Title 23: Division of Medicaid

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

Part 208 Chapter 1: Home and Community-Based Services (HCBS) Elderly and Disabled Waiver

Rule 1.6: Covered Services

A. The Division of Medicaid covers the following services through the Elderly and Disabled (E&D) Waiver:

1. Case Management (CM) - Case Management services include the identification of resources as well as the coordination and monitoring of services by case managers to ensure the health and social needs, preferences and goals of individuals are met throughout the person centered planning process and service provision.

    a) The case management team, consisting of a registered nurse (RN) and Licensed Social Worker (LSW), must conduct face-to-face visits together using the comprehensive long-term services and support (LTSS) assessment instrument at the time of admission and recertification.

        1) Additionally, the RN and LSW must visit the person together on a quarterly basis.

        2) 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.

    b) Each case management team must maintain no more than an average, active case load of one hundred (100) E&D Waiver persons.

        1) If a case management team maintains an average, active case load greater than one hundred (100), prior approval must be obtained by the Division of Medicaid.

        2) Approval will be considered based upon causation and duration of the increase.

2. Adult Day Care Services - Adult Day Care (ADC) services include community-based comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours.

    a) ADC services must 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 and center-sponsored activities, with cost being included in the rate paid to providers, and

5) Social, health, and recreational activities which optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment and personal preferences and,

6) Provide information on, and referral to, vocational services.

b) The Division of Medicaid reimburses the ADC when the ADC:

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

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

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

2) Provides services for at least eight (8) continuous hours per day, Monday through Friday.

c) ADC 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.

d) 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 - Personal Care Services (PCS) are non-medical support services provided in the home or community 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.

a) PCS:

1) Includes assistance to functionally impaired persons allowing them to remain in their home by providing assistance with activities of daily living, instrumental activities of daily living, and assistance in participating in community activities, and

2) Must be provided in accordance with a waiver person’s PSS,

3) Are approved by the Division of Medicaid based upon assessed needs of the person with the person's involvement with sufficient documentation to substantiate the requested number of hours.

(a) The frequency cannot duplicate hours rendered for respite care and/or home health aide services.

(b) Any increase or decrease in the number of hours indicated on the PSS must be prior approved by the Division of Medicaid.

4) A personal care attendant (PCA) may accompany persons during community activities as a passenger in the vehicle.

(a) The PCA cannot drive the vehicle.

(b) If transportation is provided by a Medicaid Non-Emergency Transportation (NET) provider, there must be documentation that it is medically necessary for a PCA to accompany person.

b) PCA responsibilities include:

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

(a) Mouth and denture care,

(b) Shaving,

(c) Finger and toe nail care excluding the cutting of the nails,

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

(e) Bathing in the tub or shower or a complete or partial bed bath,

(f) Dressing,

(g) Toileting including emptying and cleaning a bed pan, commode chair, or urinal,

(h) Reminding person to take prescribed medication,

(i) Eating,

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

(k) Ambulation.

2) Performing housekeeping tasks including, but not limited to:

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

(b) Preparing shopping lists,

(c) Purchasing and storing groceries,

(d) Preparing and serving meals,

(e) Laundering and ironing clothes,

(f) Running errands,

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

(h) Changing linen and making the bed, and

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

3) Reporting to the PCS supervisor, PCS director, or the individual designated to supervise the PCS program.

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

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

2) Making home visits with PCAs to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

3) Reviewing and approving PCS duties on the approved service plans,

4) Receiving and processing requests for services,

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

6) Evaluating the work, skills, and job performance of the PCA,

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

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

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

10) Performing 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, and

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

d) Persons enrolled in the E&D Waiver who elect to receive PCS must allow providers to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system and must:

1) Not allow the one (1) time password (OTP) device to be removed from their home except by the Case Management Agency if an OTP is being utilized, and

2) Not submit service begin and end times on behalf of personal care provider.

4. In-Home or Institutional Respite Services - In-Home or Institutional Respite Services, either in an institutional or home setting, is covered for persons unable to care for themselves in the absence, or need for relief, of the person's primary full-time, live-in caregiver(s) on a short-term basis during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the person.

a) In-Home Respite Care Services are non-medical, unskilled services which are covered:

1) For the person who:

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

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

2) No more than sixty (60) hours per month are allowed. In-Home Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

3) When the person enrolled in the E&D Waiver who elects to receive In-Home Respite allows the provider to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system must:

(a) Not allow the one (1) time password (OTP) devices to be removed from their home except by the Case Management Agency if an OTP is being utilized, and

(b) Not submit service begin and end times on behalf of the personal care provider.

b) Institutional Respite Care Services are covered only when provided in a Mississippi Medicaid enrolled Title XIX hospital, nursing facility, or licensed swing bed facility.

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

2) Are covered no more than thirty (30) calendar days per state fiscal year.

5. Home Delivered Meals are covered when the person is unable to leave home without assistance, unable to prepare their own meals, and/or have no responsible caregiver in the home and must meet the following requirements:

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

1) Ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health (MSDH) regulations governing food service sanitation.

2) Provide, at a minimum, the following service supplies with each individual meal:

(a) Straw which is six (6) inches individually wrapped (jumbo size),

(b) Napkin which is thirteen (13) inches by seventeen (17) inches,

(c) Flatware with each individually wrapped package to contain non-brittle medium weight plastic fork or spoon and serrated knife with handles at least three and one half ($3^{1/2}$) inches long,

(d) Carry-out tray which is Federal Drug Administration (FDA) approved compartment tray for hot foods.

(e) Condiments to include individual packets of iodized salt and pepper and when necessary to complete the menu other individually packed condiments, such as ketchup, mustard, mayonnaise, salad dressings, and tartar sauce.

(f) Cups which are four (4) ounce styrofoam, with covers for cold foods to accompany carry-out trays.

3) Use transporting equipment designed to protect the meal from potential contamination, and designed to hold the food at a temperature below forty-five (45) degrees Fahrenheit, or above one hundred forty (140) degrees Fahrenheit, as appropriate.

4) Have contingency plans to ensure that in the event of an emergency enrolled persons will have access to a nutritionally balanced meal.

5) Bring to the attention of the appropriate officials for follow-up any conditions or circumstances which place the person or the household in imminent danger.

6) Comply with all state and local health laws and ordinances concerning preparation, handling and service of food.

7) Must have available for use, upon request, appropriate food containers and utensils for blind and individuals with limited dexterity or mobility.

8) Must ensure all food preparation employees be under the supervision of an employee who will ensure the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must consult with the service provider dietitian for advice and consultation, as necessary.

9) May use various methods of delivery. However, all food preparation standards set forth in this section must be met.

10) Must ensure only one (1) hot meal is delivered per day and no more than fourteen (14) frozen meals per delivery.

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

    If person, or designated caregiver, is not home at time of delivery, the meals must not be delivered.

    (b) Meals delivered to anyone other than the person or their caregiver is not billable.

12) Establish procedures to be implemented by employees during an emergency (fire, disaster) and train employees in their assigned responsibilities. In emergency situations, such as under severe weather conditions, the provider may leave nonperishable meals or food items for a person, provided that proper storage and heating facilities are available in the home, and the person is able to prepare the meal with available assistance.

13) Forward billing information including the delivery documentation to the case manager on a monthly basis.

6. Extended Home Health Services, including skilled nursing and home health aide services, are covered when the following are met:

    a) When prior approved by the Division of Medicaid, additional home health visits after the initial thirty-six (36) State Plan home health visits have been exhausted.

    b) Home Health Agencies must follow all rules and regulations set forth in Miss. Admin. Code Part 215.

        1) The word "waiver" does not apply to anything other than Home Health visits with prior approval from the Division of Medicaid.

        2) Persons are subject to home health co-payment requirements through the thirty-sixth (36^{th}) visit of State Plan home health services.

        3) Beginning with the thirty-seventh (37^{th}) prior approved waiver home health visit, within the state fiscal year, the person is exempt from home health co-payment requirements.

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

7. Physical therapy services are covered when:

    a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a physical therapist who:

        1) Has a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi, and

        2) Meets the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

    b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

8. Speech therapy services are covered when:

    a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a speech therapist who:

        1) Has a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi, and

        2) Meets the state and federal licensing and/or certification requirements to perform

physical therapy services in the State of Mississippi.

b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

9. Community Transition Services are covered for initial expenses required for setting up a household. The expenses must be included in the approved PSS and expenses are limited as designated by the Division of Medicaid.

   a) Community Transition Services are covered when the person meets all of the following criteria:

      1) Be in a long- term care (LTC) facility for greater than ninety (90) days in a long-term care service track with a minimum of one (1) day paid by Medicaid.

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

      3) Be transitioning from a nursing facility where these covered items and services were provided, and transitioning to a residence where these covered items and services are not normally furnished.

      4) Must meet the level of care criteria for a nursing facility and, if not for the provision of HCB long-term care services, the person would continue to require the level of care provided in the nursing facility.

      5) Be transitioning to a qualified residence which must pass a U.S. Department of Housing and Urban Development (HUD) Housing Quality Standards inspection and be prior approved by the Division of Medicaid and meet one (1) of the following criteria:

         (a) A home owned or leased by the transitioning person or the person's family member,

         (b) An apartment with lockable access leased to the transitioning person which includes living, sleeping, bathing, and cooking areas over which the person or the person's family has domain and control, or

         (c) A residence in a community-based residential setting in which no more than four (4) unrelated persons reside.

   b) Community Transition Services include the following:

      1) Security and Utility Deposits which:

         (a) Has a limit of $1,000.00 per individual transitioning from the nursing facility back into the community.

(b) Must be required to occupy and use a community domicile.

(c) Only includes deposits for telephone, electricity, heating, and water.

(d) Includes payment of past due bills which inhibit the person's ability to transition from the nursing facility into the community when no other payment source is available.

(e) Must be listed on the PSS prior to transitioning from the facility.

2) Essential Household Furnishings which must be documented on the Division of Medicaid's required form and listed in the PSS prior to the person transitioning from the nursing facility and includes:

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

(b) Purchased items including furniture, window coverings, food preparation items, bed/bath items, one (1) time pantry stocking to ensure proper nutrition, and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the individuals' health and safety, which has a limit of two hundred and fifty dollars ($250.00) to ensure that all belongings from the institution of the person are able to be taken to the community residence.

4) Necessary Home Accessibility Adaptations (HAA) are covered for physical adaptations to the private residence of the person or the person's family, required by the person's Plan of Services and Supports (PSS), that are necessary to ensure the health, welfare, and their safety or that enable the person to function with greater independence in the residence.

(a) Covered HAA include:

(1) The installation of ramps and grab bars,

(2) Widening of doorways,

(3) Modification of bathroom facilities, and

(4) Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.

(b) Non-covered HAA include, but are not limited to:

(1) Those that are of general utility and are not of a direct medical or remedial benefit to the person, or

(2) Those that add to the total square footage of the home except when necessary to complete an adaptation to include improving entrance/egress to a home or configuring a bathroom to accommodate a wheelchair.

(c) HAA will be authorized for persons up to ninety (90) consecutive days prior to the transition of an institutionalized person to the community setting.

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

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

(f) All providers/subcontracted entities rendering environmental accessibility adaptation services must:

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

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

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

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

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

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

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

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

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

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

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

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

(a) Required by the person's PSS,

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

(c) It enables the person to function with greater independence in the home when no other payment source is available.

6) Community Navigation:

(a) Is defined as activities required to:

(1) Access, arrange for, and procure needed resources,

(2) Develop the person's profile to assist in the PSS development, including conducting person-centered planning meetings, discovery, identification of housing, and assistance with completion of applications for community resources and housing.

(b) Has a maximum unit allowance of two hundred (200) units or one hundred eighty (180) days.

(c) Is reimbursed per a 15 minute unit rate up to a hundred (100) units for a maximum of thirty (30) days post transition into the community.

c) Community Transition Services are furnished only to the extent that:

1) They are reasonable and necessary as determined through the service plan development process, and

(a) Clearly identified in the service plan, and

(b) The person is unable to pay for the expense or when the services cannot be obtained from other sources.

d) Community Transition Services do not include:

1) Monthly rental or mortgage expenses,

2) Regular utility charges,

3) Food except for the one time pantry stocking, and/or

4) Household appliances or items that are intended for purely diversional/recreational purposes.

e) Community Transition Services must be essential to:

1) Ensuring that the 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 setting.

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

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017; Revised eff. 01/01/2013.

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Part 208 Chapter 1: Home and Community-Based Services (HCBS) Elderly and Disabled Waiver

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        1) Additionally, the RN and LSW must visit the person together on a quarterly basis.

        2) 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.

    b) Each case management team must maintain no more than an average, active case load of one hundred (100) E&D Waiver persons.

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        2) Approval will be considered based upon causation and duration of the increase.

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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.

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3) When the person enrolled in the E&D Waiver who elects to receive In-Home Respite allows the provider to utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system must:

(a) Not allow the one (1) time password (OTP) devices to be removed from their home except by the Case Management Agency if an OTP is being utilized, and

(b) Not submit service begin and end times on behalf of the personal care provider.

b) Institutional Respite Care Services are covered only when provided in a Mississippi Medicaid enrolled Title XIX hospital, nursing facility, or licensed swing bed facility.

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

2) Are covered no more than thirty (30) calendar days per state fiscal year.

5. Home Delivered Meals are covered when the person is unable to leave home without assistance, unable to prepare their own meals, and/or have no responsible caregiver in the home and must meet the following requirements:

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

1) Ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health (MSDH) regulations governing food service sanitation.

2) Provide, at a minimum, the following service supplies with each individual meal:

(a) Straw which is six (6) inches individually wrapped (jumbo size),

(b) Napkin which is thirteen (13) inches by seventeen (17) inches,

(c) Flatware with each individually wrapped package to contain non-brittle medium weight plastic fork or spoon and serrated knife with handles at least three and one half ($3^{1/2}$) inches long,

(d) Carry-out tray which is Federal Drug Administration (FDA) approved compartment tray for hot foods.

(e) Condiments to include individual packets of iodized salt and pepper and when necessary to complete the menu other individually packed condiments, such as ketchup, mustard, mayonnaise, salad dressings, and tartar sauce.

(f) Cups which are four (4) ounce styrofoam, with covers for cold foods to accompany carry-out trays.

3) Use transporting equipment designed to protect the meal from potential contamination, and designed to hold the food at a temperature below forty-five (45) degrees Fahrenheit, or above one hundred forty (140) degrees Fahrenheit, as appropriate.

4) Have contingency plans to ensure that in the event of an emergency enrolled persons will have access to a nutritionally balanced meal.

5) Bring to the attention of the appropriate officials for follow-up any conditions or circumstances which place the person or the household in imminent danger.

6) Comply with all state and local health laws and ordinances concerning preparation, handling and service of food.

7) Must have available for use, upon request, appropriate food containers and utensils for blind and individuals with limited dexterity or mobility.

8) Must ensure all food preparation employees be under the supervision of an employee who will ensure the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must consult with the service provider dietitian for advice and consultation, as necessary.

9) May use various methods of delivery. However, all food preparation standards set forth in this section must be met.

10) Must ensure only one (1) hot meal is delivered per day and no more than fourteen (14) frozen meals per delivery.

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

If person, or designated caregiver, is not home at time of delivery, the meals must not be delivered.

(b) Meals delivered to anyone other than the person or their caregiver is not billable.

12) Establish procedures to be implemented by employees during an emergency (fire, disaster) and train employees in their assigned responsibilities. In emergency situations, such as under severe weather conditions, the provider may leave nonperishable meals or food items for a person, provided that proper storage and heating facilities are available in the home, and the person is able to prepare the meal with available assistance.

13) Forward billing information including the delivery documentation to the case manager on a monthly basis.

6. Extended Home Health Services, including skilled nursing and home health aide services, are covered when the following are met:

    a) When prior approved by the Division of Medicaid, additional home health visits after the initial ~~twenty~~thirty-six~~five~~ (~~25~~36) State Plan home health visits have been exhausted.

    b) Home Health Agencies must follow all rules and regulations set forth in Miss. Admin. Code Part 215.

        1) The word "waiver" does not apply to anything other than Home Health visits with prior approval from the Division of Medicaid.

        2) Persons are subject to home health co-payment requirements through the ~~twenty~~thirty-~~fifth~~ sixth (36~~25~~th) visit of State Plan home health services.

        3) Beginning with the ~~twenty~~thirty-~~sixth~~seventh (~~26~~37th) prior approved~~,~~ waiver home health visit, within the state fiscal year, the person is exempt from home health co-payment requirements.

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

7. Physical therapy services are covered when:

    a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a physical therapist who:

        1) Has a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi, and

        2) Meets the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

    b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

8. Speech therapy services are covered when:

    a) Provided by a currently enrolled Mississippi Medicaid home health agency that employs a speech therapist who:

        1) Has a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi, and

2) Meets the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

b) Provided in accordance with Miss. Admin. Code Title 23, Part 213.

9. Community Transition Services are covered for initial expenses required for setting up a household. The expenses must be included in the approved PSS and expenses are limited as designated by the Division of Medicaid.

a) Community Transition Services are covered when the person meets all of the following criteria:

1) Be in a long- term care (LTC) facility for greater than ninety (90) days in a long-term care service track with a minimum of one (1) day paid by Medicaid.

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

3) Be transitioning from a nursing facility where these covered items and services were provided, and transitioning to a residence where these covered items and services are not normally furnished.

4) Must meet the level of care criteria for a nursing facility and, if not for the provision of HCB long-term care services, the person would continue to require the level of care provided in the nursing facility.

5) Be transitioning to a qualified residence which must pass a U.S. Department of Housing and Urban Development (HUD) Housing Quality Standards inspection and be prior approved by the Division of Medicaid and meet one (1) of the following criteria:

(a) A home owned or leased by the transitioning person or the person's family member,

(b) An apartment with lockable access leased to the transitioning person which includes living, sleeping, bathing, and cooking areas over which the person or the person's family has domain and control, or

(c) A residence in a community-based residential setting in which no more than four (4) unrelated persons reside.

b) Community Transition Services include the following:

1) Security and Utility Deposits which:

(a) Has a limit of $1,000.00 per individual transitioning from the nursing facility back into the community.

(b) Must be required to occupy and use a community domicile.

(c) Only includes deposits for telephone, electricity, heating, and water.

(d) Includes payment of past due bills which inhibit the person's ability to transition from the nursing facility into the community when no other payment source is available.

(e) Must be listed on the PSS prior to transitioning from the facility.

2) Essential Household Furnishings which must be documented on the Division of Medicaid's required form and listed in the PSS prior to the person transitioning from the nursing facility and includes:

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

(b) Purchased items including furniture, window coverings, food preparation items, bed/bath items, one (1) time pantry stocking to ensure proper nutrition, and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the individuals' health and safety, which has a limit of two hundred and fifty dollars ($250.00) to ensure that all belongings from the institution of the person are able to be taken to the community residence.

4) Necessary Home Accessibility Adaptations (HAA) are covered for physical adaptations to the private residence of the person or the person's family, required by the person's Plan of Services and Supports (PSS), that are necessary to ensure the health, welfare, and their safety or that enable the person to function with greater independence in the residence.

(a) Covered HAA include:

(1) The installation of ramps and grab bars,

(2) Widening of doorways,

(3) Modification of bathroom facilities, and

(4) Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.

(b) Non-covered HAA include, but are not limited to:

(1) Those that are of general utility and are not of a direct medical or remedial

benefit to the person, or

(2) Those that add to the total square footage of the home except when necessary to complete an adaptation to include improving entrance/egress to a home or configuring a bathroom to accommodate a wheelchair.

(c) HAA will be authorized for persons up to ninety (90) consecutive days prior to the transition of an institutionalized person to the community setting.

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

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

(f) All providers/subcontracted entities rendering environmental accessibility adaptation services must:

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

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

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

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

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

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

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

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

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

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

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

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

(a) Required by the person's PSS,

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

(c) It enables the person to function with greater independence in the home when no other payment source is available.

6) Community Navigation:

(a) Is defined as activities required to:

(1) Access, arrange for, and procure needed resources,

(2) Develop the person's profile to assist in the PSS development, including conducting person-centered planning meetings, discovery, identification of housing, and assistance with completion of applications for community resources and housing.

(b) Has a maximum unit allowance of two hundred (200) units or one hundred eighty (180) days.

(c) Is reimbursed per a 15 minute unit rate up to a hundred (100) units for a maximum of thirty (30) days post transition into the community.

c) Community Transition Services are furnished only to the extent that:

1) They are reasonable and necessary as determined through the service plan development process, and

(a) Clearly identified in the service plan, and

(b) The person is unable to pay for the expense or when the services cannot be obtained from other sources.

d) Community Transition Services do not include:

1) Monthly rental or mortgage expenses,

2) Regular utility charges,

3) Food except for the one time pantry stocking, and/or

4) Household appliances or items that are intended for purely diversional/recreational purposes.

e) Community Transition Services must be essential to:

1) Ensuring that the 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 setting.

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

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017; Revised eff. 01/01/2013.