/IID or 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 facility.
- B. Qualified residences for transitioning persons must pass a U.S. Department of Housing and Urban Development Housing Quality Standards inspection and meet one (1) of the following criteria:
- 1. A home owned or leased by the transitioning person or the person's family member,
 - 2. 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
 - 3. A residence in a community-based residential setting in which no more than four (4) unrelated persons reside.

Source: 42 USC § 1369a; Miss. Code Ann. § 43-13-121; *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

History: Revised eff. 04/01/2016; Revised to correspond with CMS approved Operational Protocol (eff. 11/04/2014) eff. 09/01/2015; New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.3: Covered Services

The following services are available to B2I persons as documented in the Plan of Services and Supports (PSS):

- A. Transition Care Management, defined as transition care planning occurring for up to one-hundred eighty (180) days pre-discharge from the institution and post-transition care planning for three hundred sixty-five (365) days following transition into the community.

1. Transition Care Management includes:

- a) Crisis Support, defined as a response to the transitioning person and/or person's caregiver who is experiencing a crisis event during the transition process.
 - 1) The service must be available twenty-four (24) hours a day, seven (7) days a week.
 - 2) Initial contact may take place over the telephone, but if the situation is determined to be an emergency, the provider must provide in-person support.
 - 3) Staff must be available to meet with the person in transition, as well as any other member of the person-centered planning team, to resolve the crisis and thereby enable the person to remain in the community.
- b) Person-Centered Planning (PCP), defined as a process directed by the person or family with long-term care needs which:
 - 1) Identifies the strengths, capacities, preferences, needs and desired outcomes of the person.
 - 2) Includes participants freely chosen by the person or family who are able to serve as important contributors.
 - 3) Assists the person to identify and access personalized paid and non-paid services and supports.
 - 4) The person identifies planning goals to achieve those personal outcomes in collaboration with those that the person has identified, including medical and professional staff.
 - 5) The identified personally-defined outcomes and the training supports, therapies, treatments and/or other services the person is to receive to achieve those outcomes as part of the Plan of Services and Supports (PSS).
 - 6) Meets all the following minimum PCP service contact requirements:
 - (a) Initial PCP meeting held within thirty (30) days of the person choosing a B2I provider,
 - (b) Pre-transition PCP meeting held a minimum of every thirty (30) days,
 - (c) Post-transition PCP meeting held a minimum of every sixty (60) days, and
 - (d) Interim PCP meetings held as circumstances change, the person and/or guardian or legal representative requests a meeting, and/or the needs of the

person require that the team meet on a more frequent basis to best coordinate care.

- 7) Includes the following documentation in the enrolled person's record:
 - (a) Discovery interviews including, but not limited to, Community Navigator Notes, dates, and individuals interviewed, such as the person and caregivers,
 - (b) Activities and observations including, but not limited to, activity, location, Community Navigator Notes, and dates,
 - (c) Profile,
 - (d) Dated Action Plans from each PCP meeting,
 - (e) Sign-in sheets of all meetings and dates, and
 - (f) Minutes from all PCP meetings.
- 8) Includes the development of the PSS which is retained in the person's record and contains:
 - (a) B2I services, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided,
 - (b) Other services received, regardless of payer source, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided, and
 - (c) Narrative of services, supports, needs and outcomes.
- 9) Includes a Risk Mitigation Plan, defined as a comprehensive and pro-active safety/risk mitigation plan developed to address any safety issue/risk that has been identified through discovery and planning. The Risk Mitigation Plan must be retained in the person's record and address any safety issue/risk in the following categories and include a detailed mitigation plan for any safety issue/risk including, but not limited to:
 - (a) Medical and physiological,
 - (b) Behavioral and psychiatric,
 - (c) Environmental including, but not limited to, living conditions or loss of a home,
 - (d) Financial,

- (e) Activities of daily living including, but not limited to, loss of natural supports,
 - (f) Service disruption,
 - (g) Legal including, but not limited to, prior convictions and recidivism risk,
 - (h) Natural disaster plan including, but not limited to, fire, flooding, hurricane and earthquake evacuation plan including emergency contact information,
 - (i) B2I provider staff contact number available twenty-four hours a day, seven days a week (24/7),
 - (j) Emergency contact numbers including, but not limited to, 911, local law enforcement office, local hospital, and regional CMHC, and
 - (k) A written and oral explanation of appropriate responses to emergencies, including health or mental health emergencies versus situations in need of immediate attention, including broken medical equipment or failure of a service provider to make an appointment.
2. Transition Care Management must be provided by a qualified community navigator who cannot be the person's HCB waiver/CMHC case manager and who meets the criteria in one (1) of the following:
- a) Licensed social worker (LSW) with valid state license and a minimum of one (1) year of relevant work experience,
 - b) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),
 - c) Registered nurse (RN) with valid state license and a minimum of one (1) year of relevant work experience, or
 - d) Others with relevant experience and training with a minimum of a bachelor's degree and one (1) year of work experience in a social or health service setting or a comparable technical and human service training will be considered and approved by the Division of Medicaid, B2I.
3. The community navigator must document in a narrative form in a Community Navigator Notes section in the record all contacts made with, about and/or on behalf of the person and include:
- a) Date of the service,
 - b) Beginning and end time of the service,

- c) Type of contact including, but not limited to, face-to-face, phone, e-mail, PCP meeting notes and activities, meetings and third party calls,
 - d) Who the contact was with including, but not limited to, the person, family member, community/natural resource, service providers, and housing partners,
 - e) Reason for the contact as well as the content and issues discussed,
 - f) All follow-up activities,
 - g) When, why, and what type of information is received about or by the person,
 - h) When, why, and what type of information is sent to another party about the person,
 - i) Any change in services,
 - j) Other situations based on individual circumstances, and
 - k) Community navigator's signature.
4. A Community navigator must provide the following minimum service contacts:
- a) Face-to-face meeting with the person and interested parties scheduled within ten (10) days of a B2I provider receiving referral,
 - b) One (1) contact per week with the person and/or family which includes during the Pre-Transition period up to one hundred eighty (180) days and the Post-Transition period during the first ninety (90) days,
 - c) One (1) face-to-face visit per month with the person Pre-Transition and Post-Transition, not including PCP meeting,
 - d) One (1) PCP team meeting every thirty (30) days Pre-Transition and every sixty (60) days Post-Transition with the initial PCP meeting held within the first thirty (30) days after the Consent to Participate Phase II is signed, and
 - e) One (1) contact per month with an assigned HCB waiver/CMHC case manager to ensure service coordination during the Post-Transition period.
5. A community navigator's case load cannot exceed:
- a) A total of thirty (30) persons, or
 - b) Fifteen (15) persons in each of the following categories:

- 1) Pre-Transition refers to persons for whom a community navigator is providing Transition Care Management services on an ongoing basis prior to transition up to one hundred eighty (180) days and in the first ninety (90) days after transition.
 - 2) Ninety (90) days Post-Transition refers to persons for whom a community navigator is continuing to provide ongoing Transition Care Management services but whose primary health care oversight and management responsibilities have been turned over to appropriate HCB waiver/CMHC case managers.
- B. Life Skills Training, defined as assisting persons with transitioning to the community through independent living skills that include, but are not limited to, money management, the use of technology, accessing community resources, employment skills development, grooming and personal hygiene, and interpersonal relationships with others in the community.
1. A life skills service plan must be developed with the person's input to address life skills needed which must be contained in the person's record and include:
 - a) Date of life skills service plan,
 - b) Life skills to be addressed,
 - c) Activities used to meet the life skill need, and
 - d) Date of goals met and improvement of life skills.
 2. Documentation of services provided must be retained in the person's record and contain:
 - a) Date of the service,
 - b) Beginning and end time of the service delivery,
 - c) Description of the service, and
 - d) Signature of staff person providing service.
- C. Peer Supports, defined as counseling from peers with similar circumstances who may be able to share their own experiences with the person to reduce feelings of isolation and to promote inclusion.
1. Peer supporters must meet the following criteria:
 - a) Be a resident of Mississippi,
 - b) Self-identify as a current or former recipient of disability services for persons with physical, intellectual, developmental, and/or mental disabilities,

- c) Complete all training required by the provider agency,
 - d) Demonstrate a minimum of six (6) consecutive months in self-directed recovery and/or of successful community living, and
 - e) Demonstrate emotional readiness to provide supports to a peer.
2. Documentation of services provided must be retained in the person's record and contain:
- a) Date of the service,
 - b) Beginning and end time of the service delivery,
 - c) Description and summary of the service, and
 - d) Signature of staff person providing the service.
- D. Caregiver Support, defined as a service to enable the caregiver to transition into a more active role and to assist identified and qualified caregivers of persons enrolled in B2I to cope with stress and to develop caregiver skills in order to help them become a source of support for the transitioning person. Caregivers qualified to receive caregiver support must perform or assist the person in one (1) or more life activities, such as finances, health care, or general decision making, and includes:
1. Peer-to-Peer service designed for identified caregivers of the person enrolled in B2I to assist with the management of stress and the development of caregiver skills and must be provided by an individual who must:
 - a) Identify as a former or current caregiver of someone with a physical, intellectual, developmental or mental disability,
 - b) Complete all training required by the provider agency, and
 - c) Demonstrate emotional readiness to provide emotional support to another caregiver and understand when to seek professional help for a caregiver.
 2. Individual Therapy Support, defined as services designed to assist identified caregivers of the person enrolled in B2I through therapy/counseling sessions and must be:
 - a) Provided by an individual who holds a master's degree and professional license as a licensed professional counselor (LPC), licensed psychologist, licensed certified social worker (LCSW) or licensed marriage and family therapist (LMFT), and
 - b) Documented in the person's record and contain:
 - 1) Date of the service,

- 2) Beginning and end time of the service delivery,
 - 3) Description and summary of the service, and
 - 4) Signature of staff providing service.
- E. Transportation, defined as any appropriate form of transporting the person from one (1) location to another to maximize community inclusion for the person.
1. Documentation of services provided must be retained in person's record and contain:
 - a) Date of service,
 - b) Time of service,
 - c) Destination to and from, and
 - d) Signature of staff providing service.
- F. Security and Utility Deposits, defined as specific up-front costs to establish a residence in the community with detailed receipts retained in the person's record.
- G. Household Furnishings and Goods, defined as, but not limited to, essential items and furnishings, appliances, household supplies, and pantry items required to set-up a household in the HCB setting based on the needs of the person with detailed receipts retained in the person's record.
- H. Moving Expenses, defined as moving costs associated with a transition for items transported from the facility in which the person is residing to their new community residence or community-based setting and may also cover commercial transportation of household furnishings from a store to the person's community residence or community-based setting with detailed receipts retained in the person's record.
- I. Environmental Accessibility Adaptations, defined as certain required modifications completed by a licensed and bonded contractor to the person's residence to enable the care of the person in a HCB setting with detailed receipts retained in the person's record. Only persons enrolled in the E&D or ID/DD Waivers are eligible for Environmental Accessibility Adaptations.
- J. Durable Medical Equipment (DME), defined as medically necessary equipment, based on the person's PSS, which allows for community living. Only persons enrolled in the E&D, ID/DD or AL Waivers are eligible for DME.
- K. Extended Pharmacy, defined as up to three (3) additional prescriptions over the Medicaid five (5) prescription limit allowed in the State Plan for a total not to exceed eight (8)

prescriptions per month with no more than five (5) of which may be non-generics.

1. The person is only eligible for the extended pharmacy benefit if their prescriptions are in excess of the Medicaid monthly prescription limit.
 2. Community navigators must assist the person in managing the extended pharmacy benefit to access needed pharmacy services under existing options in the Mississippi State Plan.
 3. Community navigators must coordinate with the person's community providers including, but not limited to, physicians and pharmacists for medication management.
 4. The person enrolled in B2I should utilize preferred medications on the Universal Preferred Drug List (PDL) and the Ninety (90) Day Maintenance List when possible, to maintain the person on the least amount of prescriptions required for therapeutic benefit.
- L. Adaptive Equipment/Technology, defined as an assistive equipment/technological device which includes an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, used to increase, maintain, or to improve the person's level of independence, ability to access needed supports and services in the community or maintain or improve the person's safety with detailed receipts retained in the person's record.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with CMS approved Operational Protocol (eff. 11/04/2014) eff. 09/01/2015; New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.4: Quality Management

B2I providers must maintain quality control measures to ensure the health, safety, and welfare of individuals including, but not limited to:

- A. A twenty-four (24) hours a day, seven (7) days a week crisis and response system,
- B. A critical incident reporting system, and
- C. A system to assess and mitigate risks to individuals.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.5: Appeals and Hearings

- A. Decisions made by B2I staff or representatives resulting in reduced, suspended or terminated services of the Division of Medicaid may be appealed. [Refer to Miss. Admin. Code Part 300: Appeals, Chapter 1: Appeals]

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Part 208 Chapter 7: 1915(i) HCBS

Rule 7.1: Eligibility

- A. The Division of Medicaid covers certain 1915(i) Home and Community-Based Services (HCBS) as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) through its State Plan. The State Plan services:

1. Offer broad discretion, not generally afforded, so that the needs of beneficiaries under the State Medicaid Plan may be addressed,
2. Are operated jointly with the Mississippi Department of Mental Health (DMH),
3. Are available statewide,
4. Carry no age restrictions, and
5. Are covered only for beneficiaries not enrolled in any HCBS Waiver program.

- B. All of the following eligibility requirements must be met to receive 1915(i) State Plan services:

1. A beneficiary must have one (1) of the following:
 - a) An intellectual disability defined by the Division of Medicaid as meeting all the following criteria:
 - 1) An IQ score of approximately seventy (70) or below,
 - 2) A determination of deficits in adaptive behavior, and
 - 3) Manifestation of disability prior to the age of eighteen (18).
 - b) A developmental disability defined by the Division of Medicaid as a severe, chronic

disability which is a condition attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability, because it results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with an intellectual disability and requires similar treatment/services.

- 1) The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely.
 - 2) The condition results in substantial functional limitations in three (3) or more of the following major life activities:
 - i) Self-care,
 - ii) Understanding and use of language,
 - iii) Learning,
 - iv) Mobility,
 - v) Self-direction, or
 - vi) Capacity for independent living and economic self-sufficiency.
 - 3) The individual also requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.
 - 4) An exception to this definition is an individual, from birth to age nine (9), who has a substantial developmental delay or specific congenital or acquired condition. He or she may be considered developmentally disabled without meeting all of the above criteria if, without services and supports, there is a high probability of meeting those criteria later in life.
- c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. Applicant must qualify for full Medicaid benefits in one (1) of the following categories:
 - a) SSI,
 - b) Low Income Families and Children Program,
 - c) Disabled Child Living at Home Program,

- d) Working Disabled,
- e) Children Under Age Nineteen (19) Under 100% of Poverty,
- f) Protected Foster Care Adolescents,
- g) CWS Foster Children and Adoption Assistance Children,
- h) IV-E Foster Children and Adoption Assistance Children, or
- i) Child under Age six (6) at 133% Federal Poverty Level.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.2: Provider Enrollment

- A. Division of Medicaid 1915(i) providers must be certified by the Mississippi Department of Mental Health (DMH), Bureau of Quality Management, Operations and Standards (BQMOS). DMH Certification is dependent upon compliance with the Mississippi Department of Mental Health Operational Standards.
- B. The provider must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the 1915(i) services and have a current Mississippi Medicaid provider number.
- C. All providers must comply with the CMS approved 1915(i) State Plan.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.3: Freedom of Choice

- A. Medicaid persons have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]
- B. Targeted Case Managers must facilitate individual choice regarding services and supports and who provides them. Targeted Case Managers must inform the person/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider.
- C. Settings are selected by the person from among setting options including non-disability specific settings based on the person's needs and preferences which are identified and

documented in the plan of services and supports.

- D. The choice made by the person/legal representative must be documented and signed by the person/legal representative and must be maintained in the person's record.

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017. New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.4: Level of Care Evaluation/Reevaluation and Plan of Care Development

- A. Level of care (LOC) evaluations and reevaluations for eligibility must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the DMH's five (5) comprehensive regional programs.

1. Re-evaluations are only required if the beneficiary has a significant change in condition.
2. Evaluations and reevaluations must be conducted in an interdisciplinary team format which must include a psychologist and social worker.
 - a) Additional team members, including, but not limited to, physical therapists and dieticians, may be utilized dependent upon the needs of the individual being evaluated or reevaluated.
 - b) All members of the D&E Teams must be licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines.

- B. An initial Person-Centered Plan of Care must be facilitated by the Case Manager and be reviewed at least every twelve (12) months and when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs. The Case Manager must:

1. Have a minimum of a Bachelor's degree in a mental health/IDD related field and be credentialed by the MS Department of Mental Health or be a Qualified Mental Retardation Professional (QMRP)/Qualified Developmental Disabilities Professional (QDDP).
2. Complete training in Person-Centered planning and demonstrate competencies associated with that process.
3. Seek active involvement from beneficiaries and their families and/or legal guardians to develop and implement a plan of care that is person-centered and addresses the outcomes desired by the beneficiaries.
4. Educate beneficiaries and their families and/or legal guardians about the person-centered

planning process.

5. Assist beneficiaries participating in 1915(i) and/or their family members and legal representatives to determine who is included in their planning process.
6. Encourage the inclusion of formal and informal providers of support to the beneficiaries in the development of a person-centered plan.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.5: Covered Services

A. A person can receive:

1. 1915(i) services if not eligible for services available:
 - a) For Prevocational Services under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17), or
 - b) For Supported Employment under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
2. Only those 1915(i) services which are documented on the Plan of Services and Supports (PSS) by the Case Manager and approved by the Department of Mental Health (DMH), and
3. Multiple 1915(i) services on the same day but not during the same time of the day.

B. Transportation between the person's residence, other habilitation sites and the employment site is a component part of Habilitation Services.

1. The cost of transportation is included in the rate paid to the provider.
2. Providers cannot bill separately for transportation services and cannot charge the persons for transportation.

C. The 1915(i) State Plan services are:

1. Day Habilitation Services defined by the Division of Medicaid as services designed to assist the person with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Habilitation Services:

- a) Must take place in a non-residential setting separate from the home or facility in which the person resides.
- b) Settings must be physically accessible to the person and must:
 - 1) Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
 - 2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.
 - 3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - 4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
 - 5) Facilitate individual choice regarding services and supports, and who provides them.
- c) Do not include the following:
 - 1) A nursing facility,
 - 2) An institution for mental diseases,
 - 3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),
 - 4) A hospital, or
 - 5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, 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).
 - d) Must be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the person's PSS.
 - e) Must be provided in DMH certified sites/community settings.
- 2. Prevocational Services defined by the Division of Medicaid as services to prepare a person for paid employment. Services address underlying habilitative goals which are associated with performing compensated work. Services include, but are not limited to, teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented but instead are aimed at a generalized result. Prevocational Services:
 - a) Must be included in the person's PSS and be directed towards habilitative objectives and not explicit employment objectives.
 - b) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs which includes, at a minimum:
 - 1) A mid-morning snack,
 - 2) A noon meal, and
 - 3) An afternoon snack.
 - c) May include personal care/assistance as a component but it cannot comprise the entirety of the service. Beneficiaries cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.
 - d) Beneficiaries must be compensated in accordance with applicable federal laws and regulations. If a person is performing productive work as a trial work experience that benefits the provider or that would have to be performed by someone else if not performed by the person, the provider must pay the person commensurate with members of the general work force doing similar work per federal wage and hour regulations.
 - e) Must be reviewed for necessity and appropriateness by the person, appropriate staff and the Case manager if the person earns more than fifty percent (50%) of the minimum wage.
 - f) Providers must inform beneficiaries about Supported Employment opportunities and other competitive employment activities in the community on an annual basis.

- g) May be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each person at least one (1) time per month.
- h) Include transportation. Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day, unless it is for the purpose of training.
- i) Settings must be physically accessible to the person and must:
 - 1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
 - 2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs 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.
- c) 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,
 - 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. Supported Employment services defined by the Division of Medicaid as intensive, ongoing support to persons who, because of their disabilities, require support to obtain and maintain an individual job in competitive or customized employment, or self-employment. Employment must be in an integrated setting in the general workforce for whom a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities. Supported Employment:
 - a) Is based on an Activity Plan that must be developed for each person based on his/her PSS.
 - b) Includes assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction, and ongoing job support and monitoring.
 - c) Includes services and supports to assist the person in achieving self-employment through the operation of a home or community based business, and may include the following:
 - 1) Aiding the person in identifying potential business opportunities.
 - 2) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business.
 - 3) Identifying supports necessary for the person to successfully operate the business.
 - 4) On-going assistance, counseling and guidance once the business has launched.
 - d) Cannot use Medicaid funds to defray the expenses associated with starting or operating a business.
 - e) Must be provided at work sites where persons without disabilities are employed and where payment is made only for the adaptations, supervision, and training required by beneficiaries receiving 1915(i) services and does not include payment for the supervisory activities rendered as a normal part of the business setting.
 - f) Must include transportation between the person's place of residence and the site of the person's job or between or between habilitation sites (in cases where the person receives habilitation services in more than one place) as a component of supported

employment. Transportation cannot comprise the entirety of the service.

- g) May include personal care/assistance as a component of Supported Employment but cannot comprise the entirety of the service.
- h) Do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer work.

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.6: Serious Events/Incidents and Abuse/Neglect/Exploitation

- A. All Department of Mental Health (DMH) providers, including support coordinators and targeted case managers, must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:
 - 1. Education as to what constitutes possible abuse/neglect/exploitation,
 - 2. Abuse/neglect/exploitation reporting requirements and procedures, and
 - 3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.
- B. Providers must provide the person/legal guardian with the provider's procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse.
 - 1. The procedures must be provided upon admission and at least annually thereafter.
 - 2. The procedures must be given orally and in writing.
 - 3. Documentation must include the person/legal guardian's signature indicating the rights have been explained in a way that is understandable to them.
 - 4. The person/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Support (OCS) or Disability Rights Mississippi.
 - 5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the person/legal representative.
- C. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:
 - 1. A written description of events and actions,

2. All written reports, including outcomes, and
 3. A record of telephone calls and written reports to DMH.
- D. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the parent/guardian/legal representative/significant person as identified by the person receiving services.
- E. DMH must submit a summary of serious incidents/events to the Division of Medicaid with each quarterly report.
- F. Serious events/incidents involving beneficiaries that must be reported to the DMH and other appropriate authorities within twenty-four (24) hours or the next business day, by telephone or written report include, but are not limited to, the following:
1. Suicide attempts on program property or at a program-sponsored event.
 2. Suspected abuse/neglect/exploitation, which must also be reported to other authorities in accordance with State law.
 3. Unexplained absence from a residential program of twelve (12) hours duration.
 4. Absence of any length of time from an adult day center providing services to persons with Alzheimer's disease and/or other dementia.
 5. Emergency hospitalization or emergency room treatment of a person receiving 1915(i) services.
 6. Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.
 7. Disasters including fires, floods, tornadoes, hurricanes, earth quakes and disease outbreaks.
 8. Use of seclusion or restraint, either mechanical or chemical. Providers are prohibited from the use of:
 - a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,
 - b) Seclusion,

- c) Time-out, and
 - d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,
- G. Death of a person on program property, at a program sponsored event or during an unexplained absence from a residential program site must be reported to the DMH within eight (8) hours of the death.
- H. If a provider has any question whether or not a situation/incident should be reported, the provider must contact DMH.
- I. Reporting guidelines are determined by the setting in which the suspected abuse/neglect/exploitation occurred.
1. Suspected abuse/neglect/exploitation that occurs in a home setting must be reported to the Vulnerable Adults Unit (VAU) at the Attorney General's Office and the Division of Family and Children Services (DFCS) at the Mississippi Department of Human Services (DHS).
 2. Complaints of abuse/neglect/exploitation of persons in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU) and the Office of the State Attorney General (AG)..
 3. Suspected abuse/neglect/exploitation that occurs in any Day Support services facility, which Division of Medicaid defines as a community-based group program for adults designed to meet the needs of adults with impairments through individual PSS, which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling beneficiaries to live in the community must be reported to DMH if the facility is certified by the DMH.
 4. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.
 5. Disease outbreaks at a provider site must be reported to Mississippi State Department of Health (MSDH).

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.7: Documentation and Record Maintenance

- A. Documentation of each service provided must be in the case record. Refer to Maintenance of

Records Part 200, Ch.1, Rule 1.3.

- B. The entry or service note must include all of the following documentation:
 - 1. Date of service,
 - 2. Type of service provide,
 - 3. Time service began and time service ended,
 - 4. Length of time spent delivering service,
 - 5. Identification of beneficiary(s) receiving or participating in the service,
 - 6. Summary of what transpired during delivery of the service,
 - 7. Evidence that the service is appropriate and approved on the Plan of Care, and
 - 8. Name, title, credential, and signature of individual providing the service.

- C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:
 - 1. Documentation requirements in the CMS approved 1915(i) State Plan Amendment,
 - 2. DMH Operational Standards,
 - 3. Evidence that the service is appropriate and approved on the Plan of Care, and
 - 4. Documentation requirements in the DMH Record Guide.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.8: Grievances and Complaints

- A. The Department of Mental Health (DMH), Office of Consumer Support (OCS) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. The DMH, Quality Management Workgroup assists the OCS in development of procedures for receiving, investigating, and resolving the grievances/complaints.

- B. Personnel issues are not within the purview of DMH.

- C. A toll-free Helpline must be available twenty-four (24) hours a day, seven (7) days per week.

All providers are required to post the DMH toll-free number in a prominent place throughout each program site.

- D. Providers of 1915(i) services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.

Source: 42 U.S.C. § 1396n; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.9: Appeals and Hearings

- A. If it is determined that a person does not meet 1915(i) eligibility criteria or if decisions made by the Department of Mental Health (DMH) result in services being denied, terminated, or reduced the /legal representative has the right to request an appeal from the DMH.
- B. If the person and/or guardian/legal representative disagrees with the decision made by the DMH Executive Director a written request to appeal the decision may be made to the Executive Director of the Division of Medicaid. [Refer to Miss. Admin. Code Part 300]
- C. During the appeals process, contested services must remain in place, unless the decision is made for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment by the service providers. The Targeted Case Manager is responsible for ensuring that the person continues to receive all services that were in place prior to the notice of change.
- D. Providers who must be certified by DMH may appeal issues related to certification to DMH as outlined in the DMH Operational Standards and Administrative Code.

Source: 42 U.S.C. § 1396n; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.10: 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 participants.
 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.
 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,
 - 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. Targeted Case Managers 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.

Source: 42 C.F.R. § 441.710.

History: New rule eff. 01/01/2017.