MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 208
Home and Community Based Services
Long Term Care

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Title 23: Division of Medicaid

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

Part 208 Chapter 1: HSBS Elderly and Disabled Waiver

Rule 1.1: General

A. Medicaid covers certain home and community based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D).

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

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); Section 1915(c) of the Social Security Act, 42 CFR §440.180(b)(9)

Rule 1.2: Eligibility

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

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

   2. Persons must require nursing facility level of care as determined by a standardized comprehensive preadmission screening tool.

   3. A person's nursing facility level of care must be certified by a physician and recertified every twelve (12) months at a minimum.

   4. Persons must be in one of the following Categories of Eligibility (COE):

      a) Supplemental Security Income (SSI), or

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

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

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

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Revised eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 1.3: Provider Enrollment

A. Providers of long term care/home and community based waiver services, excluding the intellectual disabilities/developmental disabilities waiver, must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

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

   2. Copy of current licensure card 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 must match the name noted on the W-9, and

   4. Written confirmation from the IRS confirming the provider's tax identification number and legal name.

B. To become a HCBS Elderly & Disabled Waiver Provider, the prospective provider must:

   1. Be approved by Division of Medicaid after submitting a completed proposal package.

   2. Enter into a provider agreement with the Division of Medicaid.

   3. Establish a Mississippi based physical address/office prior to enrollment and maintain the physical address/office until the provider agreement is terminated.

   4. Depending on the provider type, successfully pass a facility inspection by the Division of Medicaid staff/inspector.

   5. Conduct a criminal background check on all employees prior to employment and maintain the record in the employee personnel file.

   6. Not employ individuals nor personally have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(f) of the Mississippi Codes, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the

conviction or plea.

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

C. Provider Qualifications:

1. All providers of E&D waiver services must ensure that all employees who have direct participant contact receive an annual physical examination, including a TB skin test.

2. Providers of Adult Day Care, Personal Care Services, and In-Home Respite must satisfy the applicable qualifications to render services.

3. Qualifications for Adult Day Care Services:

   a) Adult day care services must be provided by an established, qualified facility/agency.

   b) Each adult day care service must meet the following requirements:

      1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.

      2) The facility must meet the requirements of the American Disabilities Act of 1990.

      3) The facility must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.

      4) The facility must meet the physical and social needs of each waiver participant and maintain compliance with state and federal guidelines regarding services provided.

      5) The facility must have a governing body with full legal authority and judiciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements.

      6) The facility must have an advisory committee representative of the community and participant population.

      7) The facility must have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

      8) The facility must have a qualified administrator, either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have a master's degree and one (1)

year supervisory experience, either full-time or an equivalent, in a social or health service setting; or 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.

9) The facility must have a program director, either center manager, site manager, or center coordinator, responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program in accordance with the participant's needs and any mandatory requirements. The program director must have 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 comparable technical and human services training with demonstrated competence and experience as a manage in a health or human services setting. The program director must be under the direction of the administrator.

10) The facility must have a qualified social service staff person. The staff person must be a licensed social worker (LSW) and have a master's degree in social work and at least one (1) year of professional work experience, either full-time or an equivalent, in a human services setting; or a bachelor's degree in social work and two (2) years of professional work experience, either full-time or an equivalent in a human services setting; or a bachelor's degree in a health or social services related field and two (2) years' experience, either full-time or an equivalent, in a human services field. Social Workers must comply with all licensure requirements set by the Mississippi State Board of Examiners for Social Workers and Marriage & Family Therapists. In lieu of a licensed social worker, the functions must be carried out by other health service professionals such as certified rehabilitation counselors, licensed gerontologists, licensed professional counselors, or licensed/certified mental health workers.

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

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

13) The facility must have a program assistant. The program assistant must have 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.

14) If the facility prepares food on site, there must be a food service director. The food service director must be a registered dietician (RD), dietetic technician registered (DTR), RD eligible, DTR eligible, or a four (4) year graduate of a baccalaureate program in nutrition/dietetics/food service. In addition, the food service director must have a minimum of one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. If the food is not prepared on site, the facility must contract with a reputable food service provider/caterer.

15) The facility must have a secretary/bookkeeper. The secretary/bookkeeper must, at a minimum, have a high school diploma or equivalent and the skills and training to carry out the responsibilities of the position.

16) The facility must have a driver. The driver must have a valid state driver's license, a safe driving record, and training in first aid and cardiopulmonary resuscitation (CPR). The driver must maintain compliance with all state requirements for licensure/certification. The driver must be trained in basic transfer techniques and safe ambulation.

17) The facility must record volunteer hours and activities if the facility utilizes volunteers. Volunteers must be individuals or groups who desire to work with adult day service participants. Volunteers must successfully complete an orientation/training program. The responsibilities of volunteers must be mutually determined by the volunteers and staff and performed under the supervision of facility staff members. Duties must either supplement staff in established activities or provide additional services for which the volunteer has special talent/training. The facility must not use volunteers in place of required staff and can use volunteers only on a periodic/temporary basis.

4. Qualifications for Personal Care Service:

a) The agency must be established and in business for a minimum of one (1) year.

b) The provider must provide written documentation to the Division of Medicaid stating how the required standards are to be met.

c) There must be a Medicaid provider agreement in which the provider agrees to the Home and Community-Based Waiver requirements.

d) There must be a duly constituted authority and a governing structure for assuring responsibility and for requiring accountability for performance.

e) There must be responsible fiscal management.

f) There must be responsible personnel management including:

1) Appropriate process used in the recruitment, selection, retention, and termination of personal care attendants, and;

2) Written personnel policies, and job descriptions.

g) There must be a roster of qualified personal care attendants for scheduled service.

h) There must be written criteria for service provision, including procedures for dealing with emergency service requests.

i) Each Personal Care Service provider must have qualified personal care attendants and qualified personal care service supervisors.

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

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

ii) Must successfully complete and pass the 40-hour personal care services curriculum training course and the standardized examination designated by DOM prior to rendering services unless otherwise excluded.

iii) Must demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity. Must exhibit basic qualities of compassion and maturity and be able to respond to waiver participants and situations in a responsible manner.

iv) Must be at least eighteen (18) years of age;

v) Must possess a valid Mississippi driver's license, and have access to reliable transportation;

vi) Must be able to function independently without constant observation and supervision;

vii) Must be physically able to perform the job tasks required and assurance that communicable diseases of major public health concern are not present, as verified by a physician;

viii) Must have interest in, and empathy for, people who are ill, elderly, or disabled;

ix) Must have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people;

x) Must maintain current and active first aid and CPR certification;

xi) Must be able to carry out and follow verbal and written instructions;

xii) Must have no physical/mental impairments to prevent lifting, transferring, or providing any other assistance to the waiver participant.

2) The personal care service supervisor must have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals and meet one of the following requirements:

i) A Bachelor's Degree in Social Work, Home Economics, or a related profession with one year of direct experience working with aged and disabled clients,

ii) A Licensed Registered Nurse or Licensed Practical Nurse, with one (1) year of direct experience working with aged and disabled clients, or

iii) A High School Diploma and four years of direct experience working with aged and disabled clients.

5. In-Home Respite Qualifications

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

b) All providers of in-home respite services must submit written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into a provider agreement.

c) Each in-home respite agency must have qualified in-home respite providers and supervisors.

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

i) Bachelor's degree in social work or related profession,

ii) At least one (1) year experience, either full-time or an equivalent, working

with aged and disabled clients, and

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

iv) Licensure as a RN or LPN,

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

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

vii) A high school diploma,

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

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

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

i) Eighteen (18) years of age or older.

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

iii) Certification in CPR and first aid.

iv) Valid Mississippi driver's license and access to reliable transportation.

v) Ability to function independently without constant supervision/observation.

vi) Physical ability to perform tasks required.

vii) Ability to recognize signs of abuse, neglect, and/or exploitation; ability to follow procedures required in the Vulnerable Adult Act.

viii) Knowledge of how to prevent burns, falls, and fires and knowledge of emergency numbers for contacting emergency personnel if required.

ix) Absence of communicable diseases as verified by a physician.

x) Interest in, and empathy for, individuals who are ill, elderly, and/or disabled.

xi) Emotional maturity and ability to respond to individuals and situations in a responsible manner.

xii) Effective communication and interpersonal skills with the ability to deal effectively, assertively and cooperatively with a variety of people.

xiii) Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; 42 CFR 440.180

History: Revised – 06/01/2013

Rule 1.4: Freedom of Choice

A. Medicaid participants have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Each individual found eligible for the E & D waiver must be given free choice of all qualified providers.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23); 42 CFR 431.51

History: Revised – 01/01/2013

Rule 1.5: Quality Management

A. Waiver providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services.

B. Providers must report:

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

2. Critical incidences of abuse, neglect, and exploitation within twenty (24) hours of the occurrence or knowledge of the occurrence to DOM HCBS staff and other applicable agencies as required by law.

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

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

History: Revised – 01/01/2013

Rule 1.6: Covered Services

A. Providers must meet all provider specifications as outlined in the CMS approved waiver to

provide the following services through the Elderly and Disabled Waiver:

1. Case Management (CM)

   a. Case management services are provided through the Mississippi Planning and Development Districts/Area Agencies on Aging (PDD/AAA). Each PDD/AAA providing case management services must be approved by the Division of Medicaid and must enter into a provider agreement.

   b. Case management services are rendered by two (2) member teams which are composed of the following:

      1) A Registered Nurse - The registered nurse must 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, with a minimum of two (2) years of nursing experience with aged and/or disabled individuals. If the RN has less than two (2) years experience, they must receive at least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two years of waiver experience.

      2) A Licensed Social Worker - The licensed social worker (LSW) must have a current and active social work license with a bachelor's degree in social work or other health related field and two years of experience in direct care services for the aged and/or disabled clients. If the LSW has less than two (2) years experience, they must receive at least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

   c. Each team must have an assigned case management supervisor. The case management supervisor must not carry an active caseload of clients.

   d. The case management team, consisting of the registered nurse (RN) and the licensed social worker (LSW), must conduct face to face visits together when a preadmission screen is to be performed and at the time of recertification. At a minimum thereafter, the RN must visit the participant on a quarterly basis. The RN must be available at all times for consultation. The case management services are provided to coordinate services best meet the waiver participant's needs. The case management team is allowed a maximum of one (1) visit per quarter to visit the participant at an Adult Day Care facility. This visit must not be the initial preadmission screen, recertification or quarterly visit for the RN.

2. Adult Day Care Services

   a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged

and disabled participants through an individualized care plan that includes the following:

1) Personal care and supervision,

2) Provision of meals as long as meals do not constitute a full nutritional regimen,

3) Provision of limited health care,

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

5) Social, health, and recreational activities.

b. Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the participant's assigned case manager.

c. To receive Medicaid reimbursement the participant must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the participant to and from the facility.

3. Personal Care Services

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

b. Personal care services include 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.

c. It must be medically necessary for a personal care attendant to accompany participants during transportation provided by the Medicaid Non-Emergency Transportation (NET) provider.

d. Services must be provided in accordance with a waiver participant's plan of care.

e. Eligible participants are approved for personal care services based upon needs and services will not be approved without sufficient documentation to substantiate the request. The frequency must not duplicate hours rendered for respite care and/or home health aide services. Any increase in the number of hours indicated on the plans of care must be prior approved by the Division of Medicaid. Decreases in the number

of hours do not require DOM approval but notification of the decrease must be submitted.

f. Personal care attendant responsibilities:

1) Assist with personal care:

i) Mouth and denture care,

ii) Shaving,

iii) Finger and toe nail care (no cutting),

iv) Grooming hair to include shampooing, combing, oiling,

v) Bathing or bed bath-shower or tub (partial or complete),

vi) Assist with dressing,

vii) Assist with toileting including bed pan, commode/chair, or urinal (emptying and cleaning),

viii) Remind waiver participant to take medication,

ix) Assist with eating,

x) Transferring or changing the waiver participant's body position, and

xi) Assist with ambulation.

2) Perform housekeeping tasks:

i) Assure that rooms are clean and orderly, including sweeping, mopping and dusting,

ii) Prepare shopping lists,

iii) Purchase and store groceries,

iv) Prepare and serve meals,

v) Launder and iron clothes,

vi) Run errands,

vii) Clean and operate equipment in the home such as the vacuum cleaner, stove, refrigerator, washer, dryer, and small appliances,

viii) Change linen and make the bed, and

ix) Clean the kitchen, including washing dishes, pots, and pans.

3) Report to the personal care services supervisor, agency director, or the individual designated to supervise the personal care services program.

g. Personal care attendant supervisor responsibilities:

1) The personal care attendant supervisor is responsible for providing the following:

i) Supervise no more than twenty (20) full-time personal care attendants,

ii) Make home visits with personal care attendants to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

iii) Review and approve service plans,

iv) Receive and process requests for services,

v) Be accessible to personal care attendants for emergencies, case reviews, conferences, and problem solving,

vi) Evaluate the work, skills, and job performance of the personal care attendant,

vii) Interpret agency policies and procedures relating to the personal care services program,

viii) Prepare, submit, or maintain appropriate records and reports,

ix) Plan, coordinate, and record ongoing in-service training for the personal care attendants, and

x) Perform supervised visits in the participant's home and unsupervised visits which may be performed in the participant's home or by phone, alternating on a biweekly basis to assure services and care is provided according to the plan of care.

2) The personal care services supervisor is directly responsible to the Agency's Director and is responsible for the regular, routine, activities of the personal care services program in the absence of the Director.

4. Institutional or In-Home Respite Services

   a. Respite Care provides non-medical care and supervision/assistance to participants unable to care for themselves in the absence of the participant's primary full-time, live-in caregiver(s) on a short-term basis.

   b. Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the participant.

   c. Institutional Respite Services

      1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities.

      2) 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.

      3) Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

   d. In-Home Respite Services

      1) In-Home Respite services shall be provided on a short-term basis to beneficiaries unable to care for themselves and furnished in the absence of the client's primary full-time, live-in caregiver/caregivers.

      2) Criteria for in-home respite services include all of the following:

         i) Participant must be home-bound due to physical or mental impairments, and

         ii) Participant must require twenty-four (24) hour assistance by the caregiver, meaning that the participant cannot be left alone and unattended for any period of time.

      3) In-Home Respite services are limited to no more than sixty (60) hours per month to any client. Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

5. Home Delivered Meals

   a. Requirements for Home Delivered Meals include:

      1) Beneficiaries must be unable to leave home without assistance, unable to prepare

their own meals, and/or has no responsible caregiver in the home.

2) All eligible 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 participant will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

b. Home Delivered Meal~~s~~ services must not be provided by individual providers.

6. Extended Home Health Services

a. Participants may receive twenty-five (25) home health visits each fiscal year through the Medicaid State Plan. Through the Elderly and Disabled Waiver, beneficiaries may receive additional home health visits after the initial twenty-five (25) have been exhausted, but only with prior approval from the Division of Medicaid. Home Health Services include skilled nursing, physical therapy, speech therapy and home health aide.

b. Home Health Agencies must follow all rules and regulations set forth in Part 215. The word "waiver" does not apply to anything other than Home Health visits with prior approval from the Division of Medicaid. Waiver participants are subject to home health co-payment requirements through the twenty-fifth (25th) visit. Starting with the twenty-sixth (26th) home health visit, within the state fiscal year, the Waiver participant is exempt from home health co-payment requirements.

c. Providers must be certified to participate as a home health agency under Title XVIII, Medicare, of the Social Security Act; furnish the Division of Medicaid with a copy of its certification and/or recertification; meet all applicable state and federal laws and regulations; provide the Division of Medicaid with a copy of its certificate of need approval when applicable; and execute a participation agreement with the Division of Medicaid.

d. The personal care attendant and home health aide must not be in the client's home at the same time and must not perform the same duties. Exceptions to this rule must be based on medical justification and thoroughly documented.

7. Transition Assistance

a. Transition Assistance is a one (1) time initial expense required for setting up a household. The expenses must be included in the approved plan of care. Transition Assistance Services are capped at eight hundred dollars ($800.00) one (1) time initial expense per lifetime.

b. To be eligible for Transition Services the participant must meet all of the following criteria:

1) Participant must be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid, and

2) Participant must have no other source to fund or attain the necessary items/support, and

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

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

c. Transition Assistance Services include the following:

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

2) Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items. Items such as televisions, cable TV access or VCR's are not considered furnishings,

3) Moving expenses,

4) Fees/deposits for utilities or service access such as telephone, electricity, and the like, and

5) Health and safety assurances such as pest eradication, allergen control, or one (1) time cleaning, prior to occupancy,

d. All transition services are essential to:

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

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

e. Transition Assistance is not available for participants whose stay in a nursing facility is ninety (90) days or less.

B. Participants who choose to reside in a licensed/unlicensed Personal Care Home are not eligible to receive Elderly & Disabled Waiver services.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); 42 CFR 431.53; 42 CFR 440.170(a); 42 CFR 440.180

History: Revised – 01/01/2013

Rule 1.7: Prior Approval/Physician Certification

A. Prior approval must be obtained from the Division of Medicaid before a participant can receive services through the Home and Community-Based Waiver Program. To obtain approval, the waiver provider must complete and submit current Division of Medicaid approved forms as follows:

1. Pre-Admission Screening (PAS),
2. Web Plan of Care,
3. Stand Alone Plan of Care,
4. Admitted and Discharged Form,
5. Completed Informed Choice form,
6. Section X/Certification Page Signed and dated by the Physician, and
7. Electronic Summary.

B. The Section X/Certification Page must be submitted to the Division of Medicaid within thirty (30) days of the physician's signature date or the date received by the case manager if not dated by the physician.

C. An eligible participant must be locked into only one (1) program at a time. Any request to add or increase skilled services listed on the approved plan of care must receive prior approval.

D. All requests for increases in service must be submitted to the Division of Medicaid for approval and must include documentation to substantiate the need for the increase. DOM must also receive notification of any decreases in services but approval is not required.

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

History: Revised – 01/01/2013

Rule 1.8: Documentation/Record Maintenance

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the waiver.

B. In addition, waiver providers must submit copies of all service logs and documentation of visits for each waiver participant served, to the individual's case manager no later than the fifteenth ($15^{th)}$ of the following month in which the service was rendered. Refer to

Maintenance of Records Part 200, Chapter 1, Rule 1.3.

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

History: Revised – 01/01/2013

Rule 1.9: Participant Cost Sharing

Participants enrolled in wavier programs are exempt from co-pay for waiver services. Refer to Part 200, Chapter 3, Rule 3.7.

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

History: Revised – 01/01/2013

Rule 1.10: Reimbursement

A. Requests for reimbursement for waiver services must be withheld until the first (1st) day of the month following the month in which services were rendered.

B. Extended Home Health services will be paid in accordance with the Home Health reimbursement rules.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15)

Rule 1.11: Due Process Protection

A. The Case Manager must provide written notice to the participant when any of the following occur:

    1. Services are reduced,

    2. Services are denied, or

    3. Services are terminated.

B. The recourse/appeal procedure notice, E&D Waiver or Notice of Action, must contain the following information:

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

    2. A statement of the action to be taken,

    3. A statement of the reason for the action,

    4. A specific regulation citation which supports the action,

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

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

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

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

C. Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the participant must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.307; 42 CFR 431.210; 42 CFR 431 Subpart E

History: Revised – 01/01/2013

Rule 1.12: Hearings and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.

B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431 Subpart E; 42 CFR 441.308

History: Revised - 01/01/2013

Part 208 Chapter 2: HCBS Independent Living Waiver

Rule 2.1: General

A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.

B. The IL HCBS Waiver is operated jointly by the Division of Medicaid and the Mississippi

Department of Rehabilitation Services (MDRS) through an interagency agreement with services available statewide.

C. The Division of Medicaid maintains responsibility for the administration of the waiver and formulates policies, rules, and regulations. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. The MDRS is responsible for operational functions and maintaining a current Medicaid provider number.

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

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); Section 1915(c) of the Social Security Act, 42 CFR §440.180(b)(9)

History: Revised 01/01/2013

Rule 2.2: Eligibility

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

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

2. Are able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants (PCAs), counselors, case managers or others involved in their care.

3. Are certified as medically stable by their physician. The Division of Medicaid defines medical stability as the absence of all of the following:

   a) An active, life-threatening condition requiring systematic therapeutic measures,

   b) Intravenous drip to control or support blood pressure, and

   c) Intracranial pressure or arterial monitoring.

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

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

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

1. Supplemental Security Income (SSI),

2. Parents and Other Caretaker Relatives Program,

3. Disabled Child Living at Home,

4. Children under age nineteen (19) who meet the applicable income requirements,

5. Disabled Adult Child,

6. Protected Foster Care Adolescents,

7. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

8. IV-E Foster Children and Adoption Assistance Children,

9. An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify, or

10. Working Disabled.

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

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

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

Rule 2.3: Covered Services

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

A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities:

1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs, preferences, and goals.

2. Must assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

3. Are responsible for ongoing monitoring of the provision of services included in the participant's plan of care.

4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required. More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.

5. Are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).

B. Case Management must be provided by Registered Nurses (RN) and Rehabilitation Counselors who must meet the following qualifications:

The Registered Nurse must:

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

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

Not have a history of a criminal offense which precludes him/her from working with the vulnerable population; and

Not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion list.

The Rehabilitation Counselor must:

Possess at a minimum a Bachelor's degree in Rehabilitation Counseling or other related

field; and

Have one (1) year of experience working with individuals with disabilities; and

Be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population; and

Not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.

Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Counselor. MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

MDRS must verify provider qualifications upon hire and at least annually.

C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

1. PCA services must be provided in accordance with the approved plan of care, cannot be purely diversional in nature, and must include:

   a) Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living.

   b) Food shopping and assistance with preparation of meals, but not the cost of the meals.

   c) Housekeeping chores essential to the health of the beneficiary, when specified in the approved plan of care.

   d) Support for community participation by accompanying and assisting the participant as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.

2. A personal care attendant must be chosen by the participant as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified personal care attendants. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS Rehabilitation Counselors and Registered Nurses must certify and document that the PCA meets the requirements.

3. A personal care provider must have completed training/instruction that covers the

purpose, functions, and tasks associated with the personal care attendant program. The educational program must be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants cannot be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the participant and Rehabilitation Counselor/Registered Nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care provider must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and Rehabilitation Counselor/Registered Nurse to be adequate in fulfilling the responsibilities of personal care. The training, to be conducted by the participant/caregiver and the Rehabilitation Counselor/Registered Nurse, or an agency permitted by law to train nurse aides, must include:

a) The purpose and philosophy of self-directed services by the disabled,

b) Disability awareness,

c) Employee-employer relationships and the need for respect for the participant's privacy and property.

d) Basic elements of body functions,

e) Infection control procedures,

f) Maintaining a clean and safe environment,

g) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.

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

4. The individual who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements. Competency certification for these personal care providers by the participant and Rehabilitation Counselor/Registered Nurse is required. A personal care attendant that has satisfactorily provided personal care attendant service for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.

5. Personal care services can be furnished by family members provided they are not the spouse or the parent or step-parent of a minor child. Only qualified family members not legally responsible for the waiver participant can be employed as the personal care

attendant. Family members must meet provider standards and be certified competent to perform the required tasks by the participant and the Rehabilitation Counselor/Registered Nurse. There must be adequate justification for the family member to function as the attendant such as lack of other qualified attendants in the remote area.

6. Minimum requirements include:

   a) Must be at least 18 years of age;

   b) Must be a high school graduate, have a GED or demonstrates the ability to read and write to complete required forms and reports of visits;

   c) Must be able to follow verbal and written instructions;

   d) Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;

   e) Must be certified as meeting the training and competence requirement by the participant and the Rehabilitation Counselor/Registered Nurse;

   f) Must be able to communicate effectively and carry out directions;

   g) Must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

   h) Must receive training in the areas of the Vulnerable Person's Act, care giver boundaries and dealing with difficult patients upon hire and annually thereafter.

7. MDRS must verify the competency for all personal care attendant as needed.

8. If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six (6) consecutive months, the participant is reevaluated for the need for waiver services to determine if the waiver can meet the needs of this participant.

9. MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants for employment decisions and/or actions and service provision to consumers of the department’s services. MDRS must verify that any potential personal care attendant is not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

10. If a waiver participant chooses the Participant Directed Care Service option for managing

personal care attendants, the Financial Management Service provider is responsible for obtaining the criminal background check. The FMS provider must verify that the personal care attendants employed by the waiver participant are not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

1. The need for use of such items must be documented in the assessment/case file and approved on the plan of care.

2. Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. Items not of direct medical or remedial benefit to the participant are excluded.

3. Specialized medical equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS must certify and document that providers meet the criteria/standards in the waiver document.

4. Requests for specialized medical equipment and supplies must be evaluated by the MDRS counselor or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for specialized medical equipment and/or supplies for approval.

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

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

1. Transition Assistance services include the following:

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

b) Essential furnishings required to occupy and use a community domicile. Televisions or cable TV access are not essential furnishings.

c) Moving expenses.

d) Fees/deposits for utilities and service access for a telephone.

e) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

2. Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars ($800.00) per lifetime. These expenses must be included in the approved plan of care.

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

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

   b) Have no other source to fund or obtain the necessary items/supports;

   c) Be moving from a nursing facility where these items/services were provided;

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

4. Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

5. Transition Assistance must be completed by the day the participant relocates from the institution.

6. Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

7. Transition Assistance services must be provided by a Registered Nurse and/or a Rehabilitation Counselor.

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

1. Environmental accessibility adaptations must be included in the approved plan of care.

2. Environmental accessibility adaptations include the following:

   a) Installation of ramps and grab bars.

   b) Widening of doorways.

   c) Modification of bathroom facilities.

   d) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

3. Environmental accessibility adaptations exclude the following:

    a) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.

    b) Adaptations which add to the square footage of the home.

4. Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for environmental accessibility adaptation.

5. Providers rendering environmental accessibility adaptation services must:

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

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

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

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

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

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

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

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

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

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

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

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

G. Financial Management Service (FMS):

1. FMS is a support service to assist the waiver participant who chooses the Participant-Directed Personal Care service. Participant-Directed Personal Care service recognizes the waiver participant as the employer of record.

2. The waiver participant performs budgetary and employer functions and has the ability to negotiate salaries and benefits with the personal care attendants.

3. The FMS agent assists the waiver participant with employer and budget authority by ensuring federal, state and local employment taxes and labor and worker's compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner as related to the personal care attendant.

4. The FMS agent ensures that the necessary employer related duties and tasks, including payroll, are carried out. The service must ensure initial orientation and ongoing training is provided related to responsibilities of being an employer and adhering to legal requirements for employers.

5. The FMS provider must:

   a) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS related responsibilities on behalf of the participant.

   b) Provide assistance determining personal care attendant wages and benefits.

   c) Provide assistance in hiring by verifying employees' citizenship status, conducting criminal background checks, and verifying the employee is not on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion lists.

   d) Verify and maintain documentation of employee qualifications, citizenship status, and documentation of services delivered.

   e) Provide education on recruiting, hiring and terminating employees as well as identifying the need for special skills and determining duties and schedules.

   f) Ensure appropriate payment by:

      1) Collecting timesheets,

      2) Processing timesheets,

      3) Processing payroll and payables, and

      4) Making withholdings for and payment of applicable and federal, state and local

employment related taxes.

g) Provide quarterly written reports to the waiver participant of all expenditures and the status of the waiver participant's budget.

h) Maintain a separate account for each waiver participant.

i) Make services available only to those persons deemed eligible and referred by MDRS,

j) Establish contact with the participant within five (5) working days of the referral from MDRS,

k) Conduct a face-to-face visit to initiate the FMS process within five (5) working days of establishing contact with the participant,

l) Conduct at least one (1) face-to-face meeting annually with each participant to review and update the overall function of the FMS,

m) Ensure Division of Medicaid (DOM) access to the participant's case files.

n) Employ staff members with knowledge, experience and abilities to sufficiently carry out the FMS component of service.

o) Have Medicaid provider agreements with the Division of Medicaid with the following requirements.

1) Have a minimum of five (5) years of billing and payroll experience relevant to participant-directed medical care,

2) Have a working knowledge of disability etiquette, psychology, and social aspects of disability, vulnerable persons act including reporting requirements, HCBS waivers, especially the plans of care, and W-2 employee tax reporting requirements. If the FMS lacks a working knowledge of disability etiquette, psychology and social aspects of disability, vulnerable person's act and home and community based waivers, training must be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.

p) Develop and maintain policies and procedures for the delivery of Financial Management Services.

q) Have qualifications verified by DOM initially and monitored annually or more frequently as indicated.

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

History: Revised 01/01/2013

Rule 2.4: Prior Approval/Certification

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

Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.

The physician must certify the participant is appropriate for Medicaid long term care services.

D. The plan of care is the fundamental tool which ensures the health and welfare of participants in the Independent Living Waiver.

1. A participant's plan of care must be based on a comprehensive preadmission screening process and is developed based on the waiver participant's goals, preferences and needs.

2. The case manager/counselor must engage the participant and other interested parties as requested by the participant in developing the plan of care that best meets the needs of the participant.

3. Plans of care must be approved by a Medicaid Program Nurse prior to services being provided.

4. Development of the plan of care must include an emergency preparedness plan.

5. The Plan of Care must be developed at the time of the PAS, updated quarterly, annually and as needed.

6. The Pre-Admission Screening (PAS) and the Plan of Care must be completed jointly by the Rehabilitation Counselor and Registered Nurse on initial certifications.

7. The PAS and the Plan of Care must be completed by the Rehabilitation Counselor or a combination of the Rehabilitation Counselor and the Registered Nurse at re-certification.

E. The application along with the Plan of Care must be submitted to the Division of Medicaid for approval after the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS.

F. A participant can only be enrolled in one (1) HCBS waiver program at a time.

G. Added services must be prior approved by the Division of Medicaid.

H. MDRS is responsible for implementation of the plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for plan of care implementation. Monitoring the implementation of the plan of care includes on site review activity, record reviews, annual recertification reviews, participant phone calls from the Medicaid agency, and other strategies as needed.

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

History: Revised - 01/01/2013

Rule 2.5: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.

B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

Informed of any feasible alternatives under the waiver, and

Given the choice of either institutional or home and community-based services.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(123)

History: Revised - 01/01/2013

Rule 2.6: Quality Management

A. Providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services (CMS).

B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.

C. All reports of abuse, neglect or exploitation, as defined below, must be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS and the Department of Human Services (DHS). The potential abuse, neglect, or exploitation must be reported to the Division of Medicaid/Long Term Care within twenty-four (24) hours.

1. Abuse (A) is defined as willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

2. Neglect (N) includes, but is not limited to, a single incident of the inability of a vulnerable person living alone to provide for himself and/or failure of a caretaker to provide what a reasonably prudent person would do.

3. Exploitation (E) is the illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person and includes acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

D. The Department of Human Services (DHS), Division of Aging and Adult Services is responsible for investigating allegations of Abuse, Neglect and Exploitation. The Division of Medicaid and DHS have a Memorandum of Understanding (MOU) allowing a free flow of information between the two (2) agencies to ensure the health and welfare of waiver participants.

E. Quality Management Strategy for the waiver includes the following:

1. Level of care determination consistent with the need for institutionalization,

2. Plan of care consistent with the participant's needs,

3. Providers must meet the provider specifications of the CMS approved waiver, including licensure/certification requirements,

4. Critical event/incident reporting mechanism for participants and caregivers to report concerns/incidents of abuse, neglect, and exploitation,

5. Division of Medicaid retention of administrative authority over the waiver program,

6. Division of Medicaid retention of financial accountability for the waiver program.

F. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.

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

History: Revised – 01/01/2013

Rule 2.7: Participant Direction of Services

A. Participants are encouraged to make choices in regards to participant needs, goals, preferences

and desires with all aspects of the services provided.

B. Participants have the choice of two (2) options for personal care service:

1. Co-Participant personal care service, the traditional personal care services, is a viable choice for participants who do not desire to be become the employer of record with budgetary control. Mississippi Department of Rehabilitation Services is recognized as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority, excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance.

2. Participant-Directed personal care service allows the participant to exercise employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant has the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues.

a) The FMS provides assistance to the participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS must submit claims for attendant services to the Division of Medicaid for payment and is responsible for assisting with, including but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. The participant must be given detailed information about all providers except Personal Care Service, and the participant has the opportunity and is encouraged to choose the provider they feel most comfortable and can best meet their needs.

b) The FMS must:

Provide support for financial management when the participant is the employer of the personal care attendant.

2) Assist participant in verifying personal care attendant citizenship status.

3) Collect and process timesheets of personal care attendants.

4) Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.

5) Verify the personal care attendant is not listed on the Mississippi Nurse Aide Abuse Registry.

6) Verify the personal care attendant is not listed on the Office of Inspector General (OIG) exclusion list.

7) Ensure the participant receives initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

8) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant.

9) Provide assistance determining employee wages and benefits.

10) Verify and maintain documentation of employee qualifications and documentation of services delivered.

11) Conduct criminal background checks on personal care attendants.

12) Assist the participant with recruitment of personal care attendants.

13) Maintain a separate account for each participant's participant-directed budget.

14) Track and report participant funds, disbursements and the balance of participant funds.

15) Process and pay invoices for personal care attendant services approved in the service plan.

16) Provide participant with periodic reports of expenditures and the status of the participant directed budget.

c) FMS providers must have a Medicaid provider agreement with the Division of Medicaid. The Division of Medicaid is responsible for oversight of the FMS entities by compliance reviews conducted on an annual basis or more often if needed. Reviews are instigated in the event of a complaint regarding management of funds. Any participant under-utilization or over-utilization of services must be reported to the Division of Medicaid.

d) Waiver participant's failure to comply with participant directed service guidelines will result in a corrective action plan. Repetitive non-compliance disqualifies a waiver participant for the Participant-Directed Service option.

e) A waiver participant can change from the Participant-Directed Personal Care service to the Co-Participant Directed Personal Care service at any time at their request.

f) Immediate termination of the Participant-Directed personal care service option occurs

if the following circumstances arise, including, but not limited to:

1) The participant's/employer's health or welfare is immediately jeopardized,

2) The personal care attendant is convicted of criminal offenses precluding him/her from working with the vulnerable population,

3) The participant/employer has not implemented an acceptable corrective action plan as required to continue Participant-Direction,

4) The waiver participant declines to the degree he/she is no longer able to express his/her ideas and wants verbally or nonverbally,

5) The waiver participant fails to provide adequate justification for underutilizing or over utilizing personal care services,

6) Fraud and/or abuse of funds, or

7) Unsafe environment for care providers.

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

History: Revised 01/01/2013

Rule 2.8: Monitoring Safeguards

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

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

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.9: Additional Dispute Resolution Process

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

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

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

D. MDRS must inform the participant of their rights which address disputes, complaints/ grievances and hearings.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.10: Financial Accountability

A. Claims for waiver services are based on state payment for waiver services that have been rendered to waiver participants as authorized by the plan of care, accurately billed by qualified waiver providers, and in accordance with the approved waiver.

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

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

D. DOM conducts post utilization reviews to ensure the services provided were on the participant's approved plan of care.

E. Records documenting the provision of services must be maintained by the operating agency (if applicable) and providers of waiver services for a minimum of three (3) years.

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

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

History: Revised 01/01/2013

Rule 2.11: Hearing and Appeals

A. The Division of Medicaid provides an opportunity to request a Fair Hearing to individuals:

1. Who are not given the choice of home and community-based services as an alternative to the institutional care,

2. Who are denied the service(s) of their choice or the provider(s) of their choice, or

3. Whose services are denied, suspended, reduced, or terminated.

B. MDRS must provide the individual with a Notice of Action (NOA) via certified mail as required in 42 CFR §431.210.

C. The NOA must include:

1. A description of the action the provider has taken or intends to take,

2. An explanation for the action,

3. Notification that the participant has the right to file an appeal,

4. Procedures for filing an appeal,

5. Notification of participant's right to request a Fair Hearing,

6. Notice the participant has the right to have benefits continued pending the resolution of the appeal, and

7. The specific regulations or the change in Federal or State law that supports or requires the action.

D. The waiver participant or his/her representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. The request for a local or state hearing must be made in writing by the participant or his/her legal representative.

E. The waiver participant may be represented by anyone he/she designates. If the participant elects to be represented by someone other than a legal representative, he/she must designate the person in writing.

F. The participant has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period is extended if the participant can show good cause for not filing within (30) days.

G. A hearing cannot be scheduled until a written request is received by either the MDRS or the State DOM office. If the written request is not received within the thirty (30) days of the NOA, services will be discontinued.

H. At the local hearing level, MDRS issues a determination within thirty (30) days of the date of the initial request for a hearing.

I. The participant has the right to appeal a local hearing decision by requesting a State hearing; A State hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.

J. At the State hearing level, DOM issues a determination within ninety (90) days of the date of the initial request for a hearing.

K. The waiver participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record.

2. The right to have legal representation at the hearing and to bring witnesses.

3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

L. Services must remain in place during any appeal process, except when there is a threat of harm of the participant or the service provider.

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

History: Revised 01/01/2013

Part 208 Chapter 3: HCBS Assisted Living (AL) Waiver

Rule 3.1: General

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

B. The AL Waiver is administered and operated by the Division of Medicaid.

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

Rule 3.2: Eligibility

A. To be eligible for the Assisted Living Waiver Program a waiver participant must:

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

2. Require nursing facility level of care as determined by a standardized comprehensive preadmission screening, and

3. Be in the Supplemental Security Income (SSI) Category of Eligibility (COE) or an aged,

blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

B. To be eligible for care in a Traumatic Brain Injury Residential facility a participant must:

1. Meet all the requirements in Miss. Admin. Code Part 208, Rule 3.2.A.,

2. Have a diagnosis of an acquired traumatic brain injury defined by the Division of Medicaid as a non-degenerative structural brain damage excluding a brain injury that is congenital or due to injuries induced by birth trauma,

3. Have completed acute rehabilitation treatment,

4. Be in a crisis/high stress environment with behavioral needs which place the participant at high risk for institutionalization,

5. Have documentation as to why the services could not be provided inside the State of Mississippi, and

6. Have an Executive Director's Letter of Approval for Out-of-State Placement.

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

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

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

Rule 3.3: Provider Enrollment

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

A. Submit a provider enrollment packet complete with all necessary information.

B. Submit a copy of the current and active license/certification to function as a Personal Care Home – Assisted Living Facility (PCH-AL) or meet licensure requirements deemed acceptable by the Division of Medicaid to meet minimum requirements specific for a Traumatic Brain Injury Residential facility.

C. Successfully pass a facility inspection by a Division of Medicaid inspector.

D. Satisfy all criteria and requirements for enrollment as a Medicaid provider in accordance with Miss. Admin. Code Part 208, Chapter 1, Rule 1.1, upon completion of items A., B. and C. in Miss. Admin. Code Part 208, Rule 3.3.

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

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

Rule 3.4: Freedom of Choice

Medicaid beneficiaries have the right to freedom of choice of approved Medicaid providers for services as outlined in Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.

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

Rule 3.5: Prior Approval/Physician Certification

A. Prior approval must be obtained from the Division of Medicaid before an individual can receive services through the Home and Community-Based Waiver Program.

B. Functional eligibility for waiver services is determined through a comprehensive Pre-Admission Screening.

    1. The physician must certify that the individual meets nursing home level of care.

    2. Clinical eligibility must be determined annually using the pre-admission screening for continued AL Waiver services.

C. The Plan of Care must be developed that:

    1. Is person-centered,

    2. Involves collaboration between the case manager and the participant and/or their designated representative or responsible party,

    3. Is all inclusive to meet the needs, desires and goals, including personal goals, for the participant, and

    4. Is approved by the Division of Medicaid prior to enrollment into waiver services.

D. A waiver participant shall be locked into only one (1) waiver program at a time.

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

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

Rule 3.6: Covered Services

A. The AL Waiver covers Case Management Services provided by a social worker licensed to practice in the State of Mississippi with at least two (2) years of full-time experience in direct services to elderly and disabled individuals.

B. AL Services include the following:

1. Personal care services rendered by personnel of the licensed facility,

2. Homemaker services,

3. Attendant care services,

4. Medication oversight/administration with personnel operating within the scope of applicable licenses and/or certifications,

5. Therapeutic, social, and recreational programming services,

6. Intermittent skilled nursing services and interventions ordered by the physician and provided:

    a. At least eight (8) hours a day, including weekends and holidays, to assess and assist the waiver participant with services including but not limited to medication administration and oversight, and

    b. By a nurse with an active and unencumbered license. If the facility employs a Licensed Practical Nurse (LPN), the LPN must have supervision by either a Registered Nurse (RN), nurse practitioner, or a physician.

7. Transportation services must be provided by the AL Waiver provider or through the Division of Medicaid's Non-Emergency Transportation (NET) program if the waiver participant has not reached the maximum NET service limits.

8. An electronic emergency attendant call system in each PCH-AL facility which:

    a) Is available to waiver participants who are:

        1) At risk of falling,

        2) At risk of becoming disoriented, or

3) Experiencing some disorder placing them in physical, mental or emotional jeopardy.

b) Includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides for supervision, safety and security.

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

C. AL Waiver providers must provide:

1. A setting physically accessible to the participant but is 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.

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 another legally enforceable agreement by the waiver participant, and the participant 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, and

b) Provide each waiver participant privacy in their sleeping or living unit with:

1) Lockable entrance doors with appropriate staff having keys to doors,

2) The option to share living units only at the choice of the participant, and

3) The freedom to furnish and decorate their sleeping or living units.

3. A setting which integrates and facilitates the individual'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 individual from among all available alternatives and is identified in the person-centered plan of care,

5. Protection of an individual'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 an individual with cognitive impairment supported by a specific assessed need and addressed in the plan of care,

9. Freedom and support of participants 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 participant to exercise their rights to:

    a. Attend religious and other activities of their choice,

    b. Manage their own personal financial affairs or receive a quarterly accounting of financial transactions made on their behalf,

    c. Not be required to perform services for the facility,

    d. Receive mail unopened or in compliance with the facility policy,

    e. Be treated with consideration, kindness, respect and full recognition of their dignity and individuality,

    f. Retain and use personal clothing and possessions as space permits,

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

    h. Not be confined to the licensed facility against their will and allowed to move about in the community at liberty,

    i. Free from physical and/or chemical restraints,

    j. Allowed to choose a pharmacy or pharmacist provider in accordance with State law,

    k. Decide when to go to bed and get up in the morning,

    l. Furnish and decorate their sleeping or living space,

m. Allows the participant to decide when to eat his or her meals,

n. Have nutritious snacks available at all times, and

o. Use the dining room for congregate meals and socialization.

Source: 42 CFR §§ 431.53, 440.170(a), 440.180; Miss. Code Ann. § 43-13-121.

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

Rule 3.7: Quality Management

A. AL Waiver providers must meet applicable service specifications. Refer to the Miss. Admin. Code, Part 208, Chapter 1.

B. AL Waiver providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to Division of Medicaid.

C. Providers must maintain compliance with all current waiver requirements, regulatory rules and regulations and administrative codes as specified by the licensing agency.

   1. If an AL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the AL Waiver provider demonstrates compliance with the regulatory agency.

   2. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the Division of Medicaid.

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

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

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

Rule 3.8: Documentation and Record Maintenance Requirements:

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

   1. Maintain legible, accurate, and complete records.

   2. Document the services rendered and billed under the program including when a

participant is out of the facility and the reason why.

3. Make records available immediately, upon request, to representatives of the Division of Medicaid in substantiation of any and all claims.

4 Maintain records for a minimum of six (6) years or until resolution of any pending investigation, audit or litigation.

5. Maintain statistical and financial data supporting a cost report for at least five (5) years from the date of the cost report, or amended cost report or appeals submitted to the Division of Medicaid.

6. Identify and maintain records of medication allergies of waiver participants.

7. Maintain a current, signed and dated copy of the Division of Medicaid approved admission agreement for each waiver participant which includes, at a minimum:

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

   b) Period to be covered,

   c) List of itemized charges, and

   d) Agreement regarding refunds for payments.

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

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

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

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

Rule 3.9: Beneficiary Cost Sharing

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

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

Rule 3.10: Reimbursement

A. Reimbursement for AL Waiver provider services cannot be requested earlier than the first (1st) day of the month following the month in which services were rendered.

B. Reimbursement for AL Waiver provider services is only for those services provided within the facility. The Division of Medicaid does not reimburse for room and board.

C. Transportation is an integral part of AL Waiver provider services and is not reimbursed separately.

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

Rule 3.11: Hearings and Appeals for Denied/Terminated Services

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

B. The waiver participant/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

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

Rule 3.12: Education, Training and Supervision

A. All AL Waiver providers must have policies and procedures assuring safeguards to protect the safety, health and well-being of all waiver participants which must include:

    1. Definitions of abuse, neglect and exploitation,

    2. Education for employees in detection of abuse, neglect and exploitation,

    3. Guidance for facility staff to prevent abuse, neglect and exploitation, and

    4. Reporting requirements for abuse, neglect, exploitation and critical incidents.

B. AL Waiver providers must provide all staff with training upon hire and annually thereafter in the following areas:

    1. Vulnerable Persons Act regarding prevention of abuse, neglect and exploitation,

    2. Resident Rights and Dignity,

3. Care of an Alzheimer's resident,

4. Care of residents with mental illness, and

5. How to deal with difficult residents.

C. The AL Waiver provider must maintain evidence of the training listed in the Miss. Admin. Code, Part 208, Rule 3.12.B. on file and easily accessible upon request of the Division of Medicaid.

D. The AL Waiver provider must assure:

1. Each direct care staff successfully completes forty (40) hours of course curriculum as identified by the State,

2. The training is provided prior to providing care to a waiver participant,

3. Documentation of completion of this course work be maintained at the facility and made available to the Division of Medicaid upon request.

E. AL Waiver providers must submit an acceptable plan of correction if all training requirements in the Miss. Admin. Code, Part 208, Rule 3.12 are not met continued noncompliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.

F. TBI Residential Waiver providers must train all staff upon hire in the following areas including, but not limited to:

1. Identifying, preventing and reporting abuse, neglect and exploitation,

2. Rights and dignity,

3. Crisis prevention and intervention,

4. Caring for individuals with cognitive impairments,

5. Assisting with activities of daily living,

6. HIPAA Compliance,

7. Stress reduction,

8. Behavior programs,

9. Recognition and care of individuals with seizures,

10. Rational/behavioral therapy,

11. Elopement risks,

12. Safe operation and care of individuals with assistive devices,

13. Caring for individuals with disabilities,

14. Safety, and

15. Training in CPR and first aid.

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

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

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

Rule 3.13: Background Checks

AL Waiver providers must:

A. Conduct a search of the Mississippi Nurse Aide abuse registry prior to hiring an individual who will provide care to waiver participants including, but not limited to:

1. Any individual providing direct care or supervision to the residents,

2. Owners,

3. Operators, and

4. Transportation drivers.

B. Maintain documented evidence in the personnel file of each employee to demonstrate to the Division of Medicaid that the Mississippi Nurse Aide Abuse Registry has been searched.

C. Conduct a disciplinary search with the professional licensing agency, if any, for each employee to determine if any disciplinary actions have been taken against the employee by the agency.

D. Conduct a National Criminal Background Check by submitting fingerprints to the licensing agency to be electronically submitted to the Federal Bureau of Investigations and the Mississippi Criminal Information Center as specified in the Minimum Standards For

Personal Care Homes Assisted Living, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification.

E. Deny or terminate employment of any applicant/employee with a felony conviction, a guilty plea, and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which have not been reversed on appeal, or for which a pardon has not been granted:

1. Possession or sale of drugs,
2. Murder,
3. Manslaughter,
4. Armed robbery,
5. Rape,
6. Sexual battery,
7. Sex offense listed in Section 45-33-23 (g), Mississippi Code of 1972,
8. Child abuse,
9. Arson,
10. Grand larceny,
11. Burglary,
12. Gratification of lust,
13. Aggravated assault, or
14. Felonious abuse and/or battery of vulnerable adult.

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

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

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

Rule 3.14: Disaster Preparedness

A. AL Waiver providers must have disaster preparedness and management procedures to ensure that waiver participant's care, safety, and well- being are maintained during and following instances of natural disasters, disease outbreaks, or similar situations.

B. In the event of termination of an AL Waiver provider agreement, the Division of Medicaid, the participants and their designated representatives, and the licensing agency will work collaboratively to arrange for appropriate transfer of waiver participants to other Medicaid approved providers.

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

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

Part 208 Chapter 4: HCBS Traumatic Brain Injury/Spinal Cord Injury Waiver

Rule 4.1: General

A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. Waiver services are available statewide.

B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and MDRS.

Source: Miss. Code Ann. § 43-13-121; Section 1915(c) of the Social Security Act, 42 CFR §440.180

Rule 4.2: Eligibility

A. Eligibility is limited to individuals with the following disease(s) or condition(s):

1. Traumatic brain injury which the Division of Medicaid defines as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

2. Spinal cord injury which the Division of Medicaid defines as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two (2) of the above three (3) deficits.

B. The extent of injury must be certified by the physician.

C. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

D. Individuals must be certified as medically stable by their physician. The Division of Medicaid defines medically stable as the absence of all of the following:

1. An active, life threatening condition requiring systematic therapeutic measures.

2. Intravenous drip to control or support blood pressure.

3. Intracranial pressure or arterial monitoring.

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

1. Supplemental Security Income (SSI),

2. Parents and Other Caretaker Relatives Program,

3. Disabled Child Living at home program,

4. Working Disabled,

5. Infants and Children under age nineteen (19) who meet the applicable income requirements,

6. Disabled Adult Child,

7. Protected Foster Care Adolescents,

8. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

9. IV-E Foster Children and Adoption Assistance Children, or

10. An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

F. Persons enrolled in the TBI/SCI Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

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

Rule 4.3: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Personal care services may be furnished by family members provided they are not legally responsible for the individual.

1. The Division of Medicaid defines a person legally responsible for an individual as the parent, or step-parent, of a minor child or an individual's spouse.

2. Family members must meet provider standards and must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

3. There must be adequate justification for the family member to function as the attendant.

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

Rule 4.4: Quality Assurance Standards

A. Waiver providers must meet applicable quality assurance standards.

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

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

Rule 4.5: Covered Services

A. The Division of Medicaid covers the following TBI/SCI Waiver services:

1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver and other services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.

   a) Case Management services must be provided by Mississippi Department of Rehabilitation Services (MDRS) TBI/SCI counselors/registered nurses who meet minimum qualifications listed in the waiver.

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

      1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care.

      2) Provide ongoing monitoring of the services included in the beneficiary's plan of

care.

3) Develop, review, and revise the plan of care at intervals specified in the waiver.

4) Conduct monthly contact and quarterly face-to-face visits with the beneficiary.

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

2. Attendant Care services are defined as support services provided to assist the beneficiary in meeting daily living needs and to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

a) Attendant Care is non-medical, hands-on care of both a supportive and health related nature and does not entail hands-on nursing care.

b) Services must be provided in accordance with the approved plan of care and is not purely diversional in nature.

c) Services may include, but are not limited to the following:

1) Assistance with activities of daily living defined as assistance with eating, bathing, dressing, and personal hygiene.

2) Assistance with preparation of meals, but not the cost of the meals.

3) Housekeeping chores essential to the health of the beneficiary including changing bed linens, cleaning the beneficiary's medical equipment and doing the beneficiary's laundry.

4) Assistance with community related activities including escorting the beneficiary to appointments, shopping facilities and recreational activities. The cost of activities or transportation is excluded.

d) Attendant Care providers must meet minimum requirements as specified in the waiver. MDRS TBI/SCI counselors and registered nurses are responsible for certifying and documenting that the provider meets the training and competency requirements as specified in the current waiver document.

e) Attendant Care services may be furnished by family members provided they are not legally responsible for the individual.

1) The Division of Medicaid defines legally responsible for an individual as the parent (or step-parent) of a minor child or an individual's spouse.

2) Family members must meet provider standards and they must be certified

competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

3) There must be documented justification for the relative to function as the attendant.

3. Respite services are defined as services to assistance beneficiaries unable to care for themselves. Respite care is furnished on a short-term basis because of the absence of, or the need to provide relief to, the primary caregiver(s).

   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 Department of Rehabilitation Services.

4. Specialized medical equipment and supplies are defined as devices, controls, or appliances that will enhance the beneficiary's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

   a) The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.

   b) Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under Medicaid.

   c) Items not of direct medical or remedial benefit to the beneficiary are excluded.

   d) Equipment and supplies must meet the applicable standards of manufacture, design, and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

5. Environmental Accessibility Adaptation is defined as those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence, and without which, the beneficiary would require institutionalization.

   a) The need for these adaptations must be identified in the approved plan of care.

   b) Environmental accessibility adaptations include the following:

      1) Installation of ramps and grab bars the widening of doorways.

      2) Modification of bathroom facilities.

3) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

c) Environmental accessibility adaptations exclude the following:

1) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.

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

d) Providers rendering environmental accessibility adaptations must:

1) Meet all state or local requirements for licensure of certification.

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

3) Ensure the quality of work meets standards identified in the waiver.

e) MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

6. Transition Assistance services are defined as services provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the TBI/SCI Waiver program.

a) Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars ($800.00) for the one (1) time initial expense per lifetime. The expenses must be included in the approved plan of care.

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

1) Be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid.

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

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

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

c) Transition Assistance Services include the following:

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

2) Essential furnishings defined as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Televisions and cable TV access are not essential furnishings.

3) Moving expenses.

4) Fees/deposits for utilities and service access for a telephone.

5) Health and safety assurances defined as pest eradication, allergen control, or one-time cleaning prior to occupancy.

d) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); 42 CFR 440.180

Rule 4.6: Prior Approval/Certification

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility.

B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.

C. The physician must certify the level of care.

D. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. A brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

E. The Plan of Care must be developed by the case manager and, in conjunction with the Pre-Admission Screening, should contain objectives, types of services to be furnished, and frequency of services.

F. After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, the application along with the Plan of Care (POC) must be submitted to the Division of Medicaid for approval.

G. At the time of the initial certification, the Pre-Admission Screening and the Plan of Care must be completed jointly by the TBI/SCI counselor and registered nurse.

H. At the time of recertification, the Plan of Care must be completed by the IL counselor or the registered nurse.

I. A beneficiary can only be enrolled in one HCBS waiver program at a time.

J. Request to add or change services listed on the approved plan of care requires prior approval.

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

Rule 4.7: Documentation and Record Keeping

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth for applicable waiver quality assurance standards. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. Waiver providers must submit copies of all service logs/documentation of visits.

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

Rule 4.8: Beneficiary Cost Sharing

A. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver.

B. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

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

Rule 4.9: Reimbursement

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

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Due Process Protection

Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

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

Rule 4.11: Hearings and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated,

or reduced may be appealed.

1. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

2. All appeals must be in writing.

B. The beneficiary/legal representative is entitled to initially appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor.

C. If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid no later than five (5) days after notification of the state level appeal.

D. The Division of Medicaid must assign a hearing officer.

E. The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case and the beneficiary/legal representative will receive written notification of the decision.

F. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations, or sexual harassment by the service providers. The TBI/SCI counselor/registered nurse is responsible for ensuring that the beneficiary, receive all services that were in place prior to the notice of change.

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

Part 208 Chapter 5: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver

Rule 5.1: Eligibility

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

1. Are operated jointly with the Mississippi Department of Mental Health (DMH). The Division of Medicaid is the single state Medicaid agency having administrative responsibility in the administration and supervision of the ID/DD Waiver. DMH is responsible for the daily operation of the ID/DD Waiver,

2. Are available statewide, and

3. Carry no age restrictions for eligibility.

B. All of the following eligibility requirements must be met to receive ID/DD Waiver services:

1. Applicant must require a level of care (LOC) found in an ICF/IID.

2. Applicant must qualify for full Medicaid benefits in one (1) of the following eligibility categories:

a) Supplemental Security Income (SSI),

b) Parents and Other Caretaker Relatives Program,

c) Disabled Child Living at Home Program,

d) Working Disabled,

e) Infants and Children Under Age Nineteen (19) who meet the applicable income requirements,

f) Protected Foster Care Adolescents,

g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

h) Title IV-E Foster Children and Adoption Assistance Children,

i) Disabled Adult Child,

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

3. Applicant must have one (1) of the following:

a) An intellectual disability based on the following criteria:

1) An IQ score of approximately seventy (70) or below,

2) A determination of deficits in adaptive behavior, and

3) Disability which manifested prior to the age of eighteen (18).

b) A developmental disability, defined by the Division of Medicaid as a severe, chronic disability attributable to a mental or physical impairment including, but not limited to, cerebral palsy, epilepsy, or any other condition other than mental illness found to be

closely related to an intellectual disability that results in impairments requiring similar treatment or services. A developmental disability must:

1) Have manifested prior to age twenty-two (22) and be likely to continue indefinitely,

2) Result in substantial functional limitations in three (3) or more of the following major life activities:

   (a) Self-care,

   (b) Understanding and use of language,

   (c) Learning,

   (d) Mobility,

   (e) Self-direction, or

   (f) Capacity for independent living.

3) Include individuals with a developmental delay, specific congenital or acquired condition from birth to age nine (9) that does not result in functional limitations in three (3) or more major life activities, but without services and supports would have a high probability of having three (3) or more functional limitations later in life, and

4) Require a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.

c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

C. Persons enrolled in the ID/DD Waiver can only be enrolled in one (1) home and community-based services (HCBS) waiver program at a time and must receive at least one (1) service a month to remain eligible for the ID/DD Waiver, and the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan.

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

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

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

Rule 5.2: Provider Enrollment

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

   1. Occupational therapists,

   2. Speech-language pathologists,

   3. Physical therapists, and

   4. Providers of specialized medical supplies.

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

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

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

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

Rule 5.3: Freedom of Choice of Providers

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver participants 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 participant 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 choice made by the participant and/or guardian or legal representative must be documented and signed by the participant and/or guardian or legal representative and

maintained in the ID/DD Waiver case record.

Source: 42 USC § 1396a; 42 CFR §§ 431.51, 441.302; 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 5.4: 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 participants when approved by the 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, current vehicle insurance and registration.

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 participant services, regardless of funding source, to ensure the participant's health and welfare needs are met.

a) Support Coordination activities must include:

1) Developing, reviewing, revising and ongoing monitoring and assessing of each participant's PSS which must include,

(a) Information on the individual's health and welfare, including any changes in health status,

(b) Information about the individual's satisfaction with current services(s) and providers(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 participant, and

(f) Ensuring all services an individual receives, regardless of funding source, are coordinated to maximize the benefit for the individual.

2) Informing each participant about all services offered by certified providers on the participant's PSS.

3) Submitting all required information for review, approval, or denial to the Department of Mental Health (DMH).

4) Notifying each participant 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 participant's health and welfare, and effectiveness of the back-up plan monthly,

2) Speak with the participant 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 individual's progress and accomplishments,

6) Review the individual's satisfaction with services and providers,

7) Identify any changes to the individual'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 participant and/or guardian or legal representative in the ID/DD Waiver support coordination contact summaries,

11) Inquire and document about each participant's health care needs and changes during monthly and quarterly contacts,

12) Review quarterly reports summarizing the level of support provided to each participant and compare the summary with the PSS for consistency,

13) Perform all necessary functions for the participant's annual recertification of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care (LOC),

14) Educate families on the participant's rights and the procedures for reporting instances of abuse, neglect, and exploitation, and

15) Compete the Risk Assessment Tool to be included in each provider's plan for the individual.

2. In-Home Nursing Respite is defined by the Division of Medicaid as services provided in

the individual's family's home to provide temporary, periodic relief to the primary caregivers of eligible participants 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) participant 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 participant 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 participant to be accompanied on short outings,

7) May be provided on the same day as other ID/DD Waiver services, but not during the same time period. Participants may receive the following services can be received on the same day:

(a) Day Service-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 participants:

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, or

(c) Host Home services.

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 participant's primary caregiver and promote the health and socialization of the participant through scheduled activities.

a) Community Respite service providers must:

1) Provide the participant with assistance in toileting and other hygiene needs,

2) Offer participants a choice of snacks and drinks, and

3) Have meals available if respite hours are during normal meal time.

b) Community Respite services are not provided:

1) To participants overnight,

2) To participants 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.

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 participant is not receiving day services or is not at work.

3) Oversee the participant's health care needs by assisting with:

(a) Scheduling medical appointments,

(b) Transporting and accompanying the participant to appointments, and

(c) Communicating with medical professionals if the participant 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) Headboard,

(4) Chest,

(5) Night stand, and

(6) 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 participant's PSS prior to beginning work with the participant.

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 individual 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 participants who are at least eighteen (18) years of age.

d) Supervised Living services are not provided to participants 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 individuals 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 participants 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 services may be provided in settings owned or leased by a provider agency or settings owned or leased by participants.

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 participant resides,

2) Have a community integration component that meets each participant'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 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 participant assistance with eating/drinking as needed and as indicated in each participant's PSS.

4) Offer choices of food and drinks to participants and provide:

(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.

c) Day Service-Adult participants:

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 participants 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.

5) Cannot otherwise be eligible under a program funded under the Rehabilitation Act of 1973, 29 USC § 110 or the Individuals with Disabilities Education Act (IDEA), 20 USC § 1400-01.

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 USC § 110 or IDEA, 20 USC § 1400-01.

   a) Prevocational Services must:

      1) Be reflected in the participant's PSS and be related to habilitative rather than explicit employment objectives.

      2) 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.

      3) Have procedures to ensure food/drink is available to anyone who might forget lunch/snacks.

      4) 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.

      5) Include a review with staff and the ID/DD Waiver support coordinator for the necessity and appropriateness of the services, when a participant earns more than fifty percent (50%) of the minimum wage.

      6) 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 participants about Supported Employment and other competitive employment opportunities in the community.

3) Offer community job exploration to participants 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 participant 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 participant who attends twenty-two (22) working days in a month.

c) Prevocational service participants:

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.

5) May also receive Crisis Intervention services on the same day during the same time.

7. Supported Employment services are defined by the Division of Medicaid as ongoing support enabling participants to obtain and maintain competitive employment. These services cannot otherwise be available under the Rehabilitation Act of 1973, 29 USC § 110 or IDEA, 20 USC § 1400-01.

a) Supported Employment services include:

1) Activities needed to sustain paid work by individuals 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 participant in achieving self-employment, but does not pay for expenses associated with starting up or operating a business, including the following:

(a) Aiding the participant 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 participant 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 participants 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 participants to receive other services in addition to Supported Employment if included in the approved PSS which include educational, Prevocational, Day Services-Adults, 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. Participants 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 participant'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 participant's residence and job site and between habilitation sites.

(b) Providers cannot bill separately for transportation services and cannot charge participants 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 participant's ID/DD Waiver support coordinator of any changes affecting the participant's income, and

2) Collaborate with the participant's support coordinator to maintain eligibility under the ID/DD Waiver and health and income benefits through the Social Security Administration.

8. Home and Community Supports (HCS) are defined by the Division of Medicaid as a range of services provided to participants 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) individuals who have a common direct service provider agency. Services ensure the participant 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 participant's private residence and/or community settings.

a) HCS services include:

1) Hands-on assistance or cueing/prompting the participant to perform a task.

2) Accompanying and assisting the participant in accessing community resources and participating in community activities.

3) Medication administration and other medical treatments to the extent permitted by current State law. Assistance with activities of daily living (ADLs) and

instrumental activities of daily living (IADLs) such as bathing, toileting, transferring and ambulation, meal preparation and assistance with eating.

4) Supervision and monitoring of the participant in the home, during transportation, and in the community.

5) Assistance with housekeeping directly related to the participant's disability and is necessary for the health and well-being of the participant. This cannot comprise the entirety of the service.

6) Assistance with money management, but not receiving or disbursing funds on behalf of the participant.

7) Grocery shopping, meal preparation and assistance with feeding, not to include the cost of the groceries.

8) Transportation as an incidental component, which is included in the rate paid to the provider. Providers must possess a valid driver's license, current insurance, registration 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 participant,

(b) Is the parent/step-parent of the participant,

(c) Is a spouse,

(d) Legal guardian/representative, or

(e) Anyone else who is normally expected to provide care for the participant.

3) Exceed forty (40) hours per week when provided by a DMH approved family member.

4) Be provided to participants:

(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.

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 participants 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. Behavior Support services cannot replace educationally related services available under IDEA, 20 USC § 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 participant 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 beneficiary's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for those behaviors, and how those particular behaviors impact the beneficiary'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 beneficiary 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 participant'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 participant's approved PSS,

        3) Are only available under the ID/DD Waiver when not available through the IDEA, 20 USC § 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 participant'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 Hygiene,

6) Planning and preparing meals,

7) Cleaning,

8) Transportation or assistance with securing transportation,

9) Assistance with ambulation and mobility,

10) Supervision of participant's safety and security,

11) Supervision of banking, budgeting, and shopping, and

12) Facilitation of participant's inclusion in community activities.

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 disburse funds on the part of the participant, and

4) Not sleep during billable hours.

c) Supported Living participants:

1) May share Supported Living services with up to three (3) participants 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 participant, and

(b) Health and welfare can be assured for each participant.

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 participant'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 participant 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.

d) The support coordinator must obtain approval from DMH within five (5) days of a participant's receipt of crisis intervention services.

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 participant'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 participant with behavioral and emotional support necessary to allow the participant 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 participant 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 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 participant's physical, social, and emotional well-being and growth in a family environment.

a) Host Home services are limited to one (1) participant 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, and

4) Ensure the participant 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 participant 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 participants must be:

1) At least eighteen (18) years of age, and

2) Able to self-administer their medications.

f) Host Home participants 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 participant'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 participant 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 participants 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 participants are not eligible for the following ID/DD Waiver services during the same time on the same day:

1) Prevocational services,

2) Day Services-Adult, or

3) Supported Employment.

17. Transition Assistance is defined by the Division of Medicaid as a one-time, setup expense for individuals 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 participant is using transitional funds from other sources.

a) Participants are eligible for transition assistance if:

1) There is no other funding source to attain essential furnishings to establish basic living arrangements,

2) The participant is transitioning from a setting where essential furnishings were provided, and

3) The participant 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 participant's basic living arrangement and must be on the participant'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 participants use and are property of the participant.

Source: 20 USC § 1401; 42 USC § 1396n; 42 CFR §§ 431.53, 440.170, 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: 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.

B. Services can only be provided to participants 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.

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

History: 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. All Department of Mental Health (DMH) providers, including support coordinators, 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 participant and/or guardian or legal representative upon admission and annually thereafter, oral and written communication of:

   1. DMH's program procedures for protecting participants 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 participant'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 participant and/or his/her guardian or legal representative.

c) Include a signed form that states the participant 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 participant receiving services. Incident reports regarding the serious event/incident must be completed and maintained in a central file on site that is not the participant's case record. A description of the event/incident must be documented in the participant's case record.

F. Death of an individual 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 individual 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 participant 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 physical or chemical, that is not part of a participant's Plan of Services and Support, Crisis Intervention Plan or Behavior Support Plan. 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 individual'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 individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition,

8. Incidents involving participant 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 USC § 1396n; Miss. Code Ann. §§ 41-4-7; 43-13-121.

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

Rule 5.9: Medication Management and Medical Treatment

A. Nurses employed by an agency enrolled as an Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver provider must practice within the current guidelines outlined in the Mississippi Nurse Practice Act and applicable state and federal laws and regulations, regardless of the setting.

   1. A registered nurse (RN) and/or licensed practical nurse (LPN) must be supervised by appropriately qualified staff through a home health agency or other entity allowed by state and federal laws and regulations.

   2. RNs and LPNs must be employed by a Medicaid provider and work under the direction of physician, physician assistant or nurse practitioner.

   3. If a participant cannot self-administer medications and the guardian or legal representative is unavailable, only a licensed nurse, nurse practitioner, physician, physician assistant or dentist may administer or oversee administration of medications at ID/DD Waiver program sites in the community or in the home setting.

B. The following practices must be in place to protect the health and safety of a participant who requires medications or medical procedures/treatments:

   1. Medications must be stored appropriately in their original containers if a licensed nurse is to administer them.

   2. Licensed nurses may not prepare medications in a medication planner for a non-licensed provider(s) to dispense in his/her absence.

   3. All medications must be documented in the participant's record by the appropriately licensed medical professional administering them.

   4. Documentation must reflect whether the guardian or legal representative administers the participant's medications or if a participant self-administers his/her medications.

   5. RNs must assess the participant for medication side effects and report any suspected side effects or untoward effects to the practitioner who prescribed them. Suspected side effects or potential health issues noted by an LPN must be reported promptly to an RN or appropriately qualified staff.

   6. The first-line responsibility for monitoring a participant's medication regimen lies with the licensed medical professional who prescribes the medication. A licensed medical professional is defined by the Division of Medicaid as a physician, physician assistant, certified nurse practitioner, or licensed dentist who meets the state and federal licensing and/or certification requirements.

   7. Second-line monitoring must be provided by the staff in the supervised living setting

which focuses on areas of concern identified by the physician and/or pharmacist.

C. Supervised Living providers must make arrangements for a licensed nurse to administer medication(s) if a participant who requires medication cannot self-administer while receiving services. With the participant's permission, the licensed nurse or employing agency may accompany the participant to physician visits and/or communicate with the participant's physician. After communicating with the physician, the licensed nurse employed by the Supervised Living provider or employing agency, must document the following:

   1. Physician visits including the reason for the visit,

   2. Physician instructions/orders,

   3. New prescriptions including any detailed pharmacy information supplied with the prescription, and

   4. Any pertinent information regarding the participant's medical status.

D. All medical treatments prescribed by a physician, physician assistant, or nurse practitioner must be provided or administered by a licensed nurse.

   1. Documentation must contain an assessment of the treatment and the name of the healthcare professional, including credentials, who performed the required medical treatment.

   2. If the physician, physician assistant, or nurse practitioner orders the participant and/or guardian or legal representative be taught to provide or administer treatments, only an RN may provide this service in accordance with current Mississippi nursing laws, rules and regulations.

E. Providers must have policies and procedures for the frequency of monitoring behavior, medication administration, side effects and adverse reactions.

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

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

Rule 5.10: Documentation and Record Maintenance

A. Documentation of each Intellectual Disabilities/Developmental Disabilities (ID/DD) service provided must be in the case record. [Refer to Miss. Admin. Code, Part 200, Rule 1.3.]

B. The entry or clinical note must include all of the following documentation:

   1. Date of service,

2. Type of service provided,

3. Time service began and time service ended,

4. Length of time spent delivering service,

5. Identification of participant(s) receiving or participating in the service,

6. Summary of what transpired during delivery of the service,

7. Evidence that the service is appropriate and approved on the PSS, and

8. Name, title, and signature of individual providing the service.

C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:

1. Documentation requirements in the Centers for Medicare and Medicaid Services (CMS) approved ID/DD Waiver,

2. DMH Operational Standards,

3. Evidence that the service is appropriate and approved on the PSS, and

4. Documentation requirements in the DMH Record Guide.

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

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

Rule 5.11: Beneficiary Cost Sharing

A. For beneficiaries covered under a HCBS waiver, the co-payment is exempt if the service is being paid through the waiver.
B. If services are being paid through Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Miss. Admin. Code Part 200, Rule 3.7.

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

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

Rule 5.12: Grievances and Complaints

A. The Department of Mental Health (DMH) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. Grievances may be made via phone, written letter format or email.

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

C. A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.

D. Providers of waiver services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.

E. All grievances must be resolved within thirty (30) days of receipt by DMH unless additional time is required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from DMH of the resolution and all activities performed in order to reach the resolution.

Source: Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: 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.

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

Chapter 6: Bridge to Independence (B2I)

Rule 6.1: General

A. Bridge to Independence (B2I), Mississippi's Money Follows the Person (MFP) initiative, is a six (6) year federal demonstration grant that was awarded to the Division of Medicaid on April 1, 2011, and is funded by the United States Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS).

B. The purpose of B2I is to establish a person-driven and sustainable home and community-based long-term care system offering choice and access to quality services in the community for institutionalized individuals:

   1. With a physical disability,

   2. With a mental illness,

   3. With an intellectual or developmental disability, or

   4. Sixty-five (65) years of age or older.

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

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

Rule 6.2: Eligibility

A. To participate in the Bridge to Independence (B2I) demonstration project, the person:

   1. Must reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or a nursing facility for at least ninety (90) consecutive days with at least one (1) day of the stay reimbursed by Medicaid.

   2. Cannot have received short-term rehabilitation services reimbursed under Medicare during the ninety (90) day stay requirement.

   3. Must be eligible for one (1) of the following Medicaid Home and Community-Based Services (HCBS):

a) Assisted Living (AL) Waiver,

b) Elderly and Disabled (E&D) Waiver,

c) Independent Living (IL) Waiver,

d) Intellectual Disability/Developmental Disability (ID/DD) Waiver,

e) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, and/or

f) Community Mental Health Center (CMHC) Services/Rehabilitation option of the State Plan.

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

B. Qualified residences for transitioning persons must pass a U.S. Department of Housing and Urban Development Housing Quality Standards inspection and meet one (1) of the following criteria:

1. A home owned or leased by the transitioning person or the person's family member,

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

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

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

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

Rule 6.3: Covered Services

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

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

1. Transition Care Management includes:

   a) Crisis Support, defined as a response to the transitioning person and/or person's caregiver who is experiencing a crisis event during the transition process.

      1) The service must be available twenty-four (24) hours a day, seven (7) days a week.

      2) Initial contact may take place over the telephone, but if the situation is determined to be an emergency, the provider must provide in-person support.

      3) Staff must be available to meet with the person in transition, as well as any other member of the person-centered planning team, to resolve the crisis and thereby enable the person to remain in the community.

   b) Person-Centered Planning (PCP), defined as a process directed by the person or family with long-term care needs which:

      1) Identifies the strengths, capacities, preferences, needs and desired outcomes of the person.

      2) Includes participants freely chosen by the person or family who are able to serve as important contributors.

      3) Assists the person to identify and access personalized paid and non-paid services and supports.

      4) The person identifies planning goals to achieve those personal outcomes in collaboration with those that the person has identified, including medical and professional staff.

      5) The identified personally-defined outcomes and the training supports, therapies, treatments and/or other services the person is to receive to achieve those outcomes as part of the Plan of Services and Supports (PSS).

      6) Meets all the following minimum PCP service contact requirements:

         (a) Initial PCP meeting held within thirty (30) days of the person choosing a B2I provider,

         (b) Pre-transition PCP meeting held a minimum of every thirty (30) days,

         (c) Post-transition PCP meeting held a minimum of every sixty (60) days, and

         (d) Interim PCP meetings held as circumstances change, the person and/or guardian or legal representative requests a meeting, and/or the needs of the

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

7) Includes the following documentation in the enrolled person's record:

   (a) Discovery interviews including, but not limited to, Community Navigator Notes, dates, and individuals interviewed, such as the person and caregivers,

   (b) Activities and observations including, but not limited to, activity, location, Community Navigator Notes, and dates,

   (c) Profile,

   (d) Dated Action Plans from each PCP meeting,

   (e) Sign-in sheets of all meetings and dates, and

   (f) Minutes from all PCP meetings.

8) Includes the development of the PSS which is retained in the person's record and contains:

   (a) B2I services, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided,

   (b) Other services received, regardless of payer source, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided, and

   (c) Narrative of services, supports, needs and outcomes.

9) Includes a Risk Mitigation Plan, defined as a comprehensive and pro-active safety/risk mitigation plan developed to address any safety issue/risk that has been identified through discovery and planning. The Risk Mitigation Plan must be retained in the person's record and address any safety issue/risk in the following categories and include a detailed mitigation plan for any safety issue/risk including, but not limited to:

   (a) Medical and physiological,

   (b) Behavioral and psychiatric,

   (c) Environmental including, but not limited to, living conditions or loss of a home,

   (d) Financial,

(e) Activities of daily living including, but not limited to, loss of natural supports,

(f) Service disruption,

(g) Legal including, but not limited to, prior convictions and recidivism risk,

(h) Natural disaster plan including, but not limited to, fire, flooding, hurricane and earthquake evacuation plan including emergency contact information,

(i) B2I provider staff contact number available twenty-four hours a day, seven days a week (24/7),

(j) Emergency contact numbers including, but not limited to, 911, local law enforcement office, local hospital, and regional CMHC, and

(k) A written and oral explanation of appropriate responses to emergencies, including health or mental health emergencies versus situations in need of immediate attention, including broken medical equipment or failure of a service provider to make an appointment.

2. Transition Care Management must be provided by a qualified community navigator who cannot be the person's HCB waiver/CMHC case manager and who meets the criteria in one (1) of the following:

   a) Licensed social worker (LSW) with valid state license and a minimum of one (1) year of relevant work experience,

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

   c) Registered nurse (RN) with valid state license and a minimum of one (1) year of relevant work experience, or

   d) Others with relevant experience and training with a minimum of a bachelor's degree and one (1) year of work experience in a social or health service setting or a comparable technical and human service training will be considered and approved by the Division of Medicaid, B2I.

3. The community navigator must document in a narrative form in a Community Navigator Notes section in the record all contacts made with, about and/or on behalf of the person and include:

   a) Date of the service,

   b) Beginning and end time of the service,

c) Type of contact including, but not limited to, face-to-face, phone, e-mail, PCP meeting notes and activities, meetings and third party calls,

d) Who the contact was with including, but not limited to, the person, family member, community/natural resource, service providers, and housing partners,

e) Reason for the contact as well as the content and issues discussed,

f) All follow-up activities,

g) When, why, and what type of information is received about or by the person,

h) When, why, and what type of information is sent to another party about the person,

i) Any change in services,

j) Other situations based on individual circumstances, and

k) Community navigator's signature.

4. A Community navigator must provide the following minimum service contacts:

a) Face-to-face meeting with the person and interested parties scheduled within ten (10) days of a B2I provider receiving referral,
b) One (1) contact per week with the person and/or family which includes during the Pre-Transition period up to one hundred eighty (180) days and the Post-Transition period during the first ninety (90) days,

c) One (1) face-to-face visit per month with the person Pre-Transition and Post-Transition, not including PCP meeting,

d) One (1) PCP team meeting every thirty (30) days Pre-Transition and every sixty (60) days Post-Transition with the initial PCP meeting held within the first thirty (30) days after the Consent to Participate Phase II is signed, and

e) One (1) contact per month with an assigned HCB waiver/CMHC case manager to ensure service coordination during the Post-Transition period.

5. A community navigator's case load cannot exceed:

a) A total of thirty (30) persons, or

b) Fifteen (15) persons in each of the following categories:

1) Pre-Transition refers to persons for whom a community navigator is providing Transition Care Management services on an ongoing basis prior to transition up to one hundred eighty (180) days and in the first ninety (90) days after transition.

2) Ninety (90) days Post-Transition refers to persons for whom a community navigator is continuing to provide ongoing Transition Care Management services but whose primary health care oversight and management responsibilities have been turned over to appropriate HCB waiver/CMHC case managers.

B. Life Skills Training, defined as assisting persons with transitioning to the community through independent living skills that include, but are not limited to, money management, the use of technology, accessing community resources, employment skills development, grooming and personal hygiene, and interpersonal relationships with others in the community.

1. A life skills service plan must be developed with the person's input to address life skills needed which must be contained in the person's record and include:

a) Date of life skills service plan,

b) Life skills to be addressed,

c) Activities used to meet the life skill need, and

d) Date of goals met and improvement of life skills.

2. Documentation of services provided must be retained in the person's record and contain:

a) Date of the service,

b) Beginning and end time of the service delivery,

c) Description of the service, and

d) Signature of staff person providing service.

C. Peer Supports, defined as counseling from peers with similar circumstances who may be able to share their own experiences with the person to reduce feelings of isolation and to promote inclusion.

1. Peer supporters must meet the following criteria:

a) Be a resident of Mississippi,

b) Self-identify as a current or former recipient of disability services for persons with physical, intellectual, developmental, and/or mental disabilities,

c) Complete all training required by the provider agency,

d) Demonstrate a minimum of six (6) consecutive months in self-directed recovery and/or of successful community living, and

e) Demonstrate emotional readiness to provide supports to a peer.

2. Documentation of services provided must be retained in the person's record and contain:

a) Date of the service,

b) Beginning and end time of the service delivery,

c) Description and summary of the service, and

d) Signature of staff person providing the service.

D. Caregiver Support, defined as a service to enable the caregiver to transition into a more active role and to assist identified and qualified caregivers of persons enrolled in B2I to cope with stress and to develop caregiver skills in order to help them become a source of support for the transitioning person. Caregivers qualified to receive caregiver support must perform or assist the person in one (1) or more life activities, such as finances, health care, or general decision making, and includes:

1. Peer-to-Peer service designed for identified caregivers of the person enrolled in B2I to assist with the management of stress and the development of caregiver skills and must be provided by an individual who must:

a) Identify as a former or current caregiver of someone with a physical, intellectual, developmental or mental disability,

b) Complete all training required by the provider agency, and

c) Demonstrate emotional readiness to provide emotional support to another caregiver and understand when to seek professional help for a caregiver.

2. Individual Therapy Support, defined as services designed to assist identified caregivers of the person enrolled in B2I through therapy/counseling sessions and must be:

a) Provided by an individual who holds a master's degree and professional license as a licensed professional counselor (LPC), licensed psychologist, licensed certified social worker (LCSW) or licensed marriage and family therapist (LMFT), and

b) Documented in the person's record and contain:

1) Date of the service,

2) Beginning and end time of the service delivery,

3) Description and summary of the service, and

4) Signature of staff providing service.

E. Transportation, defined as any appropriate form of transporting the person from one (1) location to another to maximize community inclusion for the person.

1. Documentation of services provided must be retained in person's record and contain:

a) Date of service,

b) Time of service,

c) Destination to and from, and

d) Signature of staff providing service.

F. Security and Utility Deposits, defined as specific up-front costs to establish a residence in the community with detailed receipts retained in the person's record.

G. Household Furnishings and Goods, defined as, but not limited to, essential items and furnishings, appliances, household supplies, and pantry items required to set-up a household in the HCB setting based on the needs of the person with detailed receipts retained in the person's record.

H. Moving Expenses, defined as moving costs associated with a transition for items transported from the facility in which the person is residing to their new community residence or community-based setting and may also cover commercial transportation of household furnishings from a store to the person's community residence or community-based setting with detailed receipts retained in the person's record.

I. Environmental Accessibility Adaptations, defined as certain required modifications completed by a licensed and bonded contractor to the person's residence to enable the care of the person in a HCB setting with detailed receipts retained in the person's record. Only persons enrolled in the E&D or ID/DD Waivers are eligible for Environmental Accessibility Adaptations.

J. Durable Medical Equipment (DME), defined as medically necessary equipment, based on the person's PSS, which allows for community living. Only persons enrolled in the E&D, ID/DD or AL Waivers are eligible for DME.

K. Extended Pharmacy, defined as up to three (3) additional prescriptions over the Medicaid five (5) prescription limit allowed in the State Plan for a total not to exceed eight (8)

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

1. The person is only eligible for the extended pharmacy benefit if their prescriptions are in excess of the Medicaid monthly prescription limit.

2. Community navigators must assist the person in managing the extended pharmacy benefit to access needed pharmacy services under existing options in the Mississippi State Plan.

3. Community navigators must coordinate with the person's community providers including, but not limited to, physicians and pharmacists for medication management.
4. The person enrolled in B2I should utilize preferred medications on the Universal Preferred Drug List (PDL) and the Ninety (90) Day Maintenance List when possible, to maintain the person on the least amount of prescriptions required for therapeutic benefit.

L. Adaptive Equipment/Technology, defined as an assistive equipment/technological device which includes an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, used to increase, maintain, or to improve the person's level of independence, ability to access needed supports and services in the community or maintain or improve the person's safety with detailed receipts retained in the person's record.

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

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

Rule 6.4: Quality Management

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

A. A twenty-four (24) hours a day, seven (7) days a week crisis and response system,

B. A critical incident reporting system, and

C. A system to assess and mitigate risks to individuals.

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

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

Rule 6.5: Appeals and Hearings

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

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

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

Part 208 Chapter 7: 1915(i) HCBS Services

Rule 7.1: Eligibility

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

1. Offer broad discretion, not generally afforded, so that the needs of beneficiaries under the State Medicaid Plan may be addressed,

2. Are operated jointly with the Mississippi Department of Mental Health (DMH),

3. Are available statewide,

4. Carry no age restrictions, and

5. Are covered only for beneficiaries not enrolled in any HCBS Waiver program.

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

1. A beneficiary must have one (1) of the following:

a) An intellectual disability defined by the Division of Medicaid as meeting all the following criteria:

1) An IQ score of approximately seventy (70) or below,

2) A determination of deficits in adaptive behavior, and

3) Manifestation of disability prior to the age of eighteen (18).

b) A developmental disability defined by the Division of Medicaid as a severe, chronic disability which is a condition attributable to cerebral palsy, epilepsy, or any other

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

1) The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely.

2) The condition results in substantial functional limitations in three (3) or more of the following major life activities:

   i) Self-care,

   ii) Understanding and use of language,

   iii) Learning,

   iv) Mobility,

   v) Self-direction, or

   vi) Capacity for independent living and economic self-sufficiency.

3) The individual also requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.

4) An exception to this definition is an individual, from birth to age nine (9), who has a substantial developmental delay or specific congenital or acquired condition. He or she may be considered developmentally disabled without meeting all of the above criteria if, without services and supports, there is a high probability of meeting those criteria later in life.

c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

2. Applicant must qualify for full Medicaid benefits in one (1) of the following categories:

   a) SSI,

   b) Low Income Families and Children Program,

   c) Disabled Child Living at Home Program,

   d) Working Disabled,

e) Children Under Age Nineteen (19) Under 100% of Poverty,

f) Protected Foster Care Adolescents,

g) CWS Foster Children and Adoption Assistance Children,

h) IV-E Foster Children and Adoption Assistance Children, or

i) Child under Age six (6) at 133% Federal Poverty Level.

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

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

Rule 7.2: Provider Enrollment

A. Division of Medicaid 1915(i) providers must be certified by the Mississippi Department of Mental Health (DMH), Bureau of Quality Management, Operations and Standards (BQMOS). DMH Certification is dependent upon compliance with the Mississippi Department of Mental Health Operational Standards.

B. The provider must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the 1915(i) services and have a current Mississippi Medicaid provider number.

C. All providers must comply with the CMS approved 1915(i) State Plan.

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

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

Rule 7.3: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Case Managers must inform the beneficiary/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. The choice made by the beneficiary/legal representative must be documented and signed by the beneficiary/legal representative and must be maintained in the beneficiary's record.

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 7.4: 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 beneficiary 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 POC by the Case Manager and approved by the DMH/BIDD, and

3. Multiple 1915(i) services on the same day but not during the same time of the day.

B. Transportation between the beneficiary'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 beneficiaries for transportation.

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

1. Day Support Services defined by the Division of Medicaid as services designed to assist the beneficiary 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 Support Services:

   a) Must take place in a non-residential setting separate from the home or facility in which the beneficiary resides.

   b) 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 beneficiary's POC.

   c) Must be provided in DMH certified sites /community settings.

2. Prevocational Services defined by the Division of Medicaid as services to prepare a beneficiary 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 beneficiary's Plan of Services and Supports and be directed towards habilitative objectives and not explicit employment objectives.

   b) Providers are not required to provide meals but must have procedures to ensure food/drink is available for beneficiaries, if necessary.

   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 beneficiary 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 beneficiary, the provider must pay the beneficiary 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 beneficiary, appropriate staff and the Case manager if the beneficiary 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 beneficiary 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.

3. Supported Employment services defined by the Division of Medicaid as intensive, ongoing support to beneficiaries 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 beneficiary 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 individuals without disabilities. Supported Employment:

a) Is based on an Activity Plan that must be developed for each beneficiary based on his/her Plan of Care.

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 beneficiary in achieving self-employment through the operation of a home or community based business, and may include the following:

    1) Aiding the beneficiary 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 beneficiary 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 beneficiary's place of residence and the site of the beneficiary's job or between or between habilitation sites (in cases where the individual 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: 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 7.6: Serious Events/Incidents and Abuse/Neglect/Exploitation

A. Case Managers and DMH certified providers must receive training at least annually regarding the reporting of suspected abuse/neglect, to include Mississippi's Vulnerable Persons Act.

   1. The training must include what constitutes possible abuse/neglect/exploitation, who must report, and the procedures for reporting and the consequences of not reporting.

   2. Providers are required to receive training about reporting Serious Incidents to the DMH/BQMOS.

B. Providers must provide the beneficiary/legal guardian with the provider's procedures for protecting beneficiaries 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 beneficiary/legal guardian's signature indicating the rights have been explained in a way that is understandable to them.

   4. The beneficiary/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 beneficiary/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/BQMOS.

D. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH/BQMOS, the agency director, and the parent/guardian/legal representative/significant person as identified by the beneficiary receiving services. Documentation regarding the event/incident must be maintained in a central file on site.

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/BQMOS 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 beneficiaries with Alzheimer's disease and/or other dementia.

5. Emergency hospitalization or emergency room treatment of a beneficiary 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.

G. Death of a beneficiary on program property, at a program sponsored event or during an unexplained absence from a residential program site must be reported to the DMH/BQMOS 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/BQMOS.

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 beneficiaries in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU), Office of the State Attorney General (AG) and to the Mississippi Department of Health.

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 Plans of Care, 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 the DMH/BQMOS 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: Social Security Act § 1915(i); Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: 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, Office of Consumer Support (DMH/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/OCS.

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/OCS 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.

E. Request for reports generated through the Information and Referral Database must be made through the Director of BQMOS.

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 7.9: Appeals and Hearings

A. If it is determined that a beneficiary does not meet 1915(i) eligibility criteria or decisions made by the DMH/BIDD result in services being denied, terminated, or reduced the beneficiary/legal representative has the right to request an appeal.

   1. The beneficiary/legal representative has thirty (30) calendar days from the date of the notification of the denial of eligibility or denial, termination or reduction of services to submit an appeal in writing to the Director of BIDD. The beneficiary/legal representative may submit justification with the appeal. The notification must be included with the appeal.

2. The Director of BIDD must respond in writing within thirty (30) calendar days of receipt of the appeal. If sufficient justification was not submitted with the appeal, the Director may request additional information and the time line will be extended an additional thirty (30) days.

3. If the Director of BIDD decides that the denial of eligibility or denial, termination or reduction of services should be reversed, the beneficiary/legal representative will be notified in writing and all services will remain the same.

4. If the Director of BIDD upholds the denial of eligibility or denied, terminated or reduced services the beneficiary/legal representative will be notified in writing.

5. The beneficiary/legal representative may then appeal to the DMH Executive Director. The appeal must be in writing and must be submitted within thirty (30) calendar days of the date on the notification from the Director of DMH/BIDD.

6. The DMH Executive Director must respond in writing within thirty (30) calendar days. If sufficient justification was not submitted with the appeal, the Executive Director may request additional information and the time line will be extended an additional thirty (30) days.

7. The beneficiary/legal representative will receive written notification of the DMH Executive Director's decision.

8. If the beneficiary/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 Part 300 Appeals.

C. Appeal documentation and final determination(s) are filed by DMH/BIDD and the Division of Medicaid.

D. 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 Case Manager is responsible for ensuring that the beneficiary continues to receive all services that were in place prior to the notice of change.

E. Providers who must be certified by the DMH/BQMOS may appeal issues related to certification to DMH as outlined in the DMH Operational Standards and Administrative Code.

Source: Social Security Act § 1915(i); Miss. Code Ann. §§ 41-4-7, 43-13-121.

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