Title 23: Division of Medicaid

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

Part 208 Chapter 1: HCBS Elderly and Disabled (E & D) Waiver

Rule 1.1: General

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

1. Persons enrolled in the E & D Waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

2. The Division of Medicaid does not cover E & D waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

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

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

History: Revised eff. 01/01/2017.

Rule 1.4: Freedom of Choice

A. Persons enrolled in a Medicaid Waiver have the right to freedom of choice of Medicaid providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. Each person found eligible for the Elderly and Disabled (E & D) waiver must be given free choice of all qualified providers.

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

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

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

Rule 1.6: Covered Services

A. Providers must meet all provider specifications as outlined in the Centers for Medicare and

Medicaid Services (CMS) approved waiver to provide the following services through the Elderly and Disabled (E & D) Waiver:

1. Case Management (CM)

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

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

        1) A Registered Nurse (RN) - The registered nurse must maintain an active and current unencumbered license to practice in the state of Mississippi or a privilege to_practice in Mississippi with a compact license, with a minimum of two (2) years of nursing experience with aged and/or disabled persons. If the RN has less than two years' experience, they must receive at least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

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

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

    d. The case management team, consisting of the RN and the LSW, must conduct face to face visits together using the long-term services and support assessment instrument at the time of admission and recertification. At a minimum thereafter, the RN must visit the person on a quarterly basis. The RN must be available at all times for consultation. The case managers must coordinate services that best meet the waiver person’s needs. Case management services may be provided at the Adult Day Care Facility at a maximum of one (1) visit per quarter. This visit cannot be the initial assessment, recertification assessment or quarterly visit for the RN.

2. Adult Day Care Services

    a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime

and early evening hours. This community-based service must meet the needs of aged and disabled persons through an individualized Plan of Services and Supports (PSS) that includes the following:

1) Personal care and supervision,

2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs in addition to the following:

   (a) A mid-morning snack,

   (b) A noon meal, and

   (c) An afternoon snack.

3) Provision of limited health care,

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

5) Social, health, and recreational activities.

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

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

d. Adult Day Care settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including engagement in community life, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

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

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

environment, and with whom to interact.

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

e. Adult Day Care settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

3. Personal Care Services

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

b. Personal care services include assistance to functionally impaired persons allowing them to remain in their home by providing assistance with activities of daily living, instrumental activities of daily living, and assistance in participating in community activities.

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

d. Services must be provided in accordance with a waiver person's PSS.

e. Eligible persons are approved for personal care services based upon assessed needs with the person's involvement. Services will not be approved without sufficient documentation to substantiate the request. The frequency cannot duplicate hours rendered for respite care and/or home health aide services. Any increase in the number of hours indicated on the PSS must be prior approved by the Division of Medicaid. Decreases in the number of hours do not require the Division of Medicaid's approval but notification of the decreases must be submitted.

f. Personal care attendant responsibilities:

1) Assist with personal care:

(a) Mouth and denture care,

(b) Shaving,

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

(d) Grooming hair to include shampooing, combing, and oiling,

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

(f) Assist with dressing,

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

(h) Remind waiver person to take medication,

(i) Assist with eating,

(j) Transferring or changing the waiver person's body position, and

(k) Assist with ambulation.

2) Perform housekeeping tasks:

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

(b) Prepare shopping lists,

(c) Purchase and store groceries,

(d) Prepare and serve meals,

(e) Launder and iron clothes,

(f) Run errands,

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

(h) Change linen and make the bed, and

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

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

g. Personal care attendant supervisor responsibilities:

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

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

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

(c) Review and approve PCS duties on the approved service plans,

(d) Receive and process requests for services,

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

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

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

(h) Prepare, submit, or maintain appropriate records and reports,

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

(j) Perform supervised visits in the person’s home and unsupervised visits which may be performed in the person’s home or by phone, alternating on a

biweekly basis to assure services and care are provided according to the PSS.

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

4. Institutional or In-Home Respite Services

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

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

c. Institutional Respite Services

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

2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service.

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

d. In-Home Respite Services

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

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

(a) Person must be home-bound due to physical or mental impairments, and

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

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

5. Home Delivered Meals

    a. Requirements for Home Delivered Meals include:

        1) Persons must be unable to leave home without assistance, unable to prepare their own meals, and/or have no responsible caregiver in the home.

        2) All eligible persons must receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the person will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

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

6. Extended Home Health Services

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

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

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

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

7. Transition Assistance

    a. Transition Assistance is a one (1) time initial expense required for setting up a household. The expenses must be included in the approved PSS. Transition

Assistance Services are capped at eight hundred dollars ($800.00) one (1) time initial expense per lifetime.

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

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

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

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

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

c. Transition Assistance Services include the following:

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

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

3) Moving expenses,

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

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

d. All Transition Assistance Services are essential to:

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

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

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

B. Persons who choose to reside in a licensed/unlicensed Personal Care Home are not eligible to receive Elderly & Disabled (E & D) Waiver services.

Source: 42 C.F.R. §§ 431.53, 440.170, 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

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

Rule 1.13: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. § 43-13-117.

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

Part 208 Chapter 2: HCBS Independent Living (IL) Waiver

Rule 2.1: General

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

1. Waiver participants must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

2. The Division of Medicaid does not cover IL waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

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

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

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

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

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

Rule 2.5: Freedom of Choice

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

B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the

individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed of any feasible alternatives under the waiver,

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

3. Provided a choice among providers or settings in which to receive home and community-based services (HCBS) including non-disability specific setting options.

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

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

Rule 2.12: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or

those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports

that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

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

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

Rule 3.4: Freedom of Choice

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

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

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

History: Revised eff. 01/01/2017.

Rule 3.6: Covered Services

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

B. AL Services include the following:

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

2. Homemaker services,

3. Attendant care services,

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

5. Therapeutic, social, and recreational programming services,

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

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

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

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

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

    a) Is available to waiver persons who are:

        1) At risk of falling,

        2) At risk of becoming disoriented, or

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

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

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

C. AL Waiver providers must provide:

1. A setting physically accessible to the person but not located in:

    a) A nursing facility,

    b) An institution for mental diseases,

    c) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

d) A hospital providing long-term care services, or

e) Any other location that has qualities of an institutional setting, as determined by the Division of Medicaid including, but not limited to, any setting:

1) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

2) Located in a building on the grounds of or immediately adjacent to a public institution, or

3) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

2. A private, home-like living quarter with a bathroom consisting of a toilet and sink and must:

a) Be a unit or room in a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the waiver person, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the Division of Medicaid must ensure that:

(1) A lease, residency agreement or other form of written agreement will be in place for each HCBS person, and

(2) That the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

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

2) The option to share living units only at the choice of the person.

3. A setting which integrates and facilitates the person's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals without disabilities,

4. A setting selected by the person from among all available alternatives and is identified in the person-centered Plan of Services and Supports (PSS),

5. Protection of a person's essential personal rights of privacy, dignity and respect, and

freedom from coercion and restraint,

6. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact,

7. Individual choice regarding services and supports, and who provides them,

8. An assessment of safety needs of a person with cognitive impairment supported by a specific assessed need and addressed in the PSS,

9. Freedom and support of persons to control their own schedules and activities and have access to food at any time,

10. Freedom to have visitors of their choosing at any time,

11. A living environment supportive of the person to exercise their rights to:

    a. Attend religious and other activities of their choice,

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

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

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

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

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

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

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

    i. Free from physical and/or chemical restraints,

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

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

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

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

n. Have nutritious snacks available at all times, and

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

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

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

Rule 3.15: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these

persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

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

Part 208 Chapter 4: HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver

Rule 4.1: General

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

   1. Persons enrolled in the TBI/SCI Waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

   2. The Division of Medicaid does not cover TBI/SCI waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitative Services (MDRS).

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

History: Revised eff. 01/01/2017.

Rule 4.5: Covered Services

A. The Division of Medicaid covers the following traumatic brain injury/spinal cord injury (TBI/SCI) Waiver services:

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

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

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

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

2) Provide ongoing monitoring of the services included in the person's plan of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

1) The Division of Medicaid defines legally responsible for an individual as the

parent (or step-parent) of a minor child or an individual's spouse.

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

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

3. Respite services are defined as services to assistance beneficiaries unable to care for themselves because of the absence of, or the need to provide relief to the primary caregiver. Institutional Respite is limited to thirty (30) days or less annually. In-home Companion and Nursing respite is limited to sixty (60) hours per month.

   a) Services must be provided in the person's home, foster home, group home, or in a Medicaid certified hospital, nursing facility, or licensed respite care facility.

   b) All respite providers must be certified by the Mississippi Department of Rehabilitation Services (MDRS).

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

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

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

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

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

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

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

b) Environmental accessibility adaptations include the following:

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

2) Modification of bathroom facilities.

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

c) Environmental accessibility adaptations exclude the following:

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

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

d) Providers rendering environmental accessibility adaptations must:

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

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

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

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

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

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

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

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

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

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

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

c) Transition Assistance Services include the following:

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

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

3) Moving expenses.

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

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

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

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

History: Revised eff. 01/01/2017.

Rule 4.12: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information

in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized

by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

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

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

Rule 5.3: Freedom of Choice

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

B. The person and/or guardian or legal representative must be informed of alternatives available through the ID/DD Waiver, and given the option of choosing either institutional or home and community-based services (HCBS) once eligibility requirements for the ID/DD Waiver have been met.

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

D. The choice made by the person and/or guardian or legal representative must be documented and signed by the person and/or guardian or legal representative and maintained in the ID/DD Waiver case record.

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

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

Rule 5.5: Covered Services

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services must only be provided to persons when approved by the Department of Mental Health (DMH) and authorized by the ID/DD Waiver support coordinator as part of the approved Plan of Services and Supports (PSS).

B. All providers must follow DMH Operational Standards regarding criminal background checks, valid driver's license and current vehicle insurance.

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

1. Support Coordination is defined by the Division of Medicaid as the monitoring and coordinating of all person services, regardless of funding source, to ensure the person's health and welfare needs are met.

a) Support Coordination activities must include:

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

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

(b) Information about the person's satisfaction with current 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 person, and

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

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

3) Submitting all required information for review, approval, or denial to DMH.

4) Notifying each person and/or guardian or legal representative of:

   (a) Approval or denial of initial enrollment,

   (b) Approval or denial of requests for recertification,

   (c) Approval or denial of requests for readmission,

   (d) Changes in service amounts or types,

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

   (f) Procedures for appealing the denial, reduction or termination of ID/DD Waiver services as well as providing a written copy of the appeals process.

5) Sending service authorizations to providers upon receipt of approval from DMH.

b) Support coordinators must:

1) Monitor implementation of the PSS, the person's health and welfare, and effectiveness of the back-up plan at least monthly,

2) Speak with the person and/or guardian, or legal representative:

   (a) Face-to-face at least every three (3) months which must include rotation of service settings and communicating with staff, and

   (b) At least one (1) time per month in the months when a face-to-face visit is not required,

3) Determine if necessary services and supports in the PSS have been provided,

4) Review implementation of strategies, guidelines, and action plans to ensure specified need, preferences, and desired outcomes are being met,

5) Review the person's progress and accomplishments,

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

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

8) Identify the need to change the amount or type of services and supports or to access new ID/DD Waiver or non-waiver services,

9) Identify the need to update the PSS,

10) Maintain detailed documentation of all contacts made with the person and/or guardian or legal representative in the ID/DD Waiver support coordination service notes,

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

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

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

14) Compete the Risk Assessment Tool for the PSS for inclusion in the PSS and to be included in each provider's plan for the person.

2. In-Home Nursing Respite is defined by the Division of Medicaid as services provided in the person's family's home to provide temporary, periodic relief to the primary caregivers of eligible persons who are unable to care for themselves.

a) In-Home Nursing Respite services:

1) Must be provided by a registered nurse or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations and employed by a DMH certified ID/DD Waiver provider,

2) Must be billed separately for services provided to more than one (1) person in the same residence that are related as defined by the Division of Medicaid as siblings or parents/siblings,

3) Must be ordered by a physician, nurse practitioner or a physician assistant and include:

(a) Medications, treatments and other procedures the person needs in the absence of the primary caregiver, and

(b) Time-frames for medication administration, treatments and other procedures.

4) Are provided when the primary caregiver is absent or incapacitated due to hospitalization, illness, injury, or death,

5) Are provided on a short-term basis,

6) Allows the person to be accompanied on short outings,

7) May be provided on the same day as the following ID/DD Waiver services, but not during the same time period:

(a) Day 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 persons:

1) Living alone, in group homes or staffed residences,

2) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance, or

3) Receiving:

(a) Supported Living,

(b) Supervised Living,

(c) Host Home services,

(d) Shared Supported Living.

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 person with assistance in toileting and other hygiene needs,

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

3) Have meals available if services are provided during normal meal time.

b) Community Respite services are not provided:

1) To persons overnight,

2) To persons receiving:

(a) Supervised Living services,

(b) Host Home services, or

(c) Supported Living services.

3) In place of regularly scheduled day activities including, but not limited to:

(a) Supported Employment,

(b) Day Services-Adult,

(c) Prevocational Services, or

(d) Services provided through a school system.

c) Community Respite service settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to

the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.

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

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

d) Community Respite settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

4. Supervised Living services are defined by the Division of Medicaid as services designed

to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community inclusion, transportation and leisure skill development. Supervised living, learning and instruction include elements of support, supervision and engaging participation to reflect that of daily living in settings owned or leased by a provider agency or by participants.

a) Supervised Living providers must:

1) Have staff available on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests or needs of assistance and must not sleep during billable hours.

2) Provide an appropriate level of services and supports twenty-four (24) hours a day during the hours the person is not receiving day services or is not at work.

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

(a) Scheduling medical appointments,

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

(c) Communicating with medical professionals if the person gives permission to do so.

4) Provide furnishings used in the following areas if items have not been obtained from other sources including, but not limited to:

(a) Den,

(b) Dining,

(c) Bathrooms, and

(d) Bedrooms such as:

(1) Bed frame,

(2) Mattress and box springs,

(3) Chest,

(4) Night stand, and

(5) Lamp.

5) Provide the following supplies:

(a) Kitchen supplies including, but not limited to:

(1) Refrigerator,

(2) Cooking appliance, or

(3) Eating and food preparation utensils,

(b) Two (2) sets of linens:

(1) Bath towel,

(2) Hand towel, and

(3) Wash cloth,

(c) Cleaning supplies.

6) Train staff regarding the person's PSS prior to beginning work with the person.

7) Provide nursing services as a component in accordance with the Mississippi Nurse Practice Act.

b) Supervised Living providers cannot:

1) Receive or disburse funds on the part of the person unless authorized by the Social Security Administration,

2) Bill for the cost of room and board, building maintenance, upkeep, or improvement, or

3) Bill for services provided by a family member of any degree.

c) Supervised Living is available to persons who are at least eighteen (18) years of age.

d) Supervised Living services cannot be provided to persons receiving:

1) Home and Community Supports,

2) Supported Living,

3) In-Home Nursing Respite,

4) Community Respite, or

5) Host Home services.

e) The cost to transport persons to work or day programs, social events or community activities when public transportation is not available is included in the payments made to the Supervised Living providers. Supervised Living providers may transport persons in their own vehicles as an incidental component of this service and must have a valid driver's license, current automobile insurance and registration.

f) Nursing services are also a component of Supervised Living services and must be provided in accordance with the Mississippi Nurse Practice Act.

g) Supervised Living settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.

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

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

h) Supervised Living services may be provided in settings owned or leased by a provider agency or settings owned or leased by persons.

1) The setting can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services which the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

2) If the landlord tenant laws do not apply to the setting, the DMH must ensure:

(a) A lease, residency agreement or other form of written agreement is in place for each person, and

(b) The agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

3) Each person must have privacy in their sleeping or living unit which includes:

(a) Entrance doors lockable by the person with only appropriate staff having keys to doors,

(b) A choice of roommates if individuals are sharing units, and

(c) The freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

4) Persons must have the freedom and support to control their own schedules and activities, and have access to food at any time.

5) Persons are able to have visitors of their choosing at any time.

6) The setting is physically accessible to the person.

i) Supervised Living settings do not include the following:

1) A nursing facility;

2) An institution for mental diseases;

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IDD);

4) A hospital; or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

j) Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.

a) Each person must have access to food at any time, unless prohibited by his/her individual plan.

(b) Each person must have choices of the food they eat.

(c) Each person must have choices about when and with whom they eat.

k) Supervised Living sites must duplicate a "home-like" environment.

5. Day Services-Adult is defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies included on the PSS. Activities include environments designed to foster the acquisition and maintenance of skills, build positive social behavior and interpersonal competence which foster the acquisition of skills, greater independence and personal choice.

a) Day Services-Adult must:

1) Take place in a non-residential setting, separate from the home or facility in which the person resides,

2) Be physically accessible to the person and must:

(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.

(b) Be selected by the person from among setting options including non-disability specific settings The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,

(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(d) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical

environment, and with whom to interact

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

(f) Allow persons to have visitors of their choosing at any time they are receiving Day Services-Adult services.

3) Have a community integration component that meets each person's need for community integration and participation in activities which may be:

(a) Provided at a DMH certified day program site or in the community, or

(b) Offered individually or in groups of up to three (3) people when provided in the community.

b) Day Services-Adult settings do not include the following :

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital or,

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

c) Day Services-Adult providers must:

1) Not exceed one hundred thirty-eight (138) service hours in a month with twenty-three (23) working days or one hundred thirty-two (132) service hours in a month with twenty-two (22) working days.

2) Provide assistance with personal toileting and hygiene needs during the day as well as a private changing/dressing area.

3) Provide each person assistance with eating/drinking as needed and as indicated in each person's PSS.

4) Provide choices of food and drinks to persons at any time during the day which includes, at a minimum:

(a) A mid-morning snack,

(b) A noon meal, and

(c) An afternoon snack.

5) Provide transportation as a component part of Day Services-Adult.

(a) The cost for transportation is included in the rate paid to the provider.

(b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.

(c) Transportation for community outings can be counted in the total number of service hours provided per day.

d) Day Service-Adult persons:

1) Must be at least eighteen (18) years old.

2) Can receive services that include supports designed to maintain skills and prevent or slow regression for persons with degenerative conditions and/or those who are retired.

3) Can also receive Supported Employment, Prevocational services, and Job Discovery, but not during the same time on the same day.

4) Can also receive Crisis Intervention services on same day at the same time.

6. Prevocational Services are defined by the Division of Medicaid as services intended to develop and teach a participant general skills that contribute to paid employment in an integrated community setting. These services cannot otherwise be available under a program funded under the Rehabilitation Act of 1973, 29 U.S.C. § 110 or IDEA, 20 U.S.C. § 1400-01.

a) Prevocational Services must:

1) Be physically accessible to the person and must:

   (a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

   (b) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

   (c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

   (d) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

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

3) Not exceed one hundred thirty eight (138) hours per month in a month which has twenty-three (23) working days or one hundred thirty-two (132) hours per month in a month which has twenty-two (22) working days.

4) Provide choices of food and drinks to persons who do not bring their own at any time during the day which includes, at a minimum:

   (a) A mid-morning snack,

   (b) A noon meal, and

   (c) An afternoon snack.

5) Include personal care/assistance but cannot comprise the entirety of the service; however, participants cannot be denied Prevocational Services because they require the staff's assistance with toileting and/or personal hygiene.

6) Include a review with staff and the ID/DD Waiver support coordinator for the

necessity and appropriateness of the services, when a person earns more than fifty percent (50%) of the minimum wage.

7) Be furnished in a variety of locations in the community and are not limited to fixed program locations.

b) Prevocational service providers must:

1) Provide transportation as a component part of prevocational services.

(a) The cost for transportation is included in the rate paid to the provider.

(b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.

(c) Transportation to and from the program for the purpose of training may be included in the number of hours of services provided per day for the period of time specified in the PSS.

2) Conduct an orientation annually informing persons about Supported Employment and other competitive employment opportunities in the community.

3) Offer community job exploration to persons monthly.

4) Bill only for actual amount of services provided:

(a) Bill for a maximum of one hundred thirty-eight (138) hours per month for a person who attends twenty-three (23) working days in a month, or

(b) Bill for a maximum of one hundred thirty-two (132) hours per month for a person who attends twenty-two (22) working days in a month.

c) Prevocational service persons:

1) Must be at least eighteen (18) years of age or older to participate.

2) May be compensated in accordance with applicable Federal Laws.

3) May pursue employment opportunities at any time to enter the general work force.

4) May also receive the following ID/DD Waiver services but not during the same time on the same day:

(a) Day Services-Adult,

(b) Job Discovery, and

(c) Supported Employment.

d) Prevocational service settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

e) The amount of staff supervision someone receives is based upon tiered levels of support determined by a person's score on the Inventory for Client and Agency Planning (ICAP).

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

a) Supported Employment services include:

1) Activities needed to sustain paid work by persons including:

(a) Job analysis,

(b) Job development and placement,

(c) Job training,

(d) Negotiation with prospective employers, and

(e) On-going job support and monitoring.

2) Services and supports to assist the person in achieving self-employment, but does not pay for expenses associated with starting up or operating a business, including the following:

(a) Aiding the person in identifying potential business opportunities,

(b) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business,

(c) Identifying supports necessary for the person to successfully operate the business, and

(d) On-going assistance, counseling and guidance once the business has launched.

3) Services provided at work sites where persons without disabilities are employed. Payment is made only for the adaptations, supervision, and training required by persons receiving ID/DD Waiver services.

4) Personal care/assistance as a component of Supported Employment, but it must not comprise the entirety of the service.

5) The ability for persons to receive other services in addition to Supported Employment if included in the approved PSS which include educational, Prevocational, Day Services-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. Persons can receive multiple services on the same day but not during the same time period except for Behavior Support or Crisis Intervention services which can be provided simultaneously with Supported Employment.

6) Providing transportation between the person's residence and/or other habilitation sites and the employment site as a component part.

(a) The cost of transportation is included in the rate paid to the provider and covers transportation between the person's residence and job site and between habilitation sites.

(b) Providers cannot bill separately for transportation services and cannot charge

persons for these services.

b) Supported Employment services do not include:

1) Sheltered workshops or other similar types of vocational services furnished in specialized facilities,

2) Volunteer work,

3) Payment for the supervisory activities rendered as a normal part of the business setting, or

4) Facility based or other types of services furnished in a specialized facility that are not part of the general workforce.

c) Supported Employment providers must:

1) Notify the person's ID/DD Waiver support coordinator of any changes affecting the person's income, and

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

d) Employment must be in an integrated work setting in the general workforce where a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities.

e) A person cannot receive Supported Employment services during the Job Discovery process.

8. Home and Community Supports (HCS) are defined by the Division of Medicaid as a range of services provided to persons that live in the family home and need assistance with activities of daily living, instrumental activities of daily living, and inclusion in the community and may be shared by up to three (3) persons who have a common direct service provider agency. Services ensure the person can function adequately both in the home and in the community. Services must also provide safe access to the community. HCS must be provided in a person's private residence and/or community settings.

a) HCS services include:

1) Accompanying and assisting the person in accessing community resources and participating in community activities.

2) Supervision and monitoring of the person in the home, during transportation, and in the community.

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

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

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

6) Transportation as an incidental component, which is included in the rate paid to the provider. Providers must possess a valid driver's license andcurrent insurance, and must follow DMH Operational Standards regarding criminal background checks.

b) HCS services cannot:

1) Be provided in a school setting or in lieu of school services or other available day services.

2) Be provided by someone who:

(a) Lives in the same home as the person,

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

(c) Is a spouse,

(d) Legal guardian/representative, or

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

3) Exceed 172 hours per month when provided by a DMH approved family member.

4) Be provided to persons:

(a) Living in a residential setting, or any other type of staffed residence,

(b) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility if the facility is billing Medicaid, Medicare, and/or private insurance, or

(c) Receiving the following ID/DD Waiver services:

(1) Supported Living,

(2) Supervised Living, or

(3) Host Home services.

c) HCS providers seeking approval for family members excluding those listed in Miss. Admin. Code Part 208, Rule 5.5.B.8. to provide HCS services must obtain prior approval from DMH.

9. Behavior Support services are defined by the Division of Medicaid as services providing systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for persons whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration and/or are at risk for being placed in a more restrictive setting. This service also includes consultation and training provided to families and staff living with the person. The desired outcome of the service is long term behavior change. Behavior Support services cannot replace educationally related services available under IDEA, 20 U.S.C. § 1401 or covered under an individualized family service plan (IFSP) through First Steps. Early and Periodic Screening Diagnosis and Treatment (EPSDT) services must be exhausted before ID/DD Waiver services can be provided.

a) Behavior Support service providers:

1) Must provide services in the following settings:

(a) Home,

(b) Habilitation setting, or

(c) Provider's office.

2) Cannot provide services in a public school setting. The provider may observe the person in the school setting to gather information, but may not function as an assistant in the classroom by providing direct services.

b) Behavior Support services include the following:

1) Assessing the person's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for those behaviors, and how those particular behaviors impact the person's environment and life.

2) Developing a behavior support plan, implementing the plan, collecting the data measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan.

3) Providing therapy services to the persons to assist him/her in becoming more effective in controlling his/her own behavior, either through counseling or by implementing the behavior support plan.

4) Communicating with medical and ancillary therapy providers to promote coherent and coordinated services addressing behavioral issues in order to limit the need for psychotherapeutic medications.

10. Therapy Services are defined by the Division of Medicaid as physical therapy, occupational therapy, and speech-language pathology services used for the purpose of maintaining a person's skill, range of motion, and function rather than for rehabilitative reasons.

    a) Therapy services:

        1) Are provided through the ID/DD Waiver after the termination of State Plan therapy services,

        2) Must be on the person's approved PSS,

        3) Are only available under the ID/DD Waiver when not available through the IDEA, 20 U.S.C. § 1401 or through EPSDT/Expanded EPSDT.

    b) Therapy services are limited to a:

        1) Maximum of three (3) hours per week for speech-language pathology,

        2) Maximum of three (3) hours per week for physical therapy, and

        3) Maximum of two (2) hours per week for occupational therapy.

11. Specialized Medical Supplies are defined by the Division of Medicaid as those supplies in excess of those covered in the Medicaid State Plan. These supplies which must be included on the person's PSS include:

    a) Specified types of catheters,

    b) Diapers, and

    c) Blue pads.

12. Supported Living is defined by the Division of Medicaid as services to assist participants with ADLs and IADLs who reside in their own residences (leased or owned) for the purpose of facilitating independent living in their home or community.

    a) Supported Living provides assistance with the following:

        1) Grooming,

        2) Eating,

        3) Bathing,

        4) Dressing,

        5) Personal care needs,

        6) Planning and preparing meals,

        7) Cleaning,

        8) Transportation or assistance with securing transportation,

        9) Assistance with ambulation and mobility,

        10) Supervision of person's safety and security,

        11) Assistance with banking, budgeting, and shopping,

        12) Facilitation of person's inclusion in community activities, and.

        13) Use of natural supports.

    b) Supported Living providers must:

        1) Be on call twenty-four (24) hours a day seven (7) days a week to respond to emergencies via phone or to return to the program site depending on the type of emergency.

        2) Provide transportation when necessary and have documentation of:

            (a) A valid driver's license,

            (b) Vehicle registration,

(c) Current insurance, and

(d) Must follow DMH Operational Standards regarding criminal background checks.

3) Not sleep during billable hours, and

4) Develop methods, procedures, and activities to provide meaningful days and independent living choices about activities/services/staff for people served in the community.

c) Supported Living participants:

1) May share Supported Living services with up to three (3) persons who may or may not live together and who have a common direct service provider agency.

2) May share Supported Living staff when:

(a) Agreed upon by the person, and

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

3) Must be at least eighteen (18) years of age to receive Supported Living services.

4) Cannot receive Supported Living services if they are currently:

(a) An inpatient of a:

(1) Hospital,

(2) Nursing Facility,

(3) ICF/IID, or

(4) Any type of rehabilitation facility.

(b) Receiving the following ID/DD Waiver services:

(1) Supervised Living,

(2) Host Home services,

(3) In-Home Nursing Respite,

(4) Home and Community Supports, or

(5) Community Respite.

13. Crisis Intervention is defined by the Division of Medicaid as immediate therapeutic intervention services available twenty-four (24) hours a day that are designed to stabilize the participant in crisis, prevent further deterioration of the participant, restore the participant to the level of functioning before the crisis, and provide immediate treatment in the least restrictive setting, including, but not limited to a participant's home, alternate community living setting, and/or a participant's day setting.

    a) Crisis Intervention services, regardless of setting, must be delivered in a way to maintain the person's normal routine to the maximum extent possible and may be billed at the same time on the same day as:

        1) Day Services-Adult,

        2) Prevocational Services, or

        3) Supported Employment.

    b) Crisis intervention must include consultations with family members, providers and other caregivers to design and implement individualized Crisis Intervention plans and provide additional services as needed to stabilize the situation.

    c) Crisis intervention is authorized up to twenty-four (24) hours per day in seven (7) day segments with the goal to phase out the support as the person becomes able to function appropriately in his/her daily routines/environments and is able to return to his/her home or to Supervised Living or Supported Living.

14. Crisis Support is defined by the Division of Medicaid as time-limited services provided in a Division of Medicaid licensed and certified facility when a person's behavior, or family/primary caregiver's situation regarding behavior, warrants a need for immediate specialized services that exceed the capacity of Crisis Intervention or Behavior Support services.

    a) Crisis Support services:

        1) Provide the person with behavioral and emotional support necessary to allow the person to return to his/her living arrangement.

        2) Cannot exceed the maximum of thirty (30) days per stay, unless prior authorization is obtained from DMH.

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

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

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

        1) Personal care,

        2) Leisure activities,

        3) Social development,

        4) Family inclusion, and

        5) Access to medical services.

    b) Host Home agencies must:

        1) Ensure availability, quality, and continuity of Host Home services,

        2) Recruit, train, and oversee the Host Home family,

        3) Be available twenty-four (24) hours a day to provide back-up staffing for scheduled and unscheduled absences of the Host Home family, which includes back-up staffing for scheduled and unscheduled absences of the Host Home family, and

        4) Ensure the person has basic bedroom furnishings if furnishings are not available from another source.

    c) The Host Home family must:

        1) Attend PSS meeting and participate in the development of the PSS,

        2) Follow all aspects of the PSS,

        3) Provide transportation,

4) Assist the person with attending appointments,

5) Meet all staffing requirements as outlined in the DMH Operational Standards, and

6) Participate in training provided by the Host Home agency.

d) Host Home families are not eligible for:

1) Room and board payment, or

2) Maintenance or improvement of Host Home family's residence.

e) Host Home persons must be

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

2) Able to self-administer their medications.

f) Host Home persons are not eligible for the following ID/DD Waiver services:

1) Home and Community Supports,

2) Supported Living,

3) Supervised Living,

4) In-Home Nursing Respite, or

5) Community Respite.

16. Job Discovery is defined by the Division of Medicaid as time-limited services used to develop a person's person-centered career profile and employment goals or career plan

a) Job Discovery services include, but are not limited to, the following:

1) Assisting the person with volunteerism,

2) Self-determination and self-advocacy,

3) Identifying wants and needs for supports,

4) Developing a plan for achieving integrated employment,

5) Job exploration,

6) Job shadowing,

7) Informational interviewing,

8) Labor market research,

9) Job and task analysis activities,

10) Employment preparation, and

11) Business plan development for self-employment.

b) Job Discovery persons must be:

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

2) Unemployed.

c) Staff must receive or participate in at least eight (8) hours of training on Customized Employment before providing Job Discovery services.

d) Job Discovery cannot exceed twenty (20) hours over a three (3) month period and must result in the development of a career profile and employment goals or career path.

e) Job Discovery persons are not eligible for the following ID/DD Waiver services during the same time on the same day:

1) Prevocational services, or

2) Day Services-Adult.

17. Transition Assistance is defined by the Division of Medicaid as a one-time, setup expense for persons who transition from an institution (ICF/IID or a Title XIX Nursing Home) to a less restrictive community living arrangement. These funds cannot be used if the person is using transitional funds from other sources.

a) Persons are eligible for transition assistance if:

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

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

3) The person is moving to a residence where essential furnishings are not normally

provided.

b) Transition Assistance can only be used once and is a life-time maximum allowance of eight hundred dollars ($800.00) used to establish the person's basic living arrangement and must be on the person's PSS which may include the following:

1) Expenses to transport furnishings and personal possessions from the facility to the new residence,

2) Security deposits that are required to obtain a lease on an apartment or home that do not constitute paying for housing rent,

3) Utility set-up fees or deposits for utility or service access,

4) Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy,

5) Initial stocking of pantry with basic food items,

6) Cleaning supplies,

7) Towels and linens,

8) Bed,

9) Table,

10) Chairs,

11) Window blinds, and

12) Eating utensils.

c) Transition Assistance does not include the following:

1) Monthly rental or mortgage expenses,

2) Monthly utility charges, or

3) Household appliances, items, or services that are intended purely for diversional or recreational activities.

d) Items purchased with these funds are for the persons use and are property of the person.

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

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

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

A. Department of Mental Health (DMH) certified providers must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:

1. Education as to what constitutes possible abuse/neglect/exploitation,

2. Abuse/neglect/exploitation reporting requirements and procedures, and

3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.

B. All service providers must provide to the person and/or guardian or legal representative upon admission and annually thereafter, oral and written communication of:

1. DMH's program procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse and how to report any suspected violation of rights and/or grievances to DMH, and

2. The person's rights which must:

a) Provide information on how to report:

1) Violation of rights,

2) Grievances, and

3) Abuse, neglect, or exploitation.

b) Be explained in a way that is understandable to the person and/or his/her guardian or legal representative.

c) Include a signed form that states the person and/or guardian or legal representative understood their rights.

d) Include the DMH toll-free Helpline phone number.

C. All providers must post the DMH toll-free Helpline phone number in a prominent place throughout each program site. The toll-free Helpline is available twenty-four (24) hours a

day, seven (7) days per week.

D. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:

   1. A written description of events/incidents and actions,

   2. All written reports, including outcomes, and

   3. A record of telephone calls to DMH.

E. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the guardian or legal representative as identified by the person receiving services. Incident reports regarding the serious event/incident must be completed and maintained in a central file on site that is not the person's case record. A description of the event/incident must be documented in the person's case record.

F. Death of a person on provider property, participating in a provider-sponsored event or during an unexplained absence from a residential program site, being served through a certified community living program, or during an unexplained absence of the person from a community living residential program must be reported verbally to DMH within eight (8) hours of discovery with a subsequent written report within twenty-four (24) hours.

G. The following serious events/incidents must be reported to DMH as outlined in the DMH Operational Standards including, but not limited to:

   1. Suicide attempts on provider property or at a provider-sponsored event,

   2. Suspected abuse/neglect/exploitation,

   3. Unexplained absence of any length from a community living or day program,

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

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

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

   7. Use of seclusion or restraints, either mechanical or chemical. Providers are prohibited from the use of:

a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,

b) Seclusion,

c) Time-out, and

d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,

8. Incidents involving person injury while on provider property or at a provider- sponsored event, and

9. Medication errors.

H. If an ID/DD Waiver provider has a question of whether or not an event/incident should be reported, the provider must contact DMH.

I. Suspected abuse/neglect/exploitation must also be reported to the appropriate authorities according to state law including, but not limited to, the Vulnerable Persons Unit (VPU) at the Attorney General's Office, and the Division of Family and Children Services (DFCS) and the Adult Protective Services (APS) at the Mississippi Department of Human Services (DHS), dependent upon the type of event.

J. If the alleged perpetrator of abuse/neglect/exploitation carries a professional license or certificate, a report must be made to the entity that governs their license or certificate.

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

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

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

Rule 5.12: Grievances and Complaints

A. The Department of Mental Health (DMH) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. Grievances may be made via phone, written letter format or email.

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

C. A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.

D. Providers of waiver services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.

E. All grievances must be resolved within thirty (30) days of receipt by DMH unless additional time is required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from DMH of the resolution and all activities performed in order to reach the resolution.

F. Providers must ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

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

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

Rule 5.14: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear

conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

New rule eff. 01/01/2017.

Part 208, Chapter 7: 1915(i) HCBS

Rule 7.3: Freedom of Choice

A. Medicaid persons have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. Targeted Case Managers must facilitate individual choice regarding services and supports and who provides them. Targeted Case Managers must inform the person/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider.

C. Settings are selected by the person from among setting options including non-disability specific settings based on the person's needs and preferences which are identified and documented in the plan of services and supports.

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

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

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

Rule 7.5: Covered Services

A. A person can receive:

1. 1915(i) services if not eligible for services available:

a) For Prevocational Services under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17), or

b) For Supported Employment under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

2. Only those 1915(i) services which are documented on the Plan of Services and Supports (PSS) by the Case Manager and approved by the Department of Mental Health (DMH), and

3. Multiple 1915(i) services on the same day but not during the same time of the day.

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

1. The cost of transportation is included in the rate paid to the provider.

2. Providers cannot bill separately for transportation services and cannot charge the persons for transportation.

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

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

a) Must take place in a non-residential setting separate from the home or facility in which the person resides.

b) Settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.

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

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

c) Do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

d) Must be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the person’s PSS.

e) Must be provided in DMH certified sites/community settings.

2. Prevocational Services defined by the Division of Medicaid as services to prepare a person for paid employment. Services address underlying habilitative goals which are associated with performing compensated work. Services include, but are not limited to, teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented but instead are aimed at a generalized result. Prevocational Services:

a) Must be included in the person's PSS and be directed towards habilitative objectives and not explicit employment objectives.

b) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs which includes, at a minimum:

    1) A mid-morning snack,

    2) A noon meal, and

    3) An afternoon snack.

c) May include personal care/assistance as a component but it cannot comprise the entirety of the service. Beneficiaries cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.

d) Beneficiaries must be compensated in accordance with applicable federal laws and regulations. If a person is performing productive work as a trial work experience that benefits the provider or that would have to be performed by someone else if not performed by the person, the provider must pay the person commensurate with members of the general work force doing similar work per federal wage and hour regulations.

e) Must be reviewed for necessity and appropriateness by the person, appropriate staff and the Case manager if the person earns more than fifty percent (50%) of the minimum wage.

f) Providers must inform beneficiaries about Supported Employment opportunities and other competitive employment activities in the community on an annual basis.

g) May be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each person at least one (1) time per month.

h) Include transportation. Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day, unless it is for the purpose of training.

i) Settings must be physically accessible to the person and must:

    1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access

as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

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

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

c) Settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities,

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of, or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

3. Supported Employment services defined by the Division of Medicaid as intensive, ongoing support to persons who, because of their disabilities, require support to obtain and maintain an individual job in competitive or customized employment, or self-employment. Employment must be in an integrated setting in the general workforce for whom a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work

performed by persons without disabilities. Supported Employment:

a) Is based on an Activity Plan that must be developed for each person based on his/her PSS.

b) Includes assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction, and ongoing job support and monitoring.

c) Includes services and supports to assist the person in achieving self-employment through the operation of a home or community based business, and may include the following:

    1) Aiding the person in identifying potential business opportunities.

    2) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business.

    3) Identifying supports necessary for the person to successfully operate the business.

    4) On-going assistance, counseling and guidance once the business has launched.

d) Cannot use Medicaid funds to defray the expenses associated with starting or operating a business.

e) Must be provided at work sites where persons without disabilities are employed and where payment is made only for the adaptations, supervision, and training required by beneficiaries receiving 1915(i) services and does not include payment for the supervisory activities rendered as a normal part of the business setting.

f) Must include transportation between the person's place of residence and the site of the person's job or between or between habilitation sites (in cases where the person receives habilitation services in more than one place) as a component of supported employment. Transportation cannot comprise the entirety of the service.

g) May include personal care/assistance as a component of Supported Employment but cannot comprise the entirety of the service.

h) Do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer work.

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

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

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

A. All Department of Mental Health (DMH) providers, including support coordinators and targeted case managers, must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:

   1. Education as to what constitutes possible abuse/neglect/exploitation,

   2. Abuse/neglect/exploitation reporting requirements and procedures, and

   3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.

B. Providers must provide the person/legal guardian with the provider's procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse.

   1. The procedures must be provided upon admission and at least annually thereafter.

   2. The procedures must be given orally and in writing.

   3. Documentation must include the person/legal guardian's signature indicating the rights have been explained in a way that is understandable to them.

   4. The person/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Support (OCS) or Disability Rights Mississippi.

   5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the person/legal representative.

C. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:

   1. A written description of events and actions,

   2. All written reports, including outcomes, and

   3. A record of telephone calls and written reports to DMH.

D. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the parent/guardian/legal representative/significant person as identified by the person receiving services.

E. DMH must submit a summary of serious incidents/events to the Division of Medicaid with

each quarterly report.

F. Serious events/incidents involving beneficiaries that must be reported to the DMH and other appropriate authorities within twenty-four (24) hours or the next business day, by telephone or written report include, but are not limited to, the following:

1. Suicide attempts on program property or at a program-sponsored event.

2. Suspected abuse/neglect/exploitation, which must also be reported to other authorities in accordance with State law.

3. Unexplained absence from a residential program of twelve (12) hours duration.

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

5. Emergency hospitalization or emergency room treatment of a person receiving 1915(i) services.

6. Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.

7. Disasters including fires, floods, tornadoes, hurricanes, earth quakes and disease outbreaks.

8. Use of seclusion or restraint, either mechanical or chemical. Providers are prohibited from the use of:

a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,

b) Seclusion,

c) Time-out, and

d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,

G. Death of a person on program property, at a program sponsored event or during an unexplained absence from a residential program site must be reported to the DMH within eight (8) hours of the death.

H. If a provider has any question whether or not a situation/incident should be reported, the provider must contact DMH.

I. Reporting guidelines are determined by the setting in which the suspected abuse/neglect/exploitation occurred.

1. Suspected abuse/neglect/exploitation that occurs in a home setting must be reported to the Vulnerable Adults Unit (VAU) at the Attorney General's Office and the Division of Family and Children Services (DFCS) at the Mississippi Department of Human Services (DHS).

2. Complaints of abuse/neglect/exploitation of persons in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU) and the Office of the State Attorney General (AG)..

3. Suspected abuse/neglect/exploitation that occurs in any Day Support services facility, which Division of Medicaid defines as a community-based group program for adults designed to meet the needs of adults with impairments through individual PSS, which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling beneficiaries to live in the community must be reported to DMH if the facility is certified by the DMH.

4. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.

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

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

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

Rule 7.8: Grievances and Complaints

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

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

C. A toll-free Helpline must be available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the DMH toll-free number in a prominent place throughout

each program site.

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

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

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

Rule 7.9: Appeals and Hearings

A. If it is determined that a person does not meet 1915(i) eligibility criteria or if decisions made by the Department of Mental Health (DMH) result in services being denied, terminated, or reduced the /legal representative has the right to request an appeal from the DMH.

B. If the person and/or guardian/legal representative disagrees with the decision made by the DMH Executive Director a written request to appeal the decision may be made to the Executive Director of the Division of Medicaid. [Refer to Miss. Admin. Code Part 300]

C. During the appeals process, contested services must remain in place, unless the decision is made for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment by the service providers. The Targeted Case Manager is responsible for ensuring that the person continues to receive all services that were in place prior to the notice of change.

D. Providers who must be certified by DMH may appeal issues related to certification to DMH as outlined in the DMH Operational Standards and Administrative Code.

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

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

Rule 7.10: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

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

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

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

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

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

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

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

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

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

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

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Targeted Case Managers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.710.

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