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: HCBS 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. Participant must be twenty-one (21) years of age or older.

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

3. Participant Nursing Facility level of care must be certified by a physician and recertified every twelve (12) months at a minimum.

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

    a. SSI, or

    b. An aged, blind, or disabled individual who meets all factors of eligibility if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible.

B. Participants enrolled in the Elderly & Disabled Waiver cannot reside in a licensed or unlicensed personal care home and are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 435.217; 42 CFR 441.301; 42 CFR 440.180; Social Security Act, Section 1915 (c)

History: Revised – 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 provider must provide written documentation to the Division of Medicaid stating how the required standards are to be met.

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

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

   d. There must be responsible fiscal management.

   e. 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.

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

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

h. 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 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 – 01/01/2013

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 (25^{th}) visit. Starting with the twenty-sixth (26^{th}) 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 (1^{st}) 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

Table of Contents

Title 23: Division of Medicaid

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

Part 208 Chapter 1: HCBS 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. ~~Beneficiary~~ Participant must be twenty-one (21) years of age or older.

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

3. ~~Beneficiary~~ Participant Nursing ~~Home~~ Facility level of care must be certified by a physician and ~~re-evaluated~~ recertified every twelve (12) months at a minimum.

4. ~~Beneficiary~~ Participant must be in one of the following Categories of Eligibility (COE):

   a. SSI, or

   b. An aged, blind, or disabled individual who meets all factors of eligibility ~~can qualify~~ if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible.

B. ~~Beneficiaries~~ Participants enrolled in the Elderly & Disabled Waiver cannot reside in a licensed or unlicensed personal care home and are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 435.217; 42 CFR 441.301; 42 CFR 440.180; Social Security Act, Section 1915 (c)

History: Revised – 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 ~~if it notes the~~ 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 ~~your~~ the provider's tax identification number and legal name.

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

1. ~~Submit a completed proposal package and enter into a provider agreement with the Division of Medicaid.~~ Be approved by Division of Medicaid after submitting a completed proposal package.

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

~~2. Conduct a criminal background check on all employees prior to employment and maintain the record in the employee personnel file.~~

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.

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

~~D.~~ C. Provider Qualifications:

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

2. Providers of Adult Day Care, ~~Homemaker~~ Personal Care Services, and In-Home Respite~~, and Escorted Transportation~~ 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.

      ~~3)~~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.

      ~~4)~~6)The facility must have an advisory committee~~, and the committee must be~~ representative of the community and participant population.

      ~~5)~~7)The facility must have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

      ~~6)~~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.

~~7)~~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.

~~8)~~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.

~~9)~~11) ~~If t~~The facility ~~offers nursing services, there must~~ have ~~be~~ a registered nurse (RN) on staff if the facility ~~to~~ 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.

~~10)~~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.

~~11)~~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.

~~12)~~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.

~~13)~~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.

~~14)~~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 ~~aware~~ trained ~~of~~ in basic transfer techniques and safe ambulation.

~~15)~~17)~~If t~~The facility ~~uses volunteers, there~~ must ~~be a~~ record ~~of the~~ volunteer~~'s~~ 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~~. Duties must be~~ 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 ~~should~~ can use volunteers only on a periodic/temporary basis.

~~4. Qualifications for Homemaker Services:~~

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

~~b) The agency must provide written documentation of the following:~~

~~1) The Division of Medicaid provider agreement that includes the agency's agreement to the waiver requirements.~~

~~2) Governing structure for assuring responsibility and for requiring accountability~~

for performance.

3) Fiscal management.

4) Personnel Management including personnel policies, job descriptions, and the process for recruitment, selection, retention and termination of homemakers.

5) Roster of qualified homemaker staff.

6) Criteria/procedure for the provision of services including procedures for dealing with emergency service requests.

c) Agency must have qualified homemaker supervisors which must have:

1) A bachelor's degree in social work, home economics, or a related field and at least one (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals; or

2) Licensure as a registered nurse (RN) or licensed practical nurse (LPN) and one (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals; or

3) A high school diploma and four (4) years' experience, either full-time or an equivalent, working with aged and disabled individuals; and

4) At least two (2) years supervisory experience, either full-time or an equivalent, preferably in a setting with aged and disabled individuals.

d) The homemaker supervisor may not supervise more than twenty (20) full-time homemakers. Responsibilities include, but are not limited to:

1) Making home visits with the homemaker to observe and evaluate job performance.

2) Submitting supervisor reports and monthly activity sheets.

3) Reviewing/approving service plans.

4) Processing requests for service.

5) Interpreting agency policy and procedure, maintaining appropriate records and reports.

6) Planning and documenting in-service training for homemaker staff.

7) Maintaining accessibility to homemakers for emergencies, case reviews, conferences, and problem solving.

~~e) The homemaker supervisor must report directly to the agency director.~~

~~f) Agency must have qualified homemakers. Requirements for homemakers are as follows:~~

~~1) Eighteen (18) years of age or older.~~

~~2) High school diploma, General Educational Development (GED) Test, or must demonstrate the ability to read the written homemaker assignment and write well enough to complete required forms and reports.~~

~~3) Successful completion and passing a forty (40) hour Homemaker Curriculum Training Course or the equivalent, like a Certified Nursing Assistant.~~

~~4) Valid Mississippi driver license and access to reliable transportation.~~

~~5) Ability to function independently without constant supervision/observation.~~

~~6) Physical ability to perform tasks required.~~

~~7) Absence of communicable diseases as verified by a physician.~~

~~8) Interest in, and empathy for, individuals who are ill, elderly, and/or disabled.~~

~~9) Emotional maturity and ability to respond to individuals and situations in a responsible manner.~~

~~10) Good communication and interpersonal skills; ability to deal effectively, assertively and cooperatively with a variety of people.~~

~~11) Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population.~~

~~12) Experience in caring for aged and disabled individuals is preferable but not required.~~

4. Qualifications for Personal Care Service:

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

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

c. There must be a duly constituted authority and a governing structure for assuring

responsibility and for requiring accountability for performance.

d. There must be responsible fiscal management.

e. 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.

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

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

h. 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 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) ~~Good~~ Effective communication and interpersonal skills ~~and an~~ 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.

~~6. Escorted Transportation Qualifications~~

~~a) All escorted transportation (ET) providers must, at a minimum, meet the qualifications and standards set forth for participation in the state Medicaid program as a non-emergency transportation provider. Refer to Part 201, Chapter 2.~~

~~b) All ET providers must be certified by and enter into a provider agreement with the Division of Medicaid.~~

~~c) The ET provider must not have more than two (2) traffic violations and no driving under the influence (DUI) violations.~~

~~d) Providers must obtain and submit to the Division of Medicaid official copies, provided by the Mississippi Department of Public Safety, of driving records for all drivers employed by the agency.~~

~~e) Service Documentation: Written documentation must be kept for all ET services. Each instance of service delivery must include, but is not limited to, the following:~~

~~1) Date of service,~~

~~2) Time of departure from the beneficiary's residence,~~

~~3) Actual destination,~~

~~4) Time of arrival at destination,~~

~~5) Number of miles traveled to destination,~~

~~6) Time of departure from this location,~~

~~7) Time of return arrival at the beneficiary's residence,~~

~~8) Return mileage driven to the beneficiary's residence,~~

~~9) Name and signature of the individual providing the ET service,~~

~~10) Beneficiary's signature verifying the accuracy of the documentation, and~~

~~11) Beneficiary's Medicaid identification number.~~

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

History: Revised – 01/01/2013

Rule 1.4: Freedom of Choice

A. Medicaid ~~beneficiaries~~ 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. C~~c~~hanges 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 ~~for the E&D Waiver program~~ 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 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.~~c)~~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.

~~A case management team comprised of a registered nurse and a social worker will maintain an average caseload of one hundred (100) active cases with up to five (5) cases pending approval by the Division of Medicaid. Priority will be given to beneficiaries electing to transition from nursing home to a home/community-based setting. If a case manager leaves a team, the remaining case manager will become a single CM team until the vacant position is filled. The remaining case manager will continue to maintain the caseload. Beneficiaries must not be discharged down to fifty (50) nor should new beneficiaries be added until the team member is replaced. Any exceptions must be approved by the Division of Medicaid. The Case Management Supervisor must document all efforts made to find/hire a new team member.~~

e)~~If a team has a social worker and a nurse, both must make each visit. If one (1) member is out on a prolonged leave/absence, the other team member may conduct the~~

~~monthly visits, quarterly visits, readmits, and recertification visits alone. Single, or one (1) member, case management teams may also conduct monthly visits, quarterly visits, readmits, and recertification visits alone. The Case Manager supervisor must review and approve all documents of a single case management team prior to submission to the Division of Medicaid.~~

~~2. Homemaker Services~~

~~a) Homemaker services are supportive services provided or accomplished primarily in the home and must be rendered by a trained homemaker.~~

~~b) Homemaker services will be provided to assist functionally impaired persons to remain in their home by providing assistance with the following:~~

~~1) Activities of daily living,~~

~~2) Housekeeping,~~

~~3) Laundry,~~

~~4) Meal planning,~~

~~5) Marketing,~~

~~6) Food preparation, and~~

~~7) Other types of home management tasks to prevent the risk of institutionalization.~~

~~c) The homemaker and home health aide must not be in the client's home at the same time and must not perform the same services at the same time, maintaining performance of separate duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance must be thoroughly documented.~~

~~3~~. 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 ~~beneficiaries~~ 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 ~~beneficiary~~ participant's assigned case manager.

c. To receive Medicaid reimbursement the ~~beneficiary~~ 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 ~~beneficiary~~ 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 decreases 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 ~~shall~~ provides non-medical care and supervision/assistance to ~~beneficiaries~~ participants unable to care for themselves in the absence of the ~~beneficiary~~ 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 ~~beneficiary~~ 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) ~~Beneficiary~~ Participant must be home-bound due to physical or mental impairments, and

ii) ~~Beneficiary~~ Participant must require twenty-four (24) hour assistance by the caregiver, meaning that the ~~beneficiary~~ participant cannot be left ~~alone/unattended~~ 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~~ Participants 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~~ participants must receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the ~~beneficiary~~ 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. Escorted Transportation~~

~~a) Escorted transportation is offered in addition to medical transportation. Escorted transportation is provided when the State Plan non-emergency transportation is either not available or inadequate to accommodate the needs of the beneficiary.~~

~~b) Family, friends, or community agencies shall be utilized in lieu of escorted transportation. Family members shall not be reimbursed for the provision of escorted transportation under this waiver.~~

~~c) Escorted transportation must be used for trips to doctors' appointments and trips to the pharmacy to pick up medications. The escorted transportation provider must assist the beneficiary into and out of their home, to the vehicle safely, into the doctor's office/pharmacy, remain with the beneficiary throughout the time they are in the doctor's office/pharmacy, and assist them back to the vehicle. The beneficiary must not be left alone or be dropped off unattended.~~

~~d) The escorted transportation provider must not at any time use the beneficiary's personal vehicle to provide services.~~

~~e) Escorted Transportation must be prior approved and arranged by the beneficiary's waiver case manager.~~

~~f) Providers must maintain documentation that includes, at a minimum:~~

~~1) The date of services,~~

~~2) Time of departure from the beneficiary's residence,~~

~~3) Time of arrival at the destination,~~

~~4) Number of miles traveled to the destination,~~

~~5) Time of departure from the location, and~~

~~6) Time of arrival back at beneficiary's residence.~~

~~g) Documentation must be signed and dated by both the provider and the beneficiary.~~

~~7~~6. Extended Home Health Services

a. ~~Beneficiaries~~ Participants may receive twenty-five (25) home health visits each fiscal year through the ~~regular~~ Medicaid ~~program~~ 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 ~~of~~ 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 ~~of~~ from the Division of Medicaid. Waiver ~~beneficiaries~~ participants are subject to home health co-payment requirements through the twenty-fifth (25^{th}) visit. Starting with the twenty-sixth (26^{th}) home health visit, within the state fiscal year, the Waiver ~~beneficiary~~ 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 ~~homemaker~~ 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. ~~If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance must be thoroughly documented.~~ Exceptions to this rule must be based on medical justification and thoroughly documented.

~~8~~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 ~~beneficiary~~ participant must meet all of the following criteria:

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

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

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

4) ~~Beneficiary~~ 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 beneficiaries whose stay in a nursing facility is ninety (90) days or less.

B. ~~Beneficiaries~~ Participants who choose to reside in a licensed/unlicensed Personal Care Home ~~may~~ 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 ~~beneficiary~~ 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 10/~~ 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.

~~B~~ C. An eligible ~~beneficiary~~ 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~~, along with a copy of their billing~~ for each waiver ~~beneficiary~~ 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: ~~Beneficiary~~ Participant Cost Sharing

~~Beneficiaries~~ 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 ~~beneficiary~~ 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 ~~beneficiary~~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 ~~beneficiary~~ 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 ~~beneficiary~~ 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 ~~beneficiary~~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 ~~possible~~ immediate or perceived danger, racial discrimination ~~considerations~~ or sexual harassment ~~by~~ of the service providers. The case manager will maintain responsibility for ensuring that the ~~beneficiary~~ 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