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

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. Beneficiaries enrolled in the E&D Waiver must reside in a private residence that is fully integrated with opportunities for full access to the greater community, and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

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. Beneficiaries enrolled in the E&D Waiver are prohibited from receiving additional Medicaid services through another waiver program.

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

F. 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 (eff. 07/01/2023) eff. 06/01/2025; 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. In order to qualify as a beneficiary of the Elderly & Disabled (E&D) Waiver Program, individuals must meet the following criteria:

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

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

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

   a) Supplemental Security Income (SSI) eligible under 20 C.F.R. § 416.202, 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 to qualify.

B. Beneficiaries enrolled in the E&D Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home.

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

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 (eff. 07/01/2023) eff. 06/01/2025; 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 meet all of the applicable requirements set forth in Miss. Admin. Code Title 23, Part 200, Chapter 4 in addition to the listed provider-type specific requirements as set forth in sections B. and C. below.

B. To participate as a Home and Community-Based Services (HCBS) Elderly & Disabled (E&D) Waiver provider, the provider must, unless exempted in writing by the Division of Medicaid, at the time of application and at all times thereafter:

1. Attend mandatory orientation, score at least eighty-five (85) on the orientation exam, and submit a completed proposal package to the Office of Long-Term Care for approval by the Division of Medicaid.

2. Once a provider is enrolled, submit any proposed changes to location, supervisory staffing, or organizational contact information, to the Division of Medicaid for approval prior to implementing the requested change.

3. Be established as an agency a business entity and provide the specified service(s) for a minimum of one (1) year prior to application.

4. Be approved for enrollment by Provider Enrollment and enter into a provider agreement with the Division of Medicaid within six (6) months of receiving an approved proposal

package letter from the Office of Long-Term Care.

5. Have an advisory committee, representative of the community and beneficiary population, that meets quarterly to assure responsibility and accountability for performance and quality improvement. The advisory committee must maintain an agenda and minutes for each meeting and must provide public notice of the date, time, and location of each meeting at least twenty-four (24) hours in advance of the meeting.

6. Provide proof of financial solvency by:

   a) Establishing and maintaining a business line of credit for business operations from either a financial institution licensed to conduct banking or other Financial Deposit Insurance Corporation (FDIC) or National Credit Union Administration (NCUA) insured financial institutions. 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.

   b) Providing a copy of the provider's most current filed tax return for the business along with confirmation verifying it was filed. Examples of acceptable forms of confirmation include the following:

      1) 8879 form from a tax preparer, or

      2) 9325 form from the IRS with the submission identification (SID) number.

   c) Providing a copy of the provider's itemized expense report reflecting all income and expenditures for each month for the past twelve (12) months.

7. Establish an office with a physical address in the State of Mississippi that is not located in or on the grounds of a personal residence for a minimum of six (6) months prior to enrollment and maintain an approved physical office until the provider agreement is terminated. The physical office must:

   a) Have appropriate external signage with printed lettering that is visible and readable from the road,

   b) Be compliant with applicable federal, state and local building requirements as well as all zoning, fire, OSHA, health codes and ordinances. It must also meet the requirements of the Americans with Disabilities Act (ADA),

   c) Maintain an active business privilege tax license,

   d) Ensure that beneficiaries and/or family/caregivers have access to a designated private space where they can have confidential discussions with staff and have a reasonable expectation of privacy,

e) Have lockable file storage for the security and maintenance of all files in compliance with HIPAA standards,

f) Maintain regular office hours of Monday through Friday, 8am – 5pm, with the exception of any federal or state holidays, and

g) Have a dedicated office telephone and a means to transmit secure electronic data, i.e., secure email/facsimile, that meets HIPAA standards.

8. Successfully pass a facility inspection by the Division of Medicaid depending on the provider type, as specified in Rule 1.3(c) below.

9. Prior to employment and every two (2) years thereafter, conduct a national criminal background check with fingerprints on all employees and volunteers participating in face-to-face interactions with beneficiaries. Maintain these records in the employee's personnel file.

10. Conduct registry checks before employment and monthly thereafter to ensure that employees or volunteers participating in face-to-face interactions with beneficiaries are not listed on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's Exclusion Database and maintain these records in the employee's personnel file. The provider must not employ individuals whose name appears on the registry list.

11. Not have been nor employ individuals or volunteers participating in face-to-face interactions with beneficiaries who have been convicted of or have 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(h), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, regardless of whether any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

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

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

14. Maintain policy and procedure manuals compliant with all state and federal laws and regulations, including Division of Medicaid's regulations.

15. Maintain and ensure responsible personnel management which includes:

a) Implementing an appropriate policy and process for the recruitment, selection, retention, and termination of employees.

b) Developing written personnel policies and job descriptions that include educational requirements, work experience, job duties and responsibilities.

c) Maintaining a current training plan as a component of the policies/procedures that documents 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) Maintaining a personnel file on every employee and volunteer with required information including, but not limited to, credentialing documentation, training records, and performance reviews. These files must be made available to the Division of Medicaid upon request.

e) Maintaining an organizational chart that includes the names and job titles of owners, operators, managers, administrators, and other supervisory staff. Any changes in organizational structure including ownership must be reported in writing to the Division of Medicaid within ten (10) business days.

f) Maintaining an accurate, historical employee listing that captures names, staff identification numbers, tax identification numbers, employment hire dates and employment termination dates.

16. Maintain a roster of qualified personnel necessary to provide authorized services until employment termination. The roster must include the address of the designated workspace for all supervisory staff.

17. Comply with all applicable federal and state regulations including, but not limited to, tax and labor laws.

18. Ensure all protected health information (PHI) and personal identifiable information (PII) is stored, transported and transmitted in a manner consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

19. At the time of enrollment, not be owned or operated by any individual, organization, or entity currently under investigation by the Division of Medicaid Office of Program Integrity, the Medicaid Fraud Control Unit, or any other government entity. Additionally, the provider must not have been found in violation of the Miss. Admin. Code or the Medicaid Provider Agreement in the eighteen (18) months leading up to their enrollment.

20. In the event a change of ownership occurs, must meet all of the requirements of Miss. Admin Code, Part 200, Rule 4.3, submit to the Division of Medicaid a proposal packet for review and approval within thirty-five (35) days of the change. The effective date of enrollment is retroactive to the date of the licensure, if licensure applies.

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

1. Case Management providers must meet the following requirements:

    a) Operate as a statewide network.

    b) Have a policies and procedures manual compliant with all state and federal laws and regulations, including Division of Medicaid regulations.

    c) Have two (2) person case management teams which consists of Mississippi licensed social workers (LSWs) and/or Mississippi registered nurses (RNs) who meet the following criteria:

        1) A Registered Nurse (RN) 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 documented nursing experience in direct care for aged and/or disabled persons, or

                (2) At least ninety (90) days of training 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) 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 documented experience in direct care services for the aged and/or disabled clients, or

                (2) At least ninety (90) days of training 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 beneficiaries.

4) All case management supervisors and case managers must successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services. This training course must also be attended annually for each year after hire.

(a) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(b) Person Centered Thinking including Participant Rights and Dignity,

(c) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(d) Crisis Prevention/Intervention and Emergency Preparedness,

(e) Caring for Participants with Cognitive or Behavioral Conditions,

(f) Signs and Symptoms of Illness including Seizures,

(g) HIPAA Compliance and Confidentiality,

(h) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices,

(i) Professional Documentation Practices,

(j) Universal Precautions & Infection Control, and

(k) Medicaid Administrative Code and the E&D Waiver

2. Adult day care (ADC) providers must meet the following requirements:

a) Serve counties as determined and approved by the Division of Medicaid based on location, distance, and time required for travel.

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

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

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

c) All staff /volunteers must receive orientation upon hire and ongoing training which includes at least four (4) in-service training sessions per year to enhance quality of care and job performance.

d) At the time of employment, and annually, each employee must receive training in:

1) The purpose and goals of ADC services,

2) The facility's policies and regulations,

3) The roles and responsibilities of other staff members and how they relate to one another,

4) Beneficiary rights and confidentiality,

5) The needs of the beneficiaries in the facility's target population,

6) Body mechanics/transfer techniques/assistance with Activities of Daily Living (ADLs),

7) Cardiopulmonary resuscitation (CPR), first aid and infection control,

8) Fire, safety, disaster plan, and the facility's emergency plan,

9) Basics of nutritional care, food safety, choking prevention and safe feeding techniques,

10) Mandatory reporting laws of abuse/neglect,

11) Behavioral intervention/acceptance/accommodations,

12) Person-centered thinking, and

13) The purpose and requirements of the Elderly and Disabled (E&D) Waiver.

e) Meet the physical and social needs of each beneficiary and maintain compliance with the state and federal guidelines regarding services provided.

f) Have a well-maintained facility which must have:

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

2) Restroom(s) which have:

   (a) At least one toilet for every ten (10) beneficiaries attending the ADC, at least one of which must be ADA compliant, and no more than forty (40) feet from the activity area and equipped with a call button;

   (b) Access to sinks/faucets with water temperature between 100-115 degrees Fahrenheit; and

   (c) Supplies including toilet paper, disinfecting soap, and paper towels.

3) Sufficient, adequately lit parking available to accommodate family members, caregivers, visitors, employees and volunteers. In compliance with the Americans with Disabilities Act (ADA) requirements, a minimum of one (1) parking spaces for every twenty-five (25) parking spaces must be identified as parking for those with a disability and one (1) of every six (6) of those spaces must be van accessible,

4) A rest area for beneficiaries that is separate from activity areas, reasonably near a restroom, supervised, equipped with a working call button, and appropriately furnished for safely resting and/or lying down,

5) Private space to permit staff to work and store records without interruption which must include a separate restroom and break space located within the facility,

6) A locked, storage area for all toxic substances including cleaning supplies,

7) At least two (2) well-identified ADA compliant exits with doors that must:

   (a) Be either open to the outside or no more than ten (10) feet from an outside exit;

   (b) Be side-hinged and swing out in the direction of exit,

   (c) Have an operable alarm system, and

   (d) Not be locked in a manner that would prevent immediate exit in the event of an emergency.

8) A safe, well-lit environment free from hazards including, but not limited to, obstructed walkways, weapons including knives and firearms, steps more than 7" tall, ramp grades with greater than 8.33% slope, and exposed electrical cords,

9) Sufficient, ADA-accessible safe seating available for all beneficiaries, and

10) A permit to operate a kitchen from the Mississippi State Department of Health (MSDH) if the facility is preparing food onsite, If the food is not prepared on site, the facility must contract with and utilize a food service provider/caterer licensed by MSDH to provide nutritionally well-balanced meals that address the dietary needs of beneficiaries. Home Delivered Meals (HDMs) and other government funded meal programs cannot be served in lieu of one (1) meal and two (2) snacks included as a component of the service.

11) A sufficient number of vehicles to transport beneficiaries between their residences and the facility, and to attend facility outings. Each vehicle must meet the following requirements:

    (a) Be accessible to beneficiaries to board and leave from the vehicle without difficulty,

    (b) Be equipped with a device for two-way communication or cell phone,

    (c) Meet local, state, and federal regulations including applicable ADA vehicle requirements,

    (d) Have adequately functioning heating and air-conditioning systems,

    (e) Provide seat belts for all passengers and they must be stored off the floor when not in use,

    (f) Have at least two (2) seat belt extensions available,

    (g) Be equipped with at least one seat belt cutter with a safety blade that is kept within easy reach of the driver for emergency use.

    (h) Have an accurate, operating speedometer and odometer,

    (i) Have two exterior rear view mirrors, one on each side of the vehicle,

    (j) Be equipped with an interior mirror for monitoring the passenger compartment,

    (k) Be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease, or litter; or hazardous debris or unsecured items,

    (l) Have the ADC provider's business name and telephone number clearly displayed on at least both sides of the exterior of the vehicle,

(m) Not have signage that implies that Medicaid waiver beneficiaries are being transported,

(n) Prominently display the vehicle license number and the ADC local phone number on the interior of each vehicle,

(o) Clearly display complaint procedures and make them available in written format in each vehicle for distribution to beneficiaries upon request,

(p) Prohibit smoking at all times with interior sign that states: "NO SMOKING",

(q) Carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms,

(r) Be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash,

(s) Be equipped with an appropriate working fire extinguisher that must be stored in a safe, secure location within reach of the driver,

(t) Maintain insurance coverage in compliance with state law, and any county or city ordinance,

(u) Be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer,

(v) Be inspected by a certified mechanic prior to application, upon initial use, and bi-annually thereafter following enrollment,

(w) Ensure that records of the ADC scheduled bi-annual vehicle inspections are maintained and made available to the Division of Medicaid upon request, and

(x) Only be driven by authorized employees of the ADC provider who are compliant with these requirements or with any State or federal regulations.

12) If the facility contracts transportation services, the facility must be able to show current use of the transportation contract from a licensed provider of ADA compliant transportation services. The contracted entity must meet all Division of Medicaid ADC transportation, vehicle, and driver requirements, including the criteria in Rule 1.3(c)(2)(j)(8) below.

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

h) Have the following employees who must maintain current and active first aid and CPR certification:

1) A full-time administrator, qualified to serve as 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. The administrator 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) If the Administrator is not on-site full time during operating hours, then an on-site full-time program director responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program.

(a) If required, 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.

3) A licensed nurse who may be contracted or on staff on-site a minimum of eight (8) hours per week during normal business hours and available on call as needed. The licensed nurse must have a valid state license and a minimum of one (1) year applicable experience, either full-time or the equivalent. The licensed nurse must adhere to the scope of practice pursuant to the Nursing Practice Law and the rules and regulations of the Mississippi Board of Nursing. The service hours must be tracked on a service log, including date, time in and time out.

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

5) A full-time 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.

6) A ServSafe Certified employee responsible for overseeing the preparation and serving of food, if food is prepared on site.

7) A driver who meets the following requirements, if transportation is not contracted:

   (a) Must abide by federal, state and local laws,

   (b) Must be eighteen (18) years of age and have a current driver's license to operate the assigned vehicle,

   (c) Must be courteous, patient and helpful to all passengers and be neat and clean in appearance

   (d) Must wear a visible, easily read name tag which identifies the employee and the employer,

   (e) Must provide an appropriate level of assistance to a beneficiary when requested or when necessitated by the beneficiary's mobility status or personal condition, including curb-to-curb, door-to-door, and hand-to-hand assistance, as required,

      (1) The ADC driver must confirm the beneficiary is safely inside the residence or facility before departing the drop-off point, and

      (2) The ADC driver is responsible for properly securing any mobility devices used by the beneficiary.

   (f) Must assist beneficiaries in the process of being seated, confirm all seat belts are fastened properly and all passengers are safely and properly secured,

   (g) Must park the vehicle in a safe location, out of traffic and must notify the facility to request assistance when a passenger's behavior or any other condition impedes the safe operations of the vehicle,

   (h) Must park the vehicle in a location that prevents the beneficiary from crossing streets to reach the entrance of their destination when arriving at the intended destination,

   (i) Must provide verbal directions to passengers as appropriate,

   (j) Must notify the ADC provider immediately of an emergency such as an accident/ incident or vehicle breakdown to arrange for alternative

transportation for the beneficiaries on board, and

(k) Must report all accidents/incidents and incidents and breakdowns to the ADC provider as soon as practicable.

8) The ADC Provider must ensure ADC drivers do not:

(a) Leave a beneficiary unattended at any time,

(b) Use alcohol, narcotics, illegal drugs or prescription medications that impair their ability to perform,

(c) Smoke in the vehicle, while assisting a beneficiary or in the presence of a beneficiary or allow beneficiaries or their adult attendant to smoke in the vehicle,

(d) Wear any type of headphones while on duty, except for hands-free headsets for mobile telephones which can only be used for communication with the ADC Provider or to call 911 in an emergency,

(e) Touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance which the ADC driver has been trained, and

(f) Provide services without completing a national and state background check.

9) The ADC Provider must ensure that the ADC driver is removed from service if he/she:

(a) Fails an annual random drug test.

(b) Is convicted of:

(1) Two (2) moving violations or accidents related to transportation in the previous five (5) years as verified by an annual Motor Vehicle Report (MVR), or

(2) Any federal or state crime listed in Miss. Code Ann § 43-13-121.

(c) Has a suspended or revoked driver's license for moving traffic violations in the previous five (5) years as verified by an annual MVR.

i) If the facility utilizes volunteers, they:

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

beneficiaries.

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 can only be allowed on a periodic/temporary basis.

6) Must record their hours and activities.

3. Personal care service providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office. If greater than sixty (60) miles driving distance, the provider must ensure that a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by their agency.

b) Employee qualified personal care attendants, qualified personal care service supervisors, and a director/compliance officer.

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

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

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

(c) Successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services. This training course must also be attended annually for each year after hire.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the E&D Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

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

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

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

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring.

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

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

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

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

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

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The personal care service supervisor and directors/compliance officers must ensure the requirements of the PCA staff as set forth in Rule 1.3(c)(3)(b)(1) above are met, and must meet the following additional requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

(b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

(c) Satisfy one of the following criteria:

(1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

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

(3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

(a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representative include but are not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

(b) The selected relative must be qualified to provide services as specified in Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

(c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

(d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional

requirements of the service during their designated hours.

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

4. In-Home Respite providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office, unless a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by the provider.

b) Employ qualified in-home respite employees and supervisors.

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

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

(b) Be a high school graduate have a GED or must demonstrate the ability to read the written in-home respite assignment and write adequately to complete and sign required forms and reports of visits.

(c) Successfully complete a curriculum training course upon hire and annually thereafter, covering each of the following topics. They must also pass a scored examination upon hire prior to rendering services.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the Elderly and Disabled Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

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

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

(g) Have the ability to function independently without constant supervision/observation,

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring,

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

(j) Have interest in, and empathy for, individuals 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) Maintain current and active first aid and CPR certification,

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

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The in-home respite supervisor and directors/compliance officers must ensure the requirements of the IHR staff as set forth in Rule 1.3(c)(4)(b)(1) above are met, and must meet the following additional requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

(b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

(c) Satisfy one of the following criteria:

(1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

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

(3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

(a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representatives who cannot qualify as a non-legally responsible relative include but are not limited to, spouses, parents/stepparents, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

(b) The selected relative must be qualified to provide services as specified in Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

(c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

(d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services at any time. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

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 qualified 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 Mississippi Department of Health approved 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) Submit for approval by the Division of Medicaid written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into Mississippi provider agreement.

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

    h) Provide delivery of meals at times coordinated with the beneficiary 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 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) 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 by the Mississippi Department of Health 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, and

d) 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 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) 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.

b) 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.

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

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

e) Each Community Transition Service (CTS) 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 subject to approval by the Division of Medicaid.

   (b) Have documented experience in person-centered planning.

   (c) Prior to beginning work, attend an eight (8) hour introductory CTS course that is administered by the Division of Medicaid.

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

   (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 CTS trainings administered by the Division of Medicaid unless excused, in writing, 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 both 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 information technology 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 two (2) years 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.

D. The Division of Medicaid may terminate or suspend a provider immediately for failure to comply with the requirements of the E&D waiver program. The Division of Medicaid may also require providers to submit and implement a corrective action plan (CAP) in a timely manner. Failure to submit or comply with a CAP, approved by the Division of Medicaid, may result in a suspension or termination.

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 eff. 08/01/2026. Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; 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. Beneficiaries 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. Freedom of Choice is required of all providers and is monitored by the Division of Medicaid.

The case management team must assist the beneficiary by providing them with sufficient information and assistance to make free and informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed by the case manager 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, 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2025; Revised eff. 12/01/2018; Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Elderly and Disabled (E&D) Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. Providers must maintain compliance with all current waiver requirements, rules, regulations and administrative codes as specified by the Division of Medicaid.

1. If an E&D Waiver provider fails to respond to contact attempts timely or respond to requests for documentation/training verification in established timeframes, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the E&D waiver provider establishes contact or 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.

C. Waiver providers must report:

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

2. Critical incidences including all instances 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.

D. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

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 (eff. 07/01/2023) eff. 06/01/2025; 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 services include the identification of resources as well as the coordination and monitoring of resources and services by case managers to ensure the health, social needs, preferences and goals of beneficiaries are met throughout the person centered planning process and service provision. The case management agency is responsible for monitoring and implementation of the Plan of Services and Supports (PSS). Monitoring and implementation of the PSS includes, but is not limited to, on-site review activity in the beneficiary's residence, record reviews, annual recertification reviews, telephone interviews by the Medicaid agency, and other strategies as needed.

a) The case management team must consist of a Licensed Registered Nurses (RN) and Licensed Social Worker (LSW), and will conduct the following activities.

1) Conduct face-to-face visits together using the comprehensive long-term services and support (LTSS) assessment instrument at the time of admission and recertification.

(a) Initial assessments must be conducted face-to-face with the waiver applicant in conjunction with a registered nurse.

(b) Recertification assessments must be conducted face-to-face with a beneficiary by the case manager, and a registered nurse must be available for consultation if necessary.

2) Complete face-to-face visits with the beneficiary on a quarterly basis to review the Plan of Services and Supports (PSS).

3) Complete monthly contacts with the beneficiary. Monthly contacts may be completed virtually; however, face-to-face visits for monthly contacts must be

completed with beneficiaries if any of the following concerns are identified:

(a) Beneficiary/representative is unable to communicate by phone due to an auditory, speech or cognitive impairment;

(b) Beneficiary has unmet needs that cannot be resolved by phone;

(c) The case management team has identified risks for abuse, neglect or exploitation including the use of restraints or seclusion that require in-person monitoring; or

(d) Beneficiary/representative is unable to be reached by phone.

b) Each case management team must maintain active case load of no more than one hundred and twenty (120) E&D Waiver beneficiaries.

1) If a case management team maintains an average, active case load greater than one hundred and twenty (120), 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 (ADC) Services - ADC services include community-based comprehensive programs 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 be provided in accordance with a beneficiary's approved PSS.

b) ADC services must meet the needs of aged and disabled persons through an individualized service plan (ISP) developed by the ADC through a person-centered process and must include the following:

1) Personal care and supervision,

2) A minimum of one (1) meal and two (2) snacks per day of an adult's daily nutritional requirement as established by state and federal regulations,

3) Provision of limited health care including medications while the beneficiary is at the facility,

4) Round trip transportation from the beneficiary's home to the facility and to center-sponsored activities, and escort service as needed to ensure a beneficiary's safety,

5) Social, health, and recreational activities which optimize, but not regiment, individual initiative, autonomy, and independence, including, but not limited to,

daily activities, physical environment and personal preferences, and

6) Information on, and referral to, vocational services.

c) To be eligible for reimbursement, the ADC must:

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

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

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

2) Be open and providing services for at least nine (9) continuous hours per day, Monday through Friday, 8am – 5pm with the exception of any state/federal holidays.

d) ADC settings including outdoor spaces must be safe, clean and physically accessible to the beneficiaries and must:

1) Ensure that beneficiaries receiving Medicaid HCBS have access to the greater community, including opportunities to engage in community life as individuals not receiving Medicaid HCBS.

2) Be selected by the beneficiaries 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 beneficiary's needs and preferences.

3) Ensure a beneficiary's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a beneficiary's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and social interaction.

5) Facilitate individual choice regarding services and supports, and who provides them.

6) ADC settings should not restrict a beneficiary within a setting, unless such restriction is documented in the person-centered plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

7) The person-centered service plan should identify and document setting options based on the beneficiary's needs and preferences, including non-disability specific settings, from which the beneficiary can select.

e) ADC 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 beneficiaries receiving Medicaid.

f) Beneficiaries must not be in transportation vehicles for longer than sixty (60) minutes per trip.

3. Personal Care Services - Personal Care Services (PCS) are non-medical support services provided in the home or community of eligible beneficiaries by trained personal care attendants (PCA) to assist the beneficiary 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,

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

3) Are approved by the Division of Medicaid based upon assessed needs of the beneficiary as set forth in the PSS and require sufficient documentation to

substantiate the requested number of hours.

(a) The frequency cannot duplicate hours rendered or billed 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 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 beneficiaries.

b) PCA responsibilities include:

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

(a) Mouth and denture care,

(b) Shaving,

(c) Finger and toenail 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 beneficiary to take prescribed medication,

(i) Eating,

(j) Transferring or changing the beneficiary'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 linens 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 PCAs in an area within sixty (60) miles driving distance of their designated worksite,

2) Ensuring PCA timesheets and any other documents containing protected health or identifying information are securely stored in a manner that prevents unauthorized disclosure while in the PCA or PCA supervisor's possession and returned to the main office location within ten (10) business days,

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

4) Making home visits with PCAs to observe and evaluate job performance, including evaluating the work, skills and job performance of the PCA,

5) Reviewing and approving PCA duties on the approved service plans, revising as needed,

6) Receiving and processing requests for services,

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

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

9) Preparing, submitting or maintaining appropriate records and reports, including supervisory reports and submit monthly activity sheets,

10) Planning, coordinating and recording ongoing in-service PCA training,

11) Performing supervised direct monitoring visits in the beneficiary's home while the PCA staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone while the PCA staff is not on-site, alternating on a bi-weekly basis to assure services and care are provided according to the PSS, and

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

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all applicable state and federal laws, and the CMS approved waiver.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all Office of Inspector General (OIG) and Nursing and Exclusion checks are completed timely and maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately.

6) Ensuring immediate access to all beneficiary and employee records as required for audit purposes.

e) 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 adhere to and support all policies, rules and regulations in the operations of the EVV system.

4. In-Home or Institutional Respite Services - In-Home Respite (IHR) or Institutional Respite Services, either in an institutional or home setting, is covered for beneficiaries unable to care for themselves in the absence, or need for relief, of the beneficiary'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 beneficiary.

a) In-Home Respite services are non-medical, unskilled services.

1) IHR services are covered when a beneficiary:

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

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

2) No more than sixty (60) hours of IHR services per month are allowed. IHR 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 EVV system must adhere to and support all policies, rules and regulations in the operations of the EVV system.

b) IHR staff responsibilities for respite service include, but are not limited to, the following:

1) The IHR staff providing direct respite care must provide one or more of the following primary activities:

(a) Companionship,

(b) Support or general supervision, or

(c) Feeding and personal care needs.

2) The provision of these services does not entail hands-on nursing care. Any assistance with activities of daily living is incidental to the care of the individual and are not provided as discrete services.

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

1) Supervising the IHR staff providing services within sixty (60) miles driving distance of the supervisor's designated worksite,

2) Ensuring IHR staff timesheets and any other documents containing protected health or identifying information are securely stored while in the possession of the IHR staff or supervisor in a manner that prevents unauthorized disclosure and are returned to the main office location within ten (10) business days,

3) Supervising no more than twenty (20) full-time IHR staff,

4) Making home visits with IHR staff to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

5) Reviewing and approving IHR duties on the approved service plans,

6) Receiving and processing requests for services,

7) Being accessible to IHR staff and beneficiaries/their representatives for emergencies, case reviews, conferences, and problem solving,

8) Evaluating the work, skills, and job performance of the IHR staff, including the completion of hands-on skills assessments,

9) Interpreting IHR agency policies and procedures relating to the IHR program,

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

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

12) Performing supervised direct monitoring visits in the beneficiary's home while the IHR staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone, while the IHR staff is not on-site, alternating on a biweekly basis to ensure services and care are provided according to the PSS, and

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

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all other state and federal laws, and the CMS approved waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all OIG and Nursing Exclusion checks are completed timely and maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately if necessary.

6) Ensuring immediate access to all beneficiary and employee records as required for audit purposes.

e) 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 following requirements are met:

a) The beneficiary is unable to leave without assistance and is:

(1) unable to prepare their own meals, and/or

(2) has no responsible caregiver in the home.

b) Beneficiaries 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 beneficiary will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

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

1) Attest 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 beneficiaries 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 beneficiary 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 members and members with limited dexterity or mobility.

8) Ensure all food preparation employees are supervised by a person who is familiar with the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must ensure all hygiene techniques and practices are applied and consult with the service provider dietitian for advice, 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, per beneficiary, and no more than fourteen (14) frozen meals per delivery, per beneficiary.

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

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

(b) Meals delivered to anyone other than the beneficiary 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 beneficiary, provided that proper storage and heating facilities are available in the home, and the beneficiary 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:

   a) Extended services have been prior approved by the Division of Medicaid, and are deemed medically necessary by the beneficiary's prescribing primary care provider, after the initial thirty-six (36) 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.

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

7. Physical therapy services are covered when:

   a) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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 (CT) Services provide assistance with initial expenses required for a beneficiary to set up a household. The expenses must be included in the approved PSS, and expenses are limited to those specifically designated by the Division of Medicaid.

    a) To qualify for CT services, a beneficiary must meet all of the following criteria:

        1) Reside 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 to establish a household,

        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 beneficiary 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 beneficiary or the beneficiary's family member,

            (b) An apartment with lockable access leased to the transitioning beneficiary which includes living, sleeping, bathing, and cooking areas over which the beneficiary or the beneficiary'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) Have 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 include deposits for telephone, electricity, heating, and water.

(d) May include payment of past due bills which inhibit the beneficiary'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 beneficiary transitioning from the nursing facility and are limited to:

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

(b) Purchased items may only include furniture, window coverings, food preparation items, bed/bath items and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the beneficiary's health and safety, which has a combined limit of two hundred and fifty dollars ($250.00) to ensure that all belongings of the beneficiary located in the institution 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 beneficiary or the beneficiary's family, if they are required by the beneficiary's PSS, are necessary to ensure the beneficiary's health, welfare, and their safety and enable the beneficiary 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 beneficiary, 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 up to ninety (90) consecutive days prior to the date on which an institutionalized beneficiary transitions to the community setting.

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

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

(f) All providers/subcontracted entities rendering HAA 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 manner 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, and leave 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) The modification and/or construction process cannot create any new accessibility barriers.

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

(a) Required by the beneficiary's PSS,

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

(c) It enables the beneficiary 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 beneficiary'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 sixty (260) units, which must occur no earlier than ninety (90) days prior to transition to the community.

(c) Is reimbursed per a 15-minute unit rate up to forty (40) 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) They are clearly identified in the service plan, and

(b) The beneficiary 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, 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 beneficiary is able to transition from the current nursing facility, and

2) Identifying and eliminating any identified obstacles or barriers that could prevent a successful transition to a more independent setting.

10. Environmental Safety Services are provided for the purpose of maintaining a healthy and safe living environment through the performance of tasks in and around the beneficiary's home environment that are beyond the beneficiary's capability to personally perform.

a) Environmental Safety Services must be provided in accordance with a beneficiary's PSS and may include the following services:

1) minor home maintenance and repair.

2) non-routine disposal of garbage posing a threat to the beneficiary's health and welfare.

3) pest control and services to prevent, suppress, eradicate, or remove pests posing a threat to the beneficiary's health and welfare.

b) Environmental Safety services exclude tasks that:

1) are the legal or contractual responsibility of someone other than the beneficiary.

2) can be accomplished through existing informal and formal supports.

3) do not provide a direct or remedial benefit to the beneficiary.

4) are performed or interventions available through the personal care or in-home respite services.

c) Environmental safety services shall not exceed $500.00 per beneficiary per state fiscal year. These services are limited to additional services not otherwise covered under the State Plan, including EPSDT.

d) Environmental Safety Services are coordinated and billed based on actual invoiced cost to the Division of Medicaid by approved Elderly and Disabled Waiver Case Management providers.

e) Direct services may be contracted out to local vendors. Vendors providing environmental safety services must:

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

2) Ensure the quality of work meets standards that secure the beneficiary's health and welfare.

3) Coordinate with the Case Managers and the beneficiary to ensure that services are rendered in a person-centered manner.

11. Medication Management services are provided to beneficiaries with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications. These services include consultations and follow-up visits with a licensed pharmacist and must be provided in accordance with a beneficiary's approved PSS. Medication management is limited to one initial or annual consultation and fifteen (15) follow-up visits per state fiscal year (SFY). These services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

a) Medication Management includes the following services:

1) Review of all prescription and over-the-counter medications taken by the beneficiary on at least a monthly basis in order to support the beneficiary's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors.

2) Reviews may occur more frequently, on an as needed basis, upon significant change in the beneficiary's condition or immediately following discharge from an acute hospital stay.

3) A comprehensive initial or annual consultation and subsequent follow-up consultations in which the provider will be responsible for collecting a complete medical history and list of current prescribed and over-the-counter medications in order to assess whether:

a) The beneficiary's medication is accurate, valid, non-duplicative and correct for their diagnoses.

b) Therapeutic doses and administration are at an optimal level.

c) Appropriate laboratory monitoring and follow-up are taking place.

d) Drug interactions, drug allergies and contraindications are assessed and

prevented.

4) Necessary interventions implemented by the provider including, but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery or reminder services

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. 07/01/2023) eff. 06/01/2025; Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 08/01/2019; 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 beneficiary can receive any services through the Elderly and Disabled (E&D) Waiver Program. To obtain approval, the waiver case management provider must complete and submit the 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. Any request to add or increase services listed on the approved PSS must be submitted to and receive prior approval from the Division of Medicaid and must include documentation substantiating the need for the requested change(s).

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. 07/01/2023) eff. 06/01/2025; 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

A. Documentation and record maintenance for reimbursement purposes must, at a minimum, meet requirements set forth in the Elderly and Disabled (E&D) Waiver. [Refer to Miss.

Admin. Code Part 200, Rule 1.3.]

B. All staff records should include, at a minimum, the following required credentialing and qualification documents:

1. Copy of valid, state issued ID,

2. Job description,

3. Application and date of hire,

4. High school diploma, General Educational Development (GED) certificate, other educational degrees, or proof of ability to read and write accurately,

5. Any licensure and/or certifications as required by the Division of Medicaid for job description,

6. Results of fingerprint-based National Criminal Background check(s),

7. Results of monthly Nurse Aide Abuse Registry checks,

8. Results of monthly Office of Inspector General (OIG) checks,

9. Annual attestation of health,

10. Signed confidentiality agreement that includes social media waiver, and

11. Proof of training/evaluations, required professional certifications, and credentials including CPR and First Aid.

C. Records for beneficiaries receiving Personal Care Services (PCS) & In-Home Respite (IHR) should include, at minimum:

1. Referral form/authorization,

2. Approve Plan of Services and Supports (PSS)

3. Daily activity or time sheets capturing tasks completed and the beneficiary/representative's signature verifying the provision of services, if task and global positioning system (GPS) information is not captured electronically in the state approved electronic visit verification system.

4. Service note indicating the causes of any significant variation in the case management recommended/agreed upon schedule of service provision.

D. Records for PCS/IHR offices should include at minimum:

1. Written criteria for service provision, including procedures for dealing with emergency service requests,

2. Policy and procedure manuals,

3. Records of quarterly advisory committee meetings,

4. Written personnel policies including the process used in the recruitment, selection, retention, and termination of employees,

5. Organizational chart including the names and job titles of owners, operators, managers, administrators, and other supervisory staff., and

6. Current and historical employee listing that captures names, staff/tax id numbers, and employment hire and termination dates.

E. Records for beneficiaries receiving Adult Day Care (ADC) should include, at minimum:

1. Individualized Service Plan (ISP), with documentation of annual review,

2. Approved Plan of Services and Supports (PSS),

3. Daily activity or time sheets capturing service notes and the beneficiary/representative's signature verifying the provision of services,

4. Current photograph,

5. Medical history or medical exam completed within six (6) months of admission,

6. Annual nutritional assessment, and

7. Daily Progress Notes.

F. Activity or time sheets must include:

1. Arrival/service start time and date,

2. Departure/service end time and date,

3. Activities/tasks performed, and

4. The signature of the beneficiary or their legal representative verifying the provision of services.

G. ADC facility records should include, at minimum:

1. Documentation of maintenance and janitorial services including repairs, maintenance and pest control,

2. Documentation of quarterly drills for fire and inclement weather,

3. Annual fire safety inspection reports conducted by the fire department,

4. Records of quarterly advisory committee meetings,

5. Written criteria for service provision, including procedures for detailing with emergency service requests,

6. Policy and procedure manuals,

7. Written personnel policies including the process used in the recruitment, selection, training, retention, and termination of employees,

8. Current and historical organizational charts including the names and job titles of owners, operators, managers, administrators, and other supervisory staff,

9. Current and historical employee listing that captures names, staff/tax id numbers, employment hire and termination dates, and

10. Service records of licensed nurses which includes dates in the facility, arrival and departure times, services performed, and signature of administrator or program director.

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. 07/01/2023) eff. 06/01/2025; 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: [Reserved]

Rule 1.10: Reimbursement

A. Claims must be based on services that have been rendered to beneficiaries as authorized by the Plan of Services and Supports (PSS), accurately billed by qualified waiver providers, and in accordance with the approved waiver.

B. The Division of Medicaid conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. The Division of Medicaid denies payment for services when a beneficiary or applicant is not

Medicaid eligible on the date of service.

D. The Division of Medicaid conducts post utilization reviews to ensure the services provided were on the beneficiary's approved PSS.

E. Records documenting the provision of services must be maintained by the providers of waiver services for a minimum of five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

G. 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.

H. All 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 unless an exception is approved, in writing by the Division of Medicaid. Requirements for the use of the EVV system are outlined in Miss. Admin. Code Part 200.

I. The Division of Medicaid reimburses for extended Home Health services, physical therapy services and speech therapy services in accordance with statewide uniform fee schedule.

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

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025.

Rule 1.11: Due Process Protection

A. The Division of Medicaid and the case management agencies are responsible for operating a dispute resolution process separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

1. The types of disputes addressed by an informal dispute resolution process include issues

concerning service providers, waiver services, and other issues that directly affect waiver services.

2. At the initial assessment, the case management agency must provide written notice to inform the beneficiary/representative of the specific criteria for the dispute, complaint/grievance, and hearing processes.

B. The Division of Medicaid provides an opportunity to request a Fair Hearing to beneficiaries:

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.

C. Notice of Action

1. The case management agency must provide the beneficiary with a Notice of Action (NOA) via certified mail as required in 42 C.F.R. §431.210.

2. The NOA must include:

a) A description of the action the provider has taken or intends to take,

b) An explanation for the action,

c) Notification that the person/representative has the right to file an appeal,

d) Procedures for filing an appeal,

e) Notification of person/representative's right to request a Fair Hearing,

f) Notice the person/representative has the right to have benefits continued pending the resolution of the appeal, and

g) The specific regulations or the change in federal or state law that supports or requires the action

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. 07/01/2023) eff. 06/01/2025; 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

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

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. 07/01/2023) eff. 06/01/2025; 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. Person-Centered Planning (PCP) is an ongoing process used to identify a beneficiary's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the beneficiary requires in order to achieve these outcomes and must:

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

2. Include people chosen by the beneficiary.

3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary.

5. Reflect cultural considerations of the beneficiary 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 beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, 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 beneficiaries must be provided with a clear and accessible

alternative dispute resolution process which ensures the beneficiary's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

B. The PSS must reflect the services and supports that are important for the beneficiary to meet the needs identified through an assessment of functional need, as well as what is important to the beneficiary with regard to preferences for the delivery of such services and supports and the level of need of the individual beneficiary and must:

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

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

b) Integrated in, and supports full access of beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries with disabilities and who are limited English proficient so as to be understandable to the beneficiary receiving services and supports, and the individuals important in supporting the beneficiary.

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

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

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

11. Identify those services, the purpose or control of which the beneficiary 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 content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least twelve (12) months have lapsed since the provider's last review,

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

E. All changes to the PSS require documented consent from the beneficiary 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 eff. 06/01/2025; 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.

Rule 1.15: Grievances and Complaints

A. The Division of Medicaid is responsible for investigating and documenting all grievances/complaints regarding all E&D Waiver programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format or email.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. 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 the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved E&D Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

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

History: New rule eff. 06/01/2025.

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 the Independent Living (IL) Waiver.

B. Beneficiaries enrolled in the IL Waiver must reside in a private residence, integrated with opportunities for full access to the greater community and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

C. 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).

D. IL Waiver Beneficiaries are prohibited from receiving additional Medicaid services through another waiver program.

E. IL Waiver Beneficiaries who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

F. The IL Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS).

G. 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 as outlined in an interagency agreement.

H. The average cost for an IL Waiver applicant/beneficiary must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicare and Medicaid Services (CMS) for the current waiver year. The Division of Medicaid may refuse entrance to the waiver to any otherwise eligible individual when the Division of Medicaid 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 Division of Medicaid.

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 440.180, 441.710(a)(1)(i), 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 09/01/2019; Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.2: Eligibility

A. In order to qualify as a beneficiary of the IL Waiver Program, an individual must meet the following criteria:

1. Must be age sixteen (16) or older;

2. Must require nursing facility level of care as determined by a comprehensive long-term service and supports (LTSS) assessment;

3. Must exhibit severe orthopedic and/or neurological impairments that render them dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living;

4. Must be able to express ideas and wants either verbally or nonverbally with caregivers, direct care workers, case managers or others involved in their care;

5. Must be certified as medically stable by a physician or nurse practitioner. 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.

6. Must meet the criteria in one (1) of the following Categories of Eligibility (COE):

a) Supplemental Security Income (SSI);

b) Parents and Other Caretaker Relatives Program;

c) Katie Beckett COE;

d) Children under age nineteen (19) who meet the applicable income requirements;

e) Disabled Adult Child;

f) Protected Foster Care Adolescents;

g) Child Protection Services (CPS) Foster Children and Adoption Assistance Children;

h) IV-E Foster Children and Adoption Assistance Children;

i) 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

j) Working Disabled.

B. IL Waiver beneficiaries cannot reside in a nursing facility or licensed or unlicensed personal care home.

C. In the event of imminent danger to the beneficiary, caregiver, or service provider. An IL Waiver beneficiary may be discharged from the waiver immediately.

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 IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; 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: Provider Qualifications

A. The Mississippi Department of Rehabilitation Services (MDRS), as the provider of Independent Living (IL) Waiver services, must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Chapter 4.

B. To participate as a Home and Community-Based Services (HCBS) IL Waiver provider, MDRS must:

1. Conduct a national criminal background check with fingerprints on case managers,

nurses, and direct care workers (DCW) that provide personal care and transition services prior to employment and every two (2) years thereafter and maintain the record in the employee's personnel file;

2. Conduct registry checks, prior to employment and monthly thereafter, to ensure individuals providing case management and personal care services or transition services 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. The provider must not employ individuals whose name appears on either the registry or the database;

3. Not have employed or currently employ individuals or volunteers who have been convicted of, pleaded guilty to, or pleaded 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 any other crime of violence. Any conviction or plea which was reversed on appeal or for which a pardon was granted shall not be considered;

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

5. Be compliant with all federal and state regulations; and6. Have responsible personnel management including:

    a) Appropriate processes used in the recruitment, selection, retention, and termination of employees;

    b) Maintain current written personnel policies and job descriptions;

    c) Maintain 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; and

    d) Maintain a current 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.

C. MDRS must ensure that all employees and contracted entities meet the service specific requirements below prior to the provision of services:

1. Case Management must be provided by Registered Nurses (RN) and Case Managers who must meet the following qualifications:

    a) The Registered Nurse must:

        1) Have a current and active unencumbered RN license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license; and

        2) Have at least one (1) year of experience with the aged and/or individuals with disabilities.

    b) The Case Manager must:

        1) Possess at a minimum a bachelor's degree in Rehabilitation Counseling or other related field; and

        2) Have one (1) year of experience working with the aged and/or individuals with disabilities.

    c) Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Case Manager.

    d) MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken against any nurse providing services under the IL waiver.

    e) MDRS must verify provider qualifications upon hire and at least annually and maintain documentation of that verification in the employee file.

2. Personal care Services must be provided by a DCW who must meet the following qualifications:

    a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCW;

    b) Must meet basic competencies that include both educational and functional requirements;

    c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements;

    d) Must have completed training/instruction that covers the purpose, functions, and tasks

associated with providing personal care services for the beneficiary.

1) The educational program must be personalized with participation of the beneficiary to ensure his/her specific needs are met.

2) The cost of training/instruction time for DCWs cannot be reimbursed by the Division under the waiver.

3) The individual must demonstrate competency in performing each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering any IL waiver service.

4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary/representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

   (a) DCW training must be conducted by the Case Manager, or an agency permitted by law to train nurse aides, must be tailored to the personal care required for the person, and must include:

      (1) The purpose and philosophy of self-directed services by the disabled;

      (2) Disability awareness;

      (3) Employee-employer relationships;

      (4) The need for respect for the beneficiary's privacy and property;

      (5) Basic elements of body functions;

      (6) Infection control procedures;

      (7) Maintaining a clean and safe environment;

      (8) 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; and

      (9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW 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 is deemed to meet the classroom training requirements. Competency certification for these personal care providers by the beneficiary/representative and Case Manager is required. A DCW that has satisfactorily provided personal care services to the beneficiary for four (4) weeks prior to coverage under the IL waiver program, with such service certified by and verified by the beneficiary/representative and Case Manager, is deemed meeting the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney or those designated as the beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division of Medicaid under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the Division under the waiver when the following criteria are met:

   1) There is documentation that there are no other willing/qualified providers available for selection;

   2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the IL Waiver;

   3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative;

   4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours; and

   5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The Division of Medicaid and/or the Department of Rehabilitation reserves the right to remove a selected relative from the provision of services at any time if there is a reasonable suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports (PSS). If the state removes a selected relative from the provision of services, the IL Waiver beneficiary will be asked to select an alternate qualified provider.

h) The direct care worker must meet the following requirements:

1) Be at least eighteen (18) years of age;

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

3) Be able to follow verbal and written instructions;

4) Have no physical/mental impairment to prevent lifting, transferring, or providing any other assistance to IL Waiver beneficiary;

5) Be certified as meeting the training and competence requirement by the IL Waiver beneficiary and the Case Manager; and

6) Be able to communicate effectively and carry out directions.

i) MDRS must verify the competency for all DCWs as needed.

3. Specialized Medical Equipment and Supplies must be provided by entities who meet the following qualifications:

a) Have a permanent local address and phone number;

b) Have a State of Mississippi sales tax number;

c) Have Federal identification number or social security number;

d) Have liability insurance;

e) Must honor the manufacturer's guarantee or warranty as published;

f) Must provide repair capability for products; and

g) Must meet the following additional standards if providing custom in-house seating systems, powered mobility, three-wheel scooters, and high-tech systems:

1) Must provide documented proof of attendance of training with seating and positioning;

2) Maintain a current list of power chair manufacturers represented;

3) Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer;

4) Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above;

5) Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting;

6) Must have and present at purchase all necessary manuals and written warranties;

7) Must be able to provide instruction in proper use and care of equipment;

8) Must be capable of providing training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price; and

9) Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.

4. Transition Assistance services must be provided by a Registered Nurse and/or Case Manager.

5. Environmental Accessibility Adaptation services must be provided by entities who meet the following:

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; and

8) No accessibility barriers can be created by the modification and/or construction process;

Source: 42 C.F.R. 455, Subpart E; 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff. 09/01/2019.

Rule 2.4: Freedom of Choice

A. Beneficiaries 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. The freedom of choice requirement is monitored by the operating agency and Division of Medicaid. The case management team must assist the beneficiary by providing them with sufficient information and assistance to make a free and informed choice regarding services and supports, taking into account risks that may be involved for that beneficiary.

C. Beneficiaries must be:

1. Informed by the case manager 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, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Moved and revised from Miss. Admin. Code Part 208, Rule 2.5 eff. 09/01/2019. Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Independent Living (IL) Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. Providers must maintain compliance with all current waiver requirements, rules, regulations and administrative codes as specified by the Division of Medicaid.

   1. If an IL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the IL 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.

C. Waiver providers and/or contractors must report:

   1. Changes in contact information, administrative staffing, ownership, and licensure within ten (10) calendar days to the Mississippi Department of Rehabilitation Services (MDRS) and 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-four (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 to MDRS and within fourteen (14) days to the Division of Medicaid.

D. Quality Management Strategy for the waiver must be implemented in accordance with Appendix H of the CMS approved waiver application.

E. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 440.180 and 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.6 eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.6: Covered Services

A. The Division of Medicaid covers the following services through the Independent Living (IL) Waiver:

1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver services and other services, including but not limited to medical, social and educational services, regardless of the funding source for the services.
   a) Case Management services, as an administrative activity, must be provided by Mississippi Department of Rehabilitation Services (MDRS) case managers/registered nurses who meet minimum qualifications listed in the waiver and Miss. Admin. Code Part 208, Rule 2.3.

   b) Responsibilities include, but are not limited to, the following:

      1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care. Initial assessments must be conducted in person in conjunction with a registered nurse. Annual recertification assessments must be conducted in person by the case manager and a registered nurse must be available for consultation if necessary;

      2) Provide ongoing monitoring of the services included in the beneficiary's Plan of Services and Supports (PSS);

      3) Develop, review, and revise the PSS at intervals specified in the waiver;

      4) Conduct quarterly in person visits with the beneficiary;

      5) Complete monthly contacts with the beneficiary. Monthly contacts may be completed telephonically or virtually; however, in person visits for monthly contacts must be completed with beneficiaries if any of the following concerns are identified:

         (a) Beneficiary/representative is unable to communicate by phone or virtual electronic device due to an auditory, speech or cognitive impairment;

         (b) Beneficiary has unmet needs that cannot be resolved by phone or virtual electronic device;

         (c) Beneficiary has identified risks for abuse, neglect, or exploitation including the use of restraints or seclusion that require in person monitoring;

(d) Beneficiary/representative is unable to be reached by phone or virtual electronic device.

6) Document all contacts, progress, needs, and activities carried out on behalf of the beneficiary; and

7) Ensure 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, and bowel and bladder programs).

2. Personal care 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.

a) Personal care services must be provided in accordance with the approved PSS, cannot be purely diversional in nature, and may include:

1) Support for activities of daily living such as, but not limited to, bathing (sponge/ tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation;

2) Assistance with housekeeping that is directly related to the beneficiary's disability, and which is necessary for the health and well-being of the beneficiary such as, but not limited to, changing bed linens, straightening area used by the beneficiary, doing the personal laundry of the beneficiary, preparation of meals for the beneficiary, cleaning the beneficiary's equipment such as wheelchairs or walkers;

3) Food shopping, meal preparation, and assistance with eating; however, the cost of food, groceries, and meals is not reimbursed by the Division of Medicaid.

4) Support for community participation by accompanying and assisting the beneficiary as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities; however, the cost of any such activity is not reimbursed by the Division of Medicaid.

b) If the beneficiary/representative has not located or chosen a DCW within six months after admission to the waiver, or after being without a DCW for six (6) consecutive months, the beneficiary is reevaluated to determine if the waiver can meet the needs of the beneficiary.

3. Specialized Medical Equipment and Supplies include devices, controls, or appliances,

specified in the PSS, which enable beneficiaries to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

a) The need for use of such items must be documented in the assessment/case file, ordered by a physician, and approved on the PSS.

b) Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. The cost of items which do not have a direct medical or remedial benefit to the beneficiary is not reimbursed by the Division of Medicaid.

c) Specialized medical equipment and supplies must meet the applicable standards of manufacture, design, and installation.

d) Requests for specialized medical equipment and supplies must be evaluated by the Mississippi Department of Rehabilitation Services (MDRS) case manager 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 PSS and the request for specialized medical equipment and/or supplies for approval.

e) Medicaid waiver funds are utilized as the payor of last resort.

4. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the IL Waiver program.

a) Transition Assistance services include the following:

1) Security deposits required to obtain a lease on an apartment or home;

2) Essential furnishings required to occupy and use a community domicile. Television or 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 including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

b) 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 PSS.

c) To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

1) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid,

2) Have no other source to fund or obtain the necessary items/supports,

3) Be moving from a nursing facility where these items/services were provided, and

4) Be moving to a residence where these items/services are not normally furnished.

d) Transition Assistance must be completed by the day the beneficiary relocates from the institution.

e) Beneficiaries 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.

5. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's PSS, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

a) Environmental accessibility adaptations must be included in the approved PSS.

b) Environmental accessibility adaptations may include the following:

1) Installation of ramps and grab bars;

2) Widening of doorways;

3) Modification of bathroom facilities;

4) 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 beneficiary;

2) Adaptations which add to the square footage of the home;

d) 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 PSS and the request for environmental accessibility adaptation.

e) MDRS must certify and document that providers meet the criteria/standards in the waiver.

Source: 42 U.S.C. 1396n; 42 C.F.R. §§ 431.53, 440.170, 440.180 and 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff. 09/01/2019; Revised 01/01/2013.

Rule 2.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Independent Living (IL) Waiver program. To obtain approval, the Mississippi Department of Rehabilitation Services (MDRS) must complete and submit the 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;

5. Informed Choice Form;

6. Physician or Nurse Practitioner Certification of Medical Stability and Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM or MDRS; and

7. Other supportive documentation as needed including, but not limited to, prescriptions and assistive technology recommendations.

B. Any request to add or increase services listed on the approved PSS must be submitted to and receive prior approval from the Division of Medicaid and must include documentation substantiating the need for the requested change(s).

C. MDRS is responsible for implementation of the PSS. The Division of Medicaid and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall

oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

Source: 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; Revised 01/01/2013.

Rule 2.8: Documentation/Record Maintenance

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the Independent Living (IL) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3.]

B. All staff records should include, at a minimum, the following required credentialing and qualification documents:

1. Copy of valid, state issued ID;
2. Job descriptions or DCW Certification;
3. Application and date of hire;
4. High School Diploma, General Educational Development (GED) diploma, other educational degrees, or proof of ability to read and write accurately;
5. Any licensure and/or certifications as required for job description;
6. Results of fingerprint-based National Criminal Background check(s);
7. Results of monthly Nurse Aide Abuse Registry checks;
8. Results of monthly Office of Inspector General (OIG) checks;
9. Attestation of health at hire;
10. Signed confidentiality agreement that includes social media waiver; and
11. Proof of training/evaluations required professional certifications, and credentials including CPR and First Aid.

C. Records for beneficiaries receiving personal care services should include, at minimum:

1. Referral form/authorization;

2. Approved Plan of Services and Supports (PSS);

3. Service Notes documenting monthly and quarterly case management oversight of the DCW which includes the causes of any significant variation in the recommended schedule of services provision; and

4. Daily activity or Service Notes capturing tasks completed and the beneficiary/representative's signature verifying the provision of services, if task and global positioning system (GPS) information is not captured electronically in the state approved electronic visit verification system.

D. Activity or time sheets, if needed, must include:

1. Arrival/service time and date;

2. Departure/service time and date;

3. Activities/tasks performed; and

4. The signature of the beneficiary or their legal representative verifying the provision of services.

Source: 42 C.F.R. §§ 440.180, 441.303; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.9: [Reserved]

Rule 2.10: Reimbursement

A. Claims must be based on services that have been rendered to waiver beneficiaries as authorized by the Plan of Services and Supports (PSS), accurately billed by qualified waiver providers, and in accordance with the approved waiver.

B. The Division of Medicaid conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. The Division of Medicaid denies payment for services when a waiver beneficiary or applicant is not Medicaid eligible on the date of service.

D. The Division of Medicaid conducts post utilization reviews to ensure the services provided were on the beneficiary's approved PSS.

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 five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

G. All providers of personal care services must utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system for the submission of claims unless an exception is approved, in writing, by the Division of Medicaid. Requirements for the use of the EVV system are outlined in Miss. Admin. Code Part 200.

Source: 42 CFR §§ 440.180, 441.30; Miss Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised 09/01/2019; Revised 01/01/2013.

Rule 2.11: Due Process Protection

A. The Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating a dispute resolution process separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

1. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect waiver services.

2. MDRS must inform the beneficiary/representative at the initial assessment of the specific criteria for the dispute, complaint/grievance and hearing processes.

3. MDRS must inform the beneficiary/representative of their rights which address disputes, complaints/ grievances and hearings.

4. A beneficiary participating in the IL waiver or their representative may engage the dispute resolution process by notifying MDRS or DOM of their concern either by phone or in writing.

5. The Division of Medicaid has the final authority over any dispute.

B. The Division of Medicaid provides an opportunity to request a Fair Hearing to beneficiaries:

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.

C. Notice of Action (NOA) requirements:

1. MDRS must provide the beneficiary with a Notice of Action (NOA) via certified mail as required in C.F. R. §431.210.

2. The NOA must include:

a) A description of the action the provider has taken or intends to take;

b) An explanation for the action;

c) Notification that the beneficiary/representative has the right to file an appeal;

d) Procedures for filing an appeal;

e) Notification of beneficiary/representative's right to request a Fair Hearing;

f) Notice that the beneficiary/representative has the right to have benefits continued pending the resolution of the appeal; and

g) The specific regulations or the change in federal or state law that supports or requires the action.

D. A person applying for or participating in the IL waiver has any additional rights to an appeal and/or hearing which are provided for in Title 23, Mississippi Administrative Code, Part 300.

Source: 42 C.F.R. §§ 431.210, 440.180, 441.301, 441.308; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 09/01/2019.

Rule 2.12: Hearings and Appeals

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

Source: 42 C.F.R. Part 431, Subpart E; Miss Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and Revised from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019; Revised 01/01/2013

Rule 2.13: Person Centered Planning (PCP)

A. Person Centered Planning (PCP) as an ongoing process used to identify a beneficiary'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 beneficiary to lead the process where possible with the beneficiary'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 beneficiary;

3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary;

5. Reflect cultural considerations of the beneficiary 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 beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, 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 beneficiaries must be provided with a clear and accessible alternative dispute resolution process which ensures the beneficiary's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

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

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

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

    a) Chosen by the beneficiary and/or their representative;

    b) Integrated in, and supports full access of; beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries with disabilities and who are limited English proficient so as to be understandable to the beneficiary receiving services and supports, and the individuals important in supporting the beneficiary;

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

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

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

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

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

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 content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least twelve (12) months have lapsed since the provider's last review

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

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

Source: 42 C.F.R. § 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; New rule moved from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019; New rule eff. 01/01/2017.

Rule 2.14: Monitoring Safeguards

A. Mississippi Department of Rehabilitation Services (MDRS) case managers are required to provide each waiver person with written information regarding their rights as a waiver person at 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 IL 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 suspected, 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: Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; New Rule moved from Miss. Admin. Code Part 208, Rule 2.8, eff. 09/01/2019.

Rule 2.15: Grievances and Complaints

A. The Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format, or email. The Division of Medicaid has the final authority over any complaint or grievance.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. MDRS case managers are required to provide the toll-free number at initial assessment and annually at recertification.

D. The Department of Rehabilitation Services must cooperate with the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved IL Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

Source: Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: New Rule to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

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 institutionalization in a nursing facility through the Assisted Living (AL) Waiver.

B. Beneficiaries enrolled in the AL Waiver must reside in a licensed assisted living facility which is fully integrated with opportunities for full access to the greater community and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

C. The Division of Medicaid does not cover AL Waiver services to persons in 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. Beneficiaries enrolled in the AL Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries 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.

F. 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.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.2: Eligibility

A. In order to qualify as a beneficiary of the Assisted Living Waiver, individuals must meet the following criteria:

1. Must be twenty-one (21) years of age or older,

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

3. 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. Beneficiaries enrolled in the AL Waiver cannot reside in a nursing facility or unlicensed personal care home.

C. In the event of imminent danger to the beneficiary, facility residents, or service providers, the beneficiary may be discharged from the waiver immediately.

D. To be eligible for care in a Traumatic Brain Injury Residential facility a beneficiary 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 beneficiary at high risk for institutionalization.

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 to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. 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

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

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

Enumeration System (NPPES),

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

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

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

5. A copy of business registration with the Mississippi Secretary of State.

B. To participate as a Home and Community-Based Services (HCBS) Assisted Living (AL) Waiver provider, the provider must, unless exempted in writing by the Division of Medicaid, at the time of application and at all times thereafter:

1. Attend mandatory orientation, score at least eight-five (85) on the orientation exam and submit a completed proposal package to the Office of Long-Term Care for approval by the Division of Medicaid.

2. Once a provider is enrolled, submit any proposed changes to location, supervisory staffing, or organizational contact information, to the Division of Medicaid for approval prior to implementing the requested change.

3. Be established as a business entity and provide the specified service(s) for a minimum of one (1) year prior to application.

4. Be approved for enrollment by Provider Enrollment and enter into a provider agreement with the Division of Medicaid within six (6) months of receiving an approved proposal package letter from the Office of Long-Term Care.

5. Have an advisory committee, representative of the community and beneficiary population, that meets quarterly to assure responsibility and accountability for performance and quality improvement. The advisory committee must maintain an agenda and minutes for each meeting and must provide public notice of the date, time, and location of each meeting at least twenty-four (24) hours in advance of the meeting.

6. Provide proof of financial solvency by:

a) Establishing and maintaining a business line of credit for business operations from either a financial institution licensed to conduct banking or other Financial Deposit Insurance Corporation (FDIC) or National Credit Union Administration (NCUA) insured financial institutions. 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.

b) Providing a copy of the provider's most current filed tax return for the business along with confirmation verifying it was filed. Examples of acceptable forms of confirmation include the following:

   1) 8879 form from a tax preparer, or

   2) 9325 form from the IRS with the submission identification (SID) number.

c) Providing a copy of the provider's itemized expense report reflecting all income and expenditures for each month for the past twelve (12) months.

7. Establish an office within the facility. The facility office must:

   a) Have appropriate external signage with printed lettering that is visible and readable from the road,

   b) Be compliant with applicable federal, state and local building requirements as well as all zoning, fire, OSHA, health codes and ordinances. It must also meet the requirements of the Americans with Disabilities Act (ADA),

   c) Maintain an active business privilege tax license,

   d) Ensure that beneficiaries and/or family/caregivers have access to a designated private space where they can have confidential discussions with staff and have a reasonable expectation of privacy,

   e) Have lockable file storage for the security and maintenance of all files in compliance with HIPAA standards,

   f) Maintain regular office hours of Monday through Friday, 8am – 5pm, with the exception of any federal or state holidays, and

   g) Have a dedicated office telephone and a means to transmit secure electronic data, i.e., secure email/facsimile, that meets HIPAA standards.

8. Successfully pass a facility inspection by the Division of Medicaid depending on the provider type, as specified in Rule 3.3(c) below.

9. Prior to employment and every two (2) years thereafter, conduct a national criminal background check with fingerprints on all employees and volunteers participating in face-to-face interactions with beneficiaries. Maintain these records in the employee's personnel file.

10. Conduct registry checks before employment and monthly thereafter to ensure that

employees or volunteers participating in face-to-face interactions with beneficiaries are not listed on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's Exclusion Database and maintain these records in the employee's personnel file. The provider must not employ individuals whose name appears on the registry list.

11. Not have employed or currently employ individuals or volunteers participating in face-to-face interactions with beneficiaries who have been, convicted of, or have 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(h), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, felonious abuse and/or battery of a vulnerable adult, regardless of whether any such conviction or plea which was reversed on appeal or for the conviction or plea.

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

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

14. Maintain policy and procedure manuals compliant with all state and federal laws and regulations, including Division of Medicaid's regulations.

15. Maintain and ensure responsible personnel management which includes:

    a) Implementing an appropriate policy and process for the recruitment, selection, retention, and termination of employees.

    b) Developing written personnel policies and job descriptions that include educational requirements, work experience, job duties and responsibilities.

    c) Maintaining a current training plan as a component of the policies/procedures that document 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) Maintaining a personnel file on every employee and volunteer with required information including, but not limited to, credentialing documentation, training records, and performance reviews. These files must be made available to the Division of Medicaid upon request.

    e) Maintaining an organizational chart that includes the names and job titles of owners, operators, managers, administrators, and other supervisory staff. Any changes in organizational structure including ownership must be reported in writing to the Division of Medicaid within ten (10) business days.

    f) Maintaining an accurate, historical employee listing that captures names, staff

identification numbers, tax identification numbers, employment hire dates and employment termination dates.

16. Maintain a roster of qualified personnel necessary to provide authorized services until employment termination. The roster must include the address of the designated workspace for all supervisory staff.

17. Comply with all applicable federal and state regulations including, but not limited to, tax and labor laws.

18. Ensure all protected health information (PHI) and personal identifiable information (PII) is stored and transported in a manner consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

19. At the time of enrollment, not be owned or operated by any individual or organization currently under investigation based on a credible allegation of fraud or abuse by the Division of Medicaid Office of Program Integrity, the Medicaid Fraud Control Unit or any other government entity, or that has been found in violation of the Miss. Admin. Code or the Medicaid Provider Agreement within the eighteen (18) months leading up to their enrollment.

20. In the event a change of ownership occurs, and complies with all requirements of Miss. Admin Code, Part 200, Rule 4.3, submit to the Division of Medicaid a proposal packet for review and approval within thirty-five (35) days of the change. The effective date of enrollment is retroactive to the date of the licensure, if licensure applies.

C. AL providers must satisfy the following training requirements, as applicable, to render services:

1. Assisted Living service providers must provide all staff, excluding any RN, LPN, or CNA who maintains an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, with training upon hire prior to rendering services and annually thereafter in the following areas:

   a) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

   b) Person Centered Thinking including Participant Rights and Dignity,

   c) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

   d) Crisis Prevention/Intervention and Emergency Preparedness,

   e) Caring for Participants with Cognitive or Behavioral Conditions,

f) Signs and Symptoms of Illness including Seizures,

g) HIPAA Compliance and Confidentiality,

h) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices,

i) Professional Documentation Practices,

j) Universal Precautions & Infection Control,

k) Medication Assistance, and

l) Medicaid Administrative Code and the Assisted Living Waiver

2. TBI Residential Waiver providers must provide training to all staff which consists of all topics listed in the Miss. Admin. Code, Part 208, Rule 3.3(C)(1) as well as the following areas:

a) Stress Reduction,

b) Behavior Programs, and

c) Rational/Behavioral Therapy.

3. All staff must pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

4. All staff must maintain current and active first aid and cardiopulmonary resuscitation (CPR) certification.

5. Each TBI residential provider must have a program manager who is nationally certified as a Brain Injury Specialist.

E. AL Waiver providers must provide a licensed nurse at the facility for a minimum of eight (8) hours a day to assist the beneficiaries with medication administration or oversight. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facility must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate the Nursing Practice Law or Administrative Code in any manner.

F. If the facility utilizes volunteers, they:

1. Must be individuals or groups who desire to work with Assisted Living waiver beneficiaries.

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 can only be allowed on a periodic/temporary basis.

6. Must record their hours and activities.

G. The Division of Medicaid may terminate or suspend a provider immediately for failure to comply with the requirements of the AL waiver program. The Division of Medicaid may also require providers to submit and implement a corrective action plan (CAP) in a timely manner. Failure to submit or comply with a CAP, approved by the Division of Medicaid, may result in a suspension or termination.

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

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; 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. Beneficiaries enrolled in a Medicaid Waiver have the right to freedom of choice of approved Medicaid providers for services. [Refer to Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.]

B. Freedom of Choice is required of all providers and is monitored by the Division of Medicaid. The Division of Medicaid case manager must assist the beneficiary by providing them with sufficient information and assistance to make free and informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed by the case manager 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 and 441.302; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 01/01/2017.

Rule 3.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Assisted Living (AL) Waiver approved by the Centers for Medicare and Medicaid Services (CMS).The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. 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.

C. Waiver providers must report:

1. Changes in contact information, administrative staffing, ownership, 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-four (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.

D. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

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

History: Revised and renamed to correspond with the AL Waiver Renewal (eff. 07/01/2023), eff. 08/01/2026. 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 3.6: Covered Services

A. The Division of Medicaid covers the following services through the Assisted Living Waiver:

1. Case Management services include the identification of resources as well as the

coordination and monitoring of resources and services by case managers to ensure the health, social needs, preferences and goals of beneficiaries are met throughout the person-centered planning process and service provision. The Division of Medicaid case manager is responsible for implementation of the PSS. The Division of Medicaid is responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

a) Case Management services are 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. Case managers will conduct the following activities.

1) Conduct face-to-face visits using comprehensive long-term services and supports (LTSS) assessment instrument at the time of admission and recertification.

2) Complete face-to-face visits with a beneficiary at the facility on a quarterly basis to review the Plan of Services and Supports.

3) Complete monthly contacts with the participant. Monthly contacts may be completed telephonically or virtually; however, in person visits for monthly contacts must be completed with beneficiaries if any of the following concerns are identified:

(a) Beneficiary/representative is unable to communicate by phone due to an auditory, speech or cognitive impairment.

(b) Beneficiary has unmet needs that cannot be resolved by phone;

(c) Beneficiary has identified risks for Abuse, Neglect, or Exploitation including the use of restraints or seclusion that require in person monitoring.

(d) Beneficiary/representative is unable to be reached by phone.

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 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 physician.

7. Medication Assistance is defined as any form of delivering medication which has been prescribed, but is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing. Medication assistance is monitored by the licensed nurse and all facility staff are required to receive training upon hire prior to rendering services.

8. Transportation services may be provided through the Division of Medicaid's Non-Emergency Transportation (NET) program if the waiver person has not reached the maximum NET service limits. The AL Waiver provider must provide transportation to all waiver beneficiaries who have reached the maximum NET service limits or who choose not to use the NET program.

9. An electronic emergency attendant call system in each Personal Care Home-Assisted Living (PCH-AL) facility which:

    a) Is available to waiver beneficiaries 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.

10. 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 beneficiaries 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 beneficiary, and the beneficiary 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 beneficiary, 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 beneficiary 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 beneficiary. The

beneficiary choosing cohabitation per room removes the reasonable expectation of privacy.

3. A setting which integrates and facilitates the beneficiary'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 beneficiary from among all available alternatives and is identified in the person-centered Plan of Services and Supports (PSS),

5. Protection of a beneficiary'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 beneficiary with cognitive impairment supported by a specific assessed need and addressed in the PSS,

9. Freedom and support of beneficiary 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 beneficiary 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. Send and receive mail or packages 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, unless doing so infringes upon the rights or health and safety of other residents,

    g. Voice grievances and recommend changes in licensed facility policies and services

without the fear of discrimination or reprisal,

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 his or her own sleep schedule,

l. Furnish and decorate their sleeping or living space within the lease or other agreement,

m. Allows the person to eat at non-traditional times or outside regular scheduled mealtime consistent with the beneficiary's plan of care,

n. Have snacks that adhere to the federal government's Dietary Guidelines for Americans available at all times, and

o. Use the dining room for congregate meals and socialization at the person's choosing.

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

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. 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: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Assisted Living (AL) Waiver program. To obtain approval, the waiver case manager must complete and submit the 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,

5. Informed Choice, and

6. Physician or Nurse Practitioner Certification of Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM.

B. All requests for increases and decreases in services must be submitted to the Division of Medicaid and must include documentation to substantiate the need for the change. Any request to add or increase services listed on the approved PSS must receive prior approval.

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

History: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; 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 3.8: Documentation/Record Maintenance Requirements

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the Assisted Living (AL) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3]

B. All staff records should include, at minimum, the following required credentialling and qualification documents:

1. Copy of valid, state issued ID,

2. Job descriptions,

3. Application and date of hire,

4. High school diploma, General Educational Development (GED) diploma, other educational degrees, or proof of ability to read and write accurately,

5. Any licensure and/or certifications as required by the Division of Medicaid for job description,

6. Results of fingerprint-based National Criminal Background check(s),

7. Results of monthly Nurse Aide Abuse Registry checks,

8. Results of monthly Office of Inspector General (OIG) checks,

9. Annual attestation of health,

10. Signed confidentiality agreement that includes social media waiver, and

11. Proof of training/evaluations, required professional certifications, and credentials including cardiopulmonary resuscitation (CPR) and First Aid.

C. Records for beneficiaries receiving AL Waiver services should include, at minimum:

1. Approved Plan of Services and Supports (PSS),

2. Daily activity logs documenting the services rendered and billed under the program, including when a beneficiary is out of the facility and the reason why,

3. Current photograph,

4. Medical history or medical exam completed within six (6) months of admission, and

5. Annual nutritional assessment and,

6. Daily progress notes.

D. Assisted Living facility records should include, at minimum:

1. Documentation of monthly maintenance and janitorial services including repairs, maintenance, and pest control,

2. Documentation of quarterly drills for fire and inclement weather,

3. Annual fire safety inspection reports conducted by the fire department,

4. Records of quarterly advisory committee meetings,

5. Written criteria for service provision, including procedures for dealing with emergency service requests,

6. Policy and procedure manuals,

7. Written personnel policies including the process used in the recruitment, selection, training, retention, and termination of employees,

8. Organizational chart including the names and job titles of owners, operators, managers, administrators, etc.,

9. Current and historical employee listing that captures names, staff/tax id numbers, employment hire and termination dates, and

10. Service record of licensed nurse which includes dates in the facility, arrival and departure times, services performed, signature of administrator or program director.

11. 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.

12. Records of medication administration and medication allergies of waiver beneficiaries.

13. A current, signed, and dated copy of the Division of Medicaid-approved admission agreement for each waiver beneficiary which includes, at a minimum:

    a) Basic charges agreed upon separating costs for room and board and personal care services,

    b) Period to be covered,

    c) List of itemized charges, and

    d) Agreement regarding refunds for payments.

E. AL Waiver providers are required to submit, within three (3) business days of the occurrence, the disposition form to the respective case manager anytime a person leaves the facility for a period of twenty-four (24) hours or longer. The disposition form should be submitted when the beneficiary leaves another one indicating their return if applicable.

Source: 42 CFR § 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 AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; 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: [Reserved]

Rule 3.10: Reimbursement

A. Claims must be based on services that have been rendered to beneficiaries as authorized by the Plan of Services and Supports (PSS), accurately billed by qualified waiver providers, and in accordance with the approved waiver.

B. The Division of Medicaid conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. The Division of Medicaid denies payment for services when a beneficiary or applicant is not Medicaid eligible on the date of service.

D. The Division of Medicaid conducts post utilization reviews to ensure the services provided were on the beneficiary's approved PSS.

E. Records documenting the provision of services must be maintained by the providers of

waiver services for a minimum of five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

G. Providers must bill for Assisted Living (AL) Waiver services no sooner than the first (1st) day of the month following the month in which services were rendered.

H. Transportation is an integral part of AL Waiver provider services and is not reimbursed separately.

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

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.11: Due Process Protection

A. The Division of Medicaid is responsible for operating the dispute mechanism for waiver beneficiaries separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

1. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect waiver services.

2. At the initial assessment, the case manager must inform the beneficiary/representative of the specific criteria for the dispute, complaint/grievance, and hearing processes.

B. The Division of Medicaid provides an opportunity to request a Fair Hearing to beneficiaries:

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.

C. Notice of Action (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 beneficiary/representative has the right to file an appeal,

4. Procedures for filing an appeal,

5. Notification of beneficiary/representative's right to request a Fair Hearing,

6. Notice the beneficiary/representative 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 support or require the action.

Source: 42 C.F.R. §§ 431.210, 440.180, 441.301, 441.308; 42 CFR; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.12: Hearings and Appeals

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

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

History: Revised and renamed to correspond with AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.13: Person Centered Planning (PCP)

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

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

   2. Include people chosen by the beneficiary.

   3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary.

5. Reflect cultural considerations of the beneficiary 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 Plan of Services and Supports (PSS) by a provider who does not provide home and community-based services (HCBS) for the beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS for the beneficiary. 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 beneficiary regarding the services and supports they receive and from whom.

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

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

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

   a) Chosen by the beneficiary,

   b) Integrated in, and supports full access of beneficiaries 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 beneficiary'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 beneficiary 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 beneficiaries with disabilities and who are limited in English proficiency so as to be understandable to the beneficiary receiving services and supports, and the individuals important in supporting the beneficiary.

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

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

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

11. Include those services, the purpose or control of which the beneficiary 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 the following content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least twelve (12) months have lapsed since the provider's last review,

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

Source: 42 C.F.R. § 441.301.

History: Revised and renamed to correspond with AL Waiver (eff. 7/01/2023) eff. 08/01/2026. New rule eff. 01/01/2017.

Rule 3.14: 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 person's 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 Assisted Living (AL) providers and their employees must immediately report orally or telephonically, within twenty-four (24) hours of discovery excluding Saturdays, Sundays and legal holidays, and in writing within seventy-two (72) hours of discovery, to the State Department of Health, the Medicaid Fraud Control Unit of the Attorney General's office, the Division of Medicaid Office of Long Term Care, and any other entity required by federal or state law any suspected, alleged or reported instances of 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: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.15: Grievances and Complaints

A. The Division of Medicaid is responsible for investigating and documenting all grievances/complaints regarding all Assisted Living Waiver programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format or email.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. All providers are required to post the toll-free number in a prominent place throughout each facility.

D. Providers of waiver services must cooperate with the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved Assisted Living Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

Source: Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised and renamed to correspond with AL Waiver (eff. 7/01/2023) eff. 08/01/2026.

Rule 3.16: Disaster Preparedness

A. Assisted Living (AL) Waiver providers must have disaster preparedness and management procedures to ensure that waiver beneficiary'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 beneficiary 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; Miss. Code Ann. § 43-13-121.

History: New rule, renamed and revised to correspond with AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

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

Rule 4.1: General

The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver.

B. Beneficiaries enrolled in the TBI/SCI Waiver must reside in a private residence which is fully integrated with opportunities for full access to the greater community and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

C. 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).

D. Beneficiaries enrolled in the TBI/SCI Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries 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. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

F. 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).

G. 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 as outlined in an interagency agreement.

H. The average cost for a waiver applicant/beneficiary must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicare and Medicaid Services (CMS) for the current waiver year. The Division of Medicaid may refuse entrance to the waiver to any otherwise eligible individual when the Division of Medicaid reasonably expects that the cost of the home 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. § 43-13-121.

History: Revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 01/01/2017.

Rule 4.2: Eligibility

A. In order to qualify as a beneficiary of the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver Program, individuals must meet the following criteria:

1. Persons must be diagnosed with one (1) of the following disease(s) or condition(s):

   a) 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.

   b) 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.

2. The extent of injury must be certified by the physician.

3. 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.

4. Must require nursing facility level of care as determined by a comprehensive long-term service and supports (LTSS) assessment.

5. Must be certified as medically stable by a physician or nurse practitioner. The Division of Medicaid defines medically stable 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.

   c) Intracranial pressure or arterial monitoring.

6. Must meet the criteria in one (1) of the following Categories of Eligibility (COE):

   a) Supplemental Security Income (SSI),

   b) Parents and Other Caretaker Relatives Program,

   c) Katie Beckett,

   d) Children under age nineteen (19) who meet the applicable income requirements,

e) Disabled Adult Child,

f) Protected Foster Care Adolescents,

g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

h) IV-E Foster Children and Adoption Assistance Children, or

i) 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

j) Working Disabled

B. Beneficiaries enrolled in the TBI/SCI Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home.

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

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 to correspond with the TBI/SCI Waiver Renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 4.2.F. eff. 06/01/2016.

Rule 4.3: Provider Enrollment

A. The Mississippi Department of Rehabilitation Services (MDRS), as the provider of Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver services, must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Rule 4.8 in addition to the listed provider-type specific requirements and provide to the Division of Medicaid.

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

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

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

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

B. To participate as a Home and Community-Based Services (HCBS) TBI/SCI Waiver provider, MDRS must:

1. Conduct a national criminal background check with fingerprints on case managers, nurses, and direct care workers (DCW) personal care or transition services prior to employment and every two (2) years thereafter, and maintain the record in the employee's personnel file;

2. Conduct registry checks, prior to employment and monthly thereafter, to ensure individuals providing case management, personal care services, or transition services are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's (OIG) Exclusion Database and maintain the record in the employee's personal file. The provider must not employ individuals whose name appears on registry or database;

3. Not have been, or employed or currently employ individuals or volunteers who have been, convicted of, pleaded guilty to, or pleased nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense defined in Miss. Code Ann. § 45-33-239(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or any other crime of violence. Any such conviction or plea which was reversed on appeal or for which a pardon was granted shall not be considered;

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

5. Be compliant with all federal and state regulations; and

6. Have responsible personnel management including:

a) Appropriate processes used in the recruitment, selection, retention, and termination of employees,

b) Maintain written personnel policies and job descriptions,

c) Maintain 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, and

d) Maintain a current 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.

C. MDRS must ensure that all employees and contracted entities meet the service specific requirements below prior to the provision of services:

1. Case Management must be provided by Registered Nurses (RN) and Case Managers who must meet the following qualifications:

a) The Registered Nurse must:

1) Have a current and active unencumbered RN license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license, and

2) Have at least one (1) year of experience with the aged and/or individuals with disabilities.

b) The Case Manager must:

1) Possess at a minimum a bachelor's degree in Rehabilitation Counseling or other related field, and

2) Have one (1) year of experience working with aged and/or individuals with disabilities.

c) Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Case Manager.

d) MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken against any nurse providing services under the TBI/SCI waiver.

e) MDRS must verify provider qualifications upon hire and at least annually and maintain documentation of that verification in the employee file.

2. Personal Care Services (PCS) must be provided by a Direct Care Worker (DCW) who must meet the following qualifications:

a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCW.

b) Must meet basic competencies that include both educational and functional requirements.

c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements.

d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with the Personal Care Services program.

1) The educational program must be personalized with participation of the beneficiary to ensure his/her specific needs are met.

2) The cost of training/instruction time for personal care attendants cannot be reimbursed by the Division under the waiver.

3) The individual must demonstrate competency to perform each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering any Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver service.

4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary /representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

(a) DCW training must be conducted by the Case Manager, or an agency permitted by law to train nurse aides, must be tailored to the personal care required for the beneficiary, and must include:

(1) The purpose and philosophy of self-directed services by the disabled,

(2) Disability awareness,

(3) Employee-employer relationships,

(4) The need for respect for the beneficiary's privacy and property,

(5) Basic elements of body functions,

(6) Infection control procedures,

(7) Maintaining a clean and safe environment,

(8) 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, and

(9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW 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 is deemed to meet the training requirements. Competency certification for these personal care providers by the beneficiary/representative and Case Manager is required. A DCW that has satisfactorily provided personal care services for four (4) weeks prior to coverage under the TBI/SCI waiver program, with such service certified by and verified by the beneficiary/representative and Case Manager, is deemed to meet the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney or those designated as the beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the Division under the waiver when the following criteria are met:

1) There is documentation that there are no other willing/qualified providers available for selection.

2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the TBI/SCI Waiver.

3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative.

4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The Division of Medicaid reserves the right to remove a selected relative from the provision of services at any time if there is a reasonable suspicion, or substantiation,

of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

h) The direct care worker must meet the following requirements:

1) Be at least eighteen (18) years of age,

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

3) Be able to follow verbal and written instructions,

4) Have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to beneficiary,

5) Be certified as meeting the training and competence requirement by the beneficiary and the Case Manager, and

6) Be able to communicate effectively and carry out directions.

i) MDRS must verify the competency for all PCAs as needed.

3. In-home respite (IHR) services must be provided by a DCW who must meet the following qualifications:

a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCWs.

b) Must meet basic competencies that include both educational and functional requirements.

c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements.

d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with the In-Home Respite Services program.

1) The educational program must be personalized with participation of the

beneficiary to ensure his/her specific needs are met.

2) The cost of training/instruction of direct care workers cannot be reimbursed under the waiver.

3) The individual must demonstrate competency to perform each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering any TBI/SCI waiver service.

4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary/representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

   (a) DCW training must be conducted by the beneficiary/representative and the Case Manager, or an agency permitted by law to train nurse aides, and must include:

      (1) The purpose and philosophy of self-directed services by the disabled,

      (2) Disability awareness,

      (3) Employee-employer relationships,

      (4) The need for respect for the beneficiary's privacy and property

      (5) Basic elements of body functions,

      (6) Infection control procedures,

      (7) Maintaining a clean and safe environment,

      (8) 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.

      (9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW 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 is deemed to meet the classroom training requirements. Competency certification for these personal care providers by the person/representative and Case Manager is required. A DCW that has satisfactorily provided In Home Respite services for four (4) weeks prior to coverage under the TBI/SCI waiver program, with such service certified by and verified by the person/representative and Case Manager, is deemed to meet the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney or those designated as the beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the Division under the waiver when the following criteria are met:

    1) There is documentation that there are no other willing/qualified providers available for selection.

    2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the TBI/SCI Waiver.

    3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative.

    4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

    5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The state reserves the right to remove a selected relative from the provision of services at any time if there is suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

h) Minimum requirements include:

    1) Be at least eighteen (18) years of age,

    2) Be a high school graduate, have a GED certificate, or must demonstrate the ability

to read the written in-home respite services assignment and write adequately to complete forms and reports of visits,

3) Be able to follow verbal and written instructions,

4) Have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to beneficiary,

5) Be certified as meeting the training and competence requirement by the beneficiary and the Case Manager, and

6) Be able to communicate effectively and carry out directions,

7) Must be a registered nurse or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations, if providing in-home nursing respite, and

i) MDRS must verify the competency for all DCWs as needed.

4. Institutional Respite must be provided in a Medicaid certified hospital, nursing facility or licensed swing bed facility.

5. Specialized Medical Equipment and Supplies must be provided by entities who meet the following qualifications:

a) Have a permanent local address and phone number,

b) Have a State of Mississippi sales tax number,

c) Have Federal identification number or social security number,

d) Have liability insurance,

e) Must honor the manufacturer's guarantee or warranty as published,

f) Must provide repair capability for products, and

g) Meet the following additional standards if providing custom in-house seating systems, powered mobility, three-wheel scooters, and high-tech systems:

1) Must provide documented proof of attendance of training with seating and positioning,

2) Maintain a current list of power chair manufacturers represented,

3) Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer,

4) Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above,

5) Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting,

6) Must have and present at purchase all necessary manuals and written warranties,

7) Must be able to provide instruction in proper use and care of equipment,

8) Must be capable of providing training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price, and

9) Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.

6. Transition Assistance services must be provided by a Registered Nurse and/or Case Manager.

7. Environmental Accessibility Adaptation services must be provided by entities who meet the following:

   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.

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

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.4: Freedom of Choice

A. Beneficiaries 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. The freedom of choice is required of all providers and is monitored by the operating agency and Division of Medicaid. The case manager must assist the beneficiary by providing 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 beneficiary.

C. Beneficiaries must be:

1. Informed by the case manager 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 including non-disability specific setting options.

Source: 42 C.F.R. §§ 431.51 and 441.302; Miss. Code Ann. § 43-13-121; §43-13-117; §1915(c) of the Social Security Act.

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.5: Quality Management

A. Waiver providers must meet applicable service specifications as referenced in the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. Providers must maintain compliance with all current waiver requirements, rules, and regulations, and administrative codes as specified by the Division of Medicaid.

    1. If a TBI/SCI Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the TBI/SCI 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.

C. Waiver providers and/or contractors must report:

    1. Changes in contact information, administrative staffing, ownership, and licensure within ten (10) calendar days to the Mississippi Department of Rehabilitation Services (MDRS) and 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-four (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 to MDRS and within fourteen (14) days to the Division of Medicaid.

D. Quality Management Strategy for the waiver must be implemented in accordance with Appendix H of the CMS approved waiver application.

E. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Renamed and revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.6: Covered Services

A. The Division of Medicaid covers the following through the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver services:

1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver services, as well as needed medical, social, educational, and educational services, regardless of the funding source for the services.

a) Case Management services, as an administrative activity, must be provided by Mississippi Department of Rehabilitation Services (MDRS) case managers/registered nurses who meet minimum qualifications listed in the waiver and Miss. Admin. Code Part 208, Rule 4.3.

b) Responsibilities include, but are not limited to, the following:

1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care. Initial and readmission assessments must be conducted in person in conjunction with a registered nurse. Annual recertification assessments must be conducted in person by the case manager, and a registered nurse must be available for consultation if necessary.

2) Provide ongoing monitoring of the services included in the beneficiary's Plan of Services and Supports (PSS).

3) Develop, review, and revise the PSS at intervals specified in the waiver.

4) Conduct quarterly in person visits with the person.

5) Complete monthly contacts with the beneficiary. Monthly contacts may be completed telephonically or virtually; however, in person visits for monthly contacts must be completed with beneficiaries if any of the following concerns are identified:

(a) Beneficiary/representative is unable to communicate by phone or virtual electronic device due to an auditory, speech or cognitive impairment

(b) Beneficiary has unmet needs that cannot be resolved by phone or virtual electronic device.

(c) Beneficiary has identified risks for Abuse, Neglect, or Exploitation including the use of restraints or seclusion that require in person monitoring.

(d) Beneficiary/representative is unable to be reached by phone or virtual electronic device.

6) Document all contacts, progress, needs, and activities carried out on behalf of the beneficiary.

7) Ensure 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).

2. Personal Care Services (PCS) are non-medical, hands-on care of both a supportive and health-related nature. PCS 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.

a) PCS services must be provided in accordance with the approved PSS, cannot be purely diversional in nature, and may include:

1) Support for activities of daily living such as, but not limited to, bathing (sponge/ tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.

2) Assistance with housekeeping that is directly related to the beneficiary's disability, and which is necessary for the health and well-being of the beneficiary such as, but not limited to, changing bed linens, straightening area used by the beneficiary, doing the personal laundry of the beneficiary, preparation of meals for the beneficiary, cleaning the beneficiary's equipment such as wheelchairs or walkers.

3) Food shopping, meal preparation and assistance with eating; however, the cost of food, groceries, and meals is not reimbursed by the Division.

4) Support for community participation by accompanying and assisting the beneficiary as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities; however, the cost of any such activity is not reimbursed by the Division.

b) If the beneficiary/representative has not located or chosen a DCW within six (6) months after admission to the waiver, or after being without a DCW for six (6) consecutive months, the beneficiary is reevaluated to determine if the waiver can meet the needs of the beneficiary.

3. Respite services are defined as services to assist beneficiaries unable to care for themselves and are necessary 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 beneficiary'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 include devices, controls, or appliances specified in the PSS, enable beneficiaries to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

a) The need for/use of such items must be documented in the assessment/case file, ordered by a physician and approved on the PSS.

b) Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under the Medicaid State Plan. Items not of direct medical or remedial benefit to the person are not covered under the waiver and cannot be reimbursed by the Division.

c) Specialized medical equipment and supplies must meet the applicable standards of manufacture, design, and installation.

d) Requests for specialized medical equipment and supplies must be evaluated by the Mississippi Department of Rehabilitation Services (MDRS) case manager 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 PSS and the request for specialized medical equipment and/or supplies for approval.

e) Medicaid waiver funds are utilized as the payor of last resort.

5. Transition Assistance services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the TBI/SCI Waiver program.

a) Transition Assistance services include the following:

1) Security deposits required to obtain a lease on an apartment or home.

2) Essential furnishings required to occupy and use a community domicile. Televisions or 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 including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

b) 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 PSS.

c) To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

1) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid.

2) Have no other source to fund or attain the necessary items/supports.

3) Be moving from a nursing facility where these items/services were provided, and

4) Be moving to a residence where these items/services are not normally furnished.

d) Transition Assistance must be completed by the day the beneficiary relocates from the institution.

e) Beneficiaries 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.

6. Environmental Accessibility Adaptation are physical adaptations to the home, required by the individual's PSS, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

a) Environmental accessibility adaptations must be included in the approved PSS.

b) Environmental accessibility adaptations include the following:

1) Installation of ramps and grab bars.

2) Widening of doorways.

3) Modification of bathroom facilities.

4) 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 beneficiary.

2) Adaptations which add to the square footage of the home.

d) 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 PSS and the request for environmental accessibility adaptation.

e) MDRS must certify and document that providers meet the criteria/standards in the waiver.

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

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 01/01/2017.

Rule 4.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. To obtain approval, the Mississippi Department of Rehabilitation Services (MDRS) must complete and submit the 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,

5. Informed Choice Form,

6. Physician or Nurse Practitioner Certification of Medical Stability and Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM or MDRS, and

7. Other supportive documentation as needed including, but not limited to, prescriptions and assistive technology recommendations.

B. Any request to add or increase services listed on the approved PSS must be submitted to and

receive prior approval from the Division of Medicaid and must include documentation substantiating the need for the requested change(s).

C. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. An individual whose brain or spinal cord injury is due to a degenerative or congenital condition, or that resulted, intentionally or unintentionally, from medical intervention is not eligible to receive services through the HCB waiver program.

D. MDRS is responsible for implementation of the PSS. The Division of Medicaid and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

Source: 42 CFR §§ 440.180, 441.301 (b)(1); Miss. Code Ann. § 43-13-121

History: Renamed and revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.8: Documentation/ Record Maintenance

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, Rule 1.3.

B. DCW staff records should include, at a minimum, the following required credentialing and qualification documents:

1. Copy of valid, state issued ID,

2. Job descriptions or DCW Certification,

3. Application and date of hire,

4. High School Diploma, General Educational Development (GED) diploma, other educational degrees, or proof of ability to read and write accurately,

5. Any licensure and/or certifications as required for job description,

6. Results of fingerprint-based National Criminal Background check(s),

7. Results of monthly Nurse Aide Abuse Registry checks,

8. Results of monthly Office of Inspector General (OIG) checks,

9. Attestation of health at hire,

10. Signed confidentiality agreement that includes social media waiver and

11. Proof of training/evaluations required professional certifications, and credentials including CPR and First Aid.

C. Records for beneficiaries receiving Personal Care Services (PCS) and In-Home Respite (IHR) services should include, at minimum:

1. Referral form/authorization,

2. Approved Plan of Services and Supports (PSS),

3. Service Notes documenting monthly and quarterly case management documenting oversight of the DCW, and

4. Daily activity or service notes capturing tasks completed and the beneficiary/representative's signature verifying the provision of services, if task and global positioning system (GPS) information is not captured electronically in the state approved electronic visit verification system.

D. Activity or service notes, if needed must include:

1. Arrival/service time and date,

2. Departure/service time and date,

3. Activities/tasks performed, and

4. The signature of the beneficiary or their legal representative verifying the provision of services.

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

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.9: [Reserved]

Rule 4.10: Reimbursement

A. Claims must be based on services that have been rendered to waiver beneficiaries as authorized by the Plan of Services and Supports (PSS), accurately billed by qualified waiver

providers, and in accordance with the approved waiver.

B. The Division of Medicaid conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. The Division of Medicaid denies payment for services when a waiver beneficiary or applicant is not Medicaid eligible on the date of service.

D. The Division of Medicaid conducts post utilization reviews to ensure the services provided were on the beneficiary's approved PSS.

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 five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

G. All 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 unless an exception is approved, in writing by the Division of Medicaid. Requirements for the use of the EVV system are outlined in Miss. Admin. Code Part 200.

Source: Miss. Code Ann. § 43-13-121

History: Revised and renamed to correspond with the TBI/SCI waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.11: Due Process Protection

A. The Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating a dispute resolution process separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

1. 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.

2. MDRS must inform the beneficiary/representative at the initial assessment of the specific criteria for the dispute, complaint/grievance and hearing processes.

3. MDRS must inform the beneficiary/representative of their rights which address disputes, complaints/ grievances and hearings.

4. A beneficiary participating in the TBI/SCI waiver or their representative may engage the

dispute resolution process by notifying MDRS or DOM of their concern either by phone or in writing.

5. The Division of Medicaid has the final authority over any dispute.

B. The Division of Medicaid provides an opportunity to request a Fair Hearing to beneficiaries:

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.

C. Notice of Action (NOA)

1. MDRS must provide the beneficiary with a Notice of Action via certified mail as required in C.F. R. §431.210.

2. The NOA must include:

a) A description of the action the provider has taken or intends to take,

b) An explanation for the action,

c) Notification that the beneficiary/representative has the right to file an appeal,

d) Procedures for filing an appeal,

e) Notification of beneficiary/representative's right to request a Fair Hearing,

f) Notice that the beneficiary/representative has the right to have benefits continued pending the resolution of the appeal, and

g) The specific regulations or the change in federal or state law that supports or requires the action.

D. A person applying for or participating in the TBI/SCI waiver has any additional rights to an appeal and/or hearing which are provided for in Title 23, Mississippi Administrative Code, Part 300.

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

History: Moved from Rule 4.10 eff. to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.12: Hearings and Appeals

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

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

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.13: Person Centered Planning (PCP)

A. Person Centered Planning (PCP) is an ongoing process used to identify a beneficiary'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 beneficiary to lead the process where possible with the beneficiary'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 beneficiary.

3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary.

5. Reflect cultural considerations of the beneficiary 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 beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, 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 beneficiaries must be provided with a clear and accessible alternative dispute resolution process which ensures the beneficiary's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

B. The PSS must reflect the services and supports that are important for the beneficiary to meet the needs identified through an assessment of functional need, as well as what is important to the beneficiary with regard to preferences for the delivery of such services and supports and the level of need of the individual beneficiary and must:

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

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

   b) Integrated in, and supports full access of beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries with disabilities and who are limited English proficient so as to be understandable to the

beneficiary receiving services and supports, and the individuals important in supporting the beneficiary.

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

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

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

11. Include those services, the purpose or control of which the beneficiary 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 content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least every twelve (12) months have lapsed since the provider's last review

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

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

Source: 42 CFR § 441.301; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.14: Monitoring Safeguards

A. Mississippi Department of Rehabilitation Services (MDRS) case managers are required to provide each waiver person with written information regarding their rights as a waiver person at 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 TBI/SCI 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 suspected, 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 rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.15 Grievances and Complaints

A. The Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by the Division of Medicaid. Grievances

may be made via phone, written letter format, or email. The Division of Medicaid has the final authority over any complaint or grievance.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. MDRS case managers are required to provide the toll-free number at initial assessment and annually at recertification.

D. The Department of Rehabilitation Services must cooperate with the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved TBI/SCI Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

Source: 42 CFR § 441.301; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

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) Katie Beckett COE,

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. 07/01/2025; 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) Compete 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: [Reserved]

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: [Reserved]

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) Katie Beckett COE,

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: Revised eff. 07/01/2025; 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.