Title 23: Division of Medicaid

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

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), up to one hundred thirty-three percent (133%) of the Federal Poverty Level,

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) An aged, blind, or disabled individual whose income is under three hundred percent (300%) of the SSI limit for an individual. If income exceeds the three hundred

percent (300%) limit, the individual must pay the amount over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible.

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. An ID/DD Waiver participant can only be enrolled in one (1) 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.

Source: 42 USC § 1396n; 42 CFR § 440.180; 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 5.2: 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.

Title 23: Division of Medicaid

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

~~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), up to one hundred thirty-three percent (133%) of the Federal Poverty Level,

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) An aged, blind, or disabled individual whose income is under three hundred percent

(300%) of the SSI limit for an individual. If income exceeds the three hundred percent (300%) limit, the individual must pay the amount over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible.

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. An ID/DD Waiver participant~~:~~

~~1. C~~can only be enrolled in one (1) HCBS waiver program at a time~~,~~ and

~~2. M~~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.

Source: 42 USC § 1396n; 42 CFR § 440.180; 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 5.2: 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) ~~and the Bureau of Intellectual Disabilities and Developmental Disabilities (BIDD)~~ 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 ~~approved~~ home and community-based services (HCBS) and the ID/DD Waiver~~. requirements.~~

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 ~~centers~~ 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 ~~S~~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~~the BIDD/Division of Home and Community-Based Services (HCBS)~~,

4. Reviewed by the Diagnostic and Evaluation (D&E) team if a significant change occurred since the baseline LOC assessment, and

5. Reviewed by ~~staff of BIDD/Division of HCBS~~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~~/BIDD~~ 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.

~~B~~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~~(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 ~~BIDD/ HCBS.~~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~~b~~)Approval or denial of requests for readmission,

(d~~c~~)Changes in service amounts or types,

(e~~d~~)Discharge from the ID/DD Waiver, and

(f~~e~~) 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.~~BIDD/Division of HCBS.~~

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~~two~~ (1~~2~~) time~~s~~ 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~~1~~) Review implementation of strategies, guidelines, and action plans to ensure specified need, preferences, and desired outcomes are being met,

5~~2~~) Review the individual's progress and accomplishments,

6~~3~~) Review the individual's satisfaction with services and providers,

7~~4~~) Identify any changes to the individual's needs, preferences, desired outcomes, or health status,

8~~5~~) 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~~6~~) Identify the need to update the PSS,

10~~7~~)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~~8~~)Inquire and document about each participant's health care needs and changes during monthly and quarterly contacts,

12~~9~~)Review~~Submit~~ quarterly reports summarizing the level of support provided to each participant and compare the summary with the PSS for consistency,

13~~10~~)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~~11~~)Educate families on the participant's rights and the procedures for reporting instances of abuse, neglect, and exploitation, and

15~~12~~)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 ~~same-day~~ 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~~:~~

~~1) A~~at least eighteen (18) years of age~~., and~~

~~2) No longer eligible for educational services based on graduation and/or receipt of a diploma/equivalency certificate, or with permanent discontinuation of educational services.~~

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 ~~s~~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) 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 participant's PSS,~~

~~3~~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,~~the Individuals with Disabilities Education Act,~~ 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 ~~the Individuals with Disabilities Education Act~~ 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 ~~PT/OT/ST~~ 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.

~~2~~3) Exceed forty (40) hours per week when provided by a DMH approved family member.

~~3~~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 ~~S~~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 ~~the Individuals with Disabilities Education Act (~~IDEA~~,~~) ~~(~~20 USC § 1401~~)~~ or covered under an ~~I~~individualized ~~F~~family service ~~P~~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 ~~an ICF/IID~~ when a participant's behavior, or family/primary caregiver's ~~notification~~ 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 ~~the Director of BIDD or~~ DMH. ~~clinical services liaison.~~

    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 ~~Department of Mental Health~~DMH~~, Office of Consumer Supports (DMH/OSC)~~ 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~~/OCS~~, 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 ~~must be~~ 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~~/OCS~~.

E. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH~~/OCS~~, the agency director, and the guardian or legal representative as identified by the participant receiving services. ~~Documentation~~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 ~~the~~ DMH~~/OCS~~ 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 ~~the~~ DMH~~/OCS~~ as outlined in the DMH Operational Standards including, but not limited to: ~~within twenty-four (24) hours of discovery, or the next business day, by secure e-mail, fax, telephone and written report. If the incident is reported by telephone, the provider must submit a completed report within five (5) business days.~~

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~~, for a twenty-four (24) hour period,~~

~~4. Absence of any length of time from an adult day center providing services to individuals with Alzheimer's disease and/or other dementia,~~

4~~5~~. Emergency hospitalization or treatment of a participant receiving Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services,

5~~6~~. Accidents associated with suspected abuse or neglect, or in which the cause is unknown or unusual,

6~~7~~. Disasters including, but not limited to, fires, floods, tornadoes, hurricanes, earthquakes and disease outbreaks,

7~~8~~. 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~~9~~. Incidents involving ~~consumer~~ participant injury while on provider property or at a provider- sponsored event, and

9~~10~~. 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./~~OCS.~~

I. Suspected abuse/neglect/exploitation must also be reported to the appropriate authorities according to ~~S~~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. ~~The licensed nurse may not accompany the participant to physician visits. However, w~~With the participant's permission, the licensed nurse or employing agency may <u>accompany the participant to physician visits and/or</u> communicate with the participant's physician. After communicating with the physician, the licensed nurse employed by the Supervised Living provider <u>or employing agency</u>, 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.~~, and~~

~~5. Voluntary informed consent was given for the use of a psychotropic medication and that information on the risks and benefits of the psychotropic medication was provided to the participant and/or guardian or legal representative.~~

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~~/BIDD~~ 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~~, Office of Consumer Supports~~ (DMH)~~/OCS)~~ is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by ~~the Department of Mental Health (~~DMH~~)~~.

~~1. The DMH Quality Management Workgroup assists the DMH/OCS in development of procedures for receiving, investigating, and resolving the grievances/complaints.~~

~~2.~~ Grievances may be made via phone, written letter format~~,~~ or email.

B. Personnel issues are not within the purview of DMH~~/OCS~~.

C. A toll-free Helpline ~~must be~~ 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~~/OCS.~~ unless additional time is required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from ~~the director of the~~ DMH~~/OCS~~ of the resolution and all activities performed in order to reach the resolution.

~~F. Requests for reports generated through the Information and Referral Database must be made through the appropriate DMH Bureau Director.~~

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 ~~and/or the Department of Mental Health (~~DMH.~~) Executive Director review of the initial evaluation denial as outlined in the DMH Operational Standards.~~

B. Decisions ~~made by the Department of Mental Health, Bureau of Intellectual Disabilities and Developmental Disabilities (DMH/BIDD)~~ that result in services being denied, terminated, or reduced may be appealed according to ~~the~~ DMH ~~Operational Standards~~ appeal procedures.

~~C.~~1. If the ~~applicant~~ participant and/or guardian or legal representative disagrees with the decision made by ~~the~~ DMH ~~Executive Director~~ 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.]

~~D.~~2. During the ~~reconsideration and~~ 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.

~~E. Providers who must be certified by the DMH/BIDD may appeal certification decisions to DMH. Certification is dependent upon compliance with the DMH Operational Standards.~~

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.