

Title 23: Division of Medicaid

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

Chapter 2: Home and Community-Based Services (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 the Independent Living (IL) Waiver.
- B. Waiver participants must reside in a private residence which is fully integrated with opportunities for full access to the greater community, and meet the requirements of a Home and Community-Based (HCB) setting.
- C. 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).
- D. The IL Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS).
- E. 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 as outlined in an interagency agreement.
- F. The average cost for a waiver applicant/person must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicare and Medicaid 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, 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.2: Eligibility

- A. Eligibility requirements for the Independent Living (IL) Waiver Program include the following:

1. Persons must be age sixteen (16) or older.
2. Persons must require nursing facility level of care as determined by a comprehensive long-term services and supports (LTSS) assessment.
3. Persons must exhibit severe orthopedic and/or neurological impairments that render them dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living.
4. Persons must be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants (PCAs), case managers or others involved in their care.
5. Persons must be certified as medically stable by a physician. The Division of Medicaid defines medical stability as the absence of all of the following:
 - a) An active, life-threatening condition requiring systematic therapeutic measures,
 - b) Intravenous drip to control or support blood pressure, and
 - c) Intracranial pressure or arterial monitoring.
6. Persons must meet the criteria in one (1) of the following Categories of Eligibility (COE):
 - a) Supplemental Security Income (SSI),
 - b) Parents and Other Caretaker Relatives Program,
 - c) Disabled Child Living at Home,
 - d) Children under age nineteen (19) who meet the applicable income requirements,
 - e) Disabled Adult Child,
 - f) Protected Foster Care Adolescents,
 - g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,
 - h) IV-E Foster Children and Adoption Assistance Children,
 - i) An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income

Trust in order to qualify, or

j) Working Disabled.

- B. Persons enrolled in the IL Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home and are prohibited from receiving additional Medicaid services through another waiver program.
- C. Persons enrolled in the IL Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 2.2.E. eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 2.3: Provider Qualifications

- A. The Mississippi Department of Rehabilitation Services (MDRS), as the provider of Independent Living (IL) Waiver services, must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Rule 4.8 in addition to the listed provider-type specific requirements and provide to the Division of Medicaid:
 - 1. A National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
 - 2. A copy of the provider's current license or permit, if applicable,
 - 3. Verification of a social security number using a social security card, driver's license with a social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification document must match the name noted on the W-9, and
 - 4. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name
- B. To participate as a Home and Community-Based Services (HCBS) IL Waiver provider, MDRS must:
 - 1. Conduct a national criminal background check with fingerprints on all employees and volunteers prior to employment and every two (2) years thereafter, and maintain the record in the employee's personnel file.

2. Conduct registry checks, prior to employment and monthly thereafter, to ensure employees or volunteers are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record in the employee's personnel file.
3. Not have been, or employ individuals or volunteers who have been, convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
4. Have written criteria for service provision, including procedures for dealing with emergency service requests.
5. Have responsible personnel management including:
 - a) An appropriate process used in the recruitment, selection, retention, and termination of employees,
 - b) Written personnel policies and job descriptions,
 - c) Maintenance of a current training plan as a component of the policies/procedures documenting the method for the completion of required training. The training plan must require all employees to meet training requirements as designated by the Division of Medicaid upon hire, and annually thereafter, and
 - d) Maintenance of a personnel file on every employee and volunteer with the following required information including, but not limited to, credentialing documentation, training records, and performance reviews which must be made available to the Division of Medicaid upon request.
6. Be compliant with all federal and state regulations.

C. MDRS must ensure that all employees and contracted entities meet the service specific requirements below prior to the provision of services:

1. Case Management must be provided by Registered Nurses (RN) and Case Managers who must meet the following qualifications:
 - a) The Registered Nurse must:

- 1) Have a current and active unencumbered Registered Nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license, and
 - 2) Have at least one (1) year of experience with the aged and/or individuals with disabilities.
- b) The Case Manager must:
- 1) Possess at a minimum a Bachelor's degree in Rehabilitation Counseling or other related field, and
 - 2) Have one (1) year of experience working with individuals with disabilities.
- c) Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Case Manager.
- d) MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken against nurse employees.
- e) MDRS must verify provider qualifications upon hire and at least annually.
2. Personal Care Attendant (PCA) services must be provided by a PCA who must meet the following qualifications:
- a) Be chosen by the person/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified PCAs.
 - b) Must meet basic competencies that include both educational and functional requirements.
 - c) Be certified by MDRS Case Managers which includes documentation that the PCA meets the requirements.
 - d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with the PCA program.
 - 1) The educational program must be personalized with participation of the person to ensure his/her specific needs are met.
 - 2) The cost of training/instruction of personal care attendants cannot be provided under the waiver.

- 3) The individual must demonstrate competency to perform each activity of daily living task to the person/representative and Case Manager prior to rendering any IL waiver service.
- 4) In addition to the technical skills required, the PCA must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the person/representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.
 - (a) PCA training must be conducted by the person/representative and the Case Manager, or an agency permitted by law to train nurse aides, and must include:
 - (i) The purpose and philosophy of self-directed services by the disabled,
 - (ii) Disability awareness,
 - (iii) Employee-employer relationships and the need for respect for the participant's privacy and property.
 - (iv) Basic elements of body functions,
 - (v) Infection control procedures,
 - (vi) Maintaining a clean and safe environment,
 - (vii) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.
 - (viii) Meal preparation and menus that provide a balanced, nutritional diet.
 - e) A prospective PCA who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities is deemed to meet the classroom training requirements. Competency certification for these personal care providers by the person/representative and Case Manager is required. A PCA that has satisfactorily provided PCA services for four (4)

weeks prior to coverage under the IL waiver program, with such service certified by and verified by the person/representative and Case Manager, is deemed to meet the training requirement.

- f) PCA services can be furnished by family members provided they are not the spouse or the parent or step-parent of a minor child, or reside in the home with the person. Only qualified family members not legally responsible for the waiver person can be employed as the PCA. Family members must meet provider standards and be certified competent to perform the required tasks by the person and Case Manager. There must be adequate justification for the family member to function as the PCA such as lack of other qualified attendants in the remote area.
 - g) Minimum requirements include:
 - 1) Must be at least 18 years of age,
 - 2) Must be a high school graduate, have a general educational development (GED) certificate or demonstrates the ability to read and write to complete required forms and reports of visits,
 - 3) Must be able to follow verbal and written instructions,
 - 4) Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to person,
 - 5) Must be certified as meeting the training and competence requirement by the person and the Case Manager, and
 - 6) Must be able to communicate effectively and carry out directions.
 - h) MDRS must verify the competency for all PCAs as needed.
3. Specialized Medical Equipment and Supplies must be provided by entities who meet the following qualifications:
- a) Have a permanent local address and phone number,
 - b) Have a State of Mississippi sales tax number,
 - c) Have Federal identification number or social security number,
 - d) Have liability insurance,
 - e) Must honor the manufacturer's guarantee or warranty as published,

- f) Must provide repair capability for products, and
- g) Meet the following additional standards if providing custom in-house seating systems, powered mobility, three wheel scooters, and high-tech systems:
 - 1) Must provide documented proof of attendance of training with seating and positioning,
 - 2) Maintain a current list of power chair manufacturers represented,
 - 3) Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer,
 - 4) Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above,
 - 5) Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting,
 - 6) Must have and present at purchase all necessary manuals and written warranties,
 - 7) Must be able to provide instruction in proper use and care of equipment,
 - 8) Must be capable to provide training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price, and
 - 9) Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.
- 4. Transition Assistance services must be provided by a Registered Nurse and/or Case Manager.
- 5. Environmental Accessibility Adaptation services must be provided by entities who meet the following:
 - a) Meet all state or local requirements for licensure/certification including, but not limited to, building contractors, plumbers, electricians or engineers.

- b) Provide services in accordance with applicable state housing and local building codes.
- c) Ensure the quality of work provided meets standards identified below:
 - 1) All work must be done in a fashion that exhibits good craftsmanship.
 - 2) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions.
 - 3) The contractor must obtain all permits required by local governmental bodies.
 - 4) All non-salvaged supplies and/or materials must be new and of best quality, without defects.
 - 5) The contractor must remove all excess materials and trash, leaving the site clear of debris at completion of the project,
 - 6) All work must be accomplished in compliance with applicable codes, ordinances, regulations and laws.
 - 7) The specifications and drawings cannot be modified without a written change order from the case manager.
 - 8) No accessibility barriers can be created by the modification and/or construction process.

Source: 42 C.F.R. 455, Subpart E; 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff. 09/01/2019.

Rule 2.4: 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. §§ 37-33-157, 43-13-117, 43-13-121.

History: Moved and revised from Miss. Admin. Code Part 208, Rule 2.5 eff. 09/01/2019. Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.5: Quality Management

- A. Waiver providers must meet applicable service specifications as referenced in the Independent Living Waiver document approved by the Centers for Medicare and Medicaid Services (CMS).
- B. Waiver providers and/or contractors must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Mississippi Department of Rehabilitative Services (MDRS) and the Division of Medicaid.
- C. All reports of abuse, neglect or exploitation, as defined below, must be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS and the Department of Human Services (DHS). The potential abuse, neglect, or exploitation must be reported to the Division of Medicaid/Long Term Care within twenty-four (24) hours.
 1. Abuse (A) is defined as willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.
 2. Neglect (N) includes, but is not limited to, a single incident of the inability of a vulnerable person living alone to provide for himself and/or failure of a caretaker to provide what a reasonably prudent person would do.
 3. Exploitation (E) is the illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person and includes acts committed pursuant to a power of attorney and can include but is not limited to a single incident.
- D. The Department of Human Services (DHS), Division of Aging and Adult Services is responsible for investigating allegations of Abuse, Neglect and Exploitation. The Division of Medicaid and DHS have a Memorandum of Understanding (MOU) allowing a free flow of

information between the two (2) agencies to ensure the health and welfare of waiver participants.

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

1. Level of care determination consistent with the need for institutionalization,
2. Plan of Services and Supports (PSS) consistent with the participant's needs,
3. Providers must meet the provider specifications of the CMS approved waiver, including licensure/certification requirements,
4. Critical event/incident reporting mechanism for participants and caregivers to report concerns/incidents of abuse, neglect, and exploitation,
5. Division of Medicaid retention of administrative authority over the waiver program,
6. Division of Medicaid retention of financial accountability for the waiver program.

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

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Moved and revised from Miss. Admin. Code Part 208, Rule 2.6 eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.6: Covered Services

A. The Division of Medicaid covers the following services through the Independent Living (IL) Waiver:

1. Case Management services are mandatory services provided by a Registered Nurse (RN) and/or a Case Manager and include the following activities:
 - a) Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the Plan of Services and Supports (PSS) to ensure services specified on the PSS are appropriate and reflective of the participant's individual needs, preferences, and goals.
 - b) Must assist waiver applicants/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

- c) Are responsible for ongoing monitoring of the provision of services included in the participant's PSS.
 - d) Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the person to ensure that services remain in place without issue and to identify any problems or changes that are required. More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.
 - e) Are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).
- C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. PCA services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.
1. PCA services must be provided in accordance with the approved PSS, cannot be purely diversional in nature, and may include:
 - a) Support for activities of daily living such as, but not limited to, bathing (sponge/ tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.
 - b) Assistance with housekeeping that is directly related to the person's disability, and which is necessary for the health and well-being of the person such as, but not limited to, changing bed linens, straightening area used by the person, doing the personal laundry of the person, preparation of meals for the person, cleaning the person's equipment such as wheelchairs or walkers.
 - c) Food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;
 - d) Support for community participation by accompanying and assisting the person as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.
 2. If the person/representative has not located or chosen a PCA within six months after admission to the waiver, or after being without a PCA for six (6) consecutive months, the person is reevaluated for the need for waiver services to determine if the waiver can meet the needs of this person.

- D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the PSS, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
1. The need for use of such items must be documented in the assessment/case file, ordered by a physician and approved on the PSS.
 2. Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. Items not of direct medical or remedial benefit to the person are excluded.
 3. Specialized medical equipment and supplies must meet the applicable standards of manufacture, design and installation.
 4. Requests for specialized medical equipment and supplies must be evaluated by the Mississippi Department of Rehabilitation Services (MDRS) counselor or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for specialized medical equipment and/or supplies for approval.
 5. Medicaid waiver funds are utilized as the payor of last resort.
- E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the IL Waiver program.
1. Transition Assistance services include the following:
 - a) Security deposits required to obtain a lease on an apartment or home.
 - b) Essential furnishings required to occupy and use a community domicile. Televisions or cable TV access are not essential furnishings.
 - c) Moving expenses.
 - d) Fees/deposits for utilities and service access for a telephone.
 - e) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.
 2. Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars (\$800.00) per lifetime. These expenses must be included in the approved PSS.

3. To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:
 - a) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid;
 - b) Have no other source to fund or obtain the necessary items/supports;
 - c) Be moving from a nursing facility where these items/services were provided;
 - d) Be moving to a residence where these items/services are not normally furnished.
 4. Transition Assistance must be completed by the day the person relocates from the institution.
 5. Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.
- F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's PSS, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.
1. Environmental accessibility adaptations must be included in the approved PSS.
 2. Environmental accessibility adaptations include the following:
 - a) Installation of ramps and grab bars.
 - b) Widening of doorways.
 - c) Modification of bathroom facilities.
 - d) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.
 3. Environmental accessibility adaptations exclude the following:
 - a) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.
 - b) Adaptations which add to the square footage of the home.
 4. Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for environmental accessibility adaptation.

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

Source: 42 U.S.C. 1396n; 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff 09/01/2019; Revised 01/01/2013.

Rule 2.7: Prior Approval/Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Independent Living (IL) Home and Community-Based Waiver program. To obtain approval, the Mississippi Department of Rehabilitation Services (MDRS) must complete and submit the current Division of Medicaid-approved forms as follows:
 1. Long Term Services and Supports (LTSS) Assessment,
 2. Bill of Rights,
 3. Plan of Services and Supports (PSS),
 4. Emergency Preparedness Plan,
 5. Informed Choice Form,
 6. Physician's Certification of Medical Stability and Nursing Facility Level of Care, and
 7. Other supportive documentation as needed including, but not limited to, prescriptions and assistive technology recommendations.
- B. An eligible person can only be enrolled in one (1) Home and Community-Based Service Waiver program at a time.
- C. Added services must be prior approved by the Division of Medicaid.
- D. MDRS is responsible for implementation of the PSS. The Division of Medicaid and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. the Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, person phone calls from the Medicaid agency, and other strategies as needed.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; Revised 01/01/2013.

Rule 2.8: Documentation/Record Maintenance

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the Independent Living (IL) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3.]

Source: 42 C.F.R. §§ 440.180, 441.303; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.9: Beneficiary Cost Sharing

- A. For persons enrolled in the Independent Living (IL) waiver, the cost-sharing is exempt if the service is being paid through the IL Waiver.
- B. If services are being paid through regular Mississippi Medicaid State Plan benefits, the cost-sharing is applicable unless exempt by one (1) of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

Source: 42 U.S.C. 1396a; 42 C.F.R. § 447.50 et seq.; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; Revised 01/01/2013.

Rule 2.10: Reimbursement

- A. Claims must be based on services that have been rendered to waiver persons as authorized by the Plan of Services and Supports (PSS), accurately billed by qualified waiver providers, and in accordance with the approved waiver.
- B. The Division of Medicaid conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.
- C. The Division of Medicaid denies payment for services when a waiver person or applicant is not Medicaid eligible on the date of service.
- D. The Division of Medicaid conducts post utilization reviews to ensure the services provided were on the person's approved PSS.
- E. Records documenting the provision of services must be maintained by the operating agency (if applicable) and providers of waiver services for a minimum of five (5) years.

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

Source: Miss Code Ann. §§ 43-13-117, 43-13-121.

History: Revised 09/01/2019; Revised 01/01/2013.

Rule 2.11: Due Process Protection

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

1. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services.
2. MDRS must inform the person/representative at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes.
3. MDRS must inform the person/representative of their rights which address disputes, complaints/ grievances and hearings.

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

1. Who are not given the choice of home and community-based services as an alternative to the institutional care,
2. Who are denied the service(s) of their choice or the provider(s) of their choice, or
3. Whose services are denied, suspended, reduced, or terminated.

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

D. The NOA must include:

1. A description of the action the provider has taken or intends to take,
2. An explanation for the action,
3. Notification that the person/representative has the right to file an appeal,
4. Procedures for filing an appeal,

5. Notification of person/representative's right to request a Fair Hearing,
6. Notice the person/representative has the right to have benefits continued pending the resolution of the appeal, and
7. The specific regulations or the change in Federal or State law that supports or requires the action.

Source: 42 C.F.R. 431, Subpart E; 42 C.F.R. §§ 440.180, 441.301, 441.307; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019.

Rule 2.12: Hearings and Appeals

- A. The waiver person or his/her representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. The request for a local or state hearing must be made in writing by the person or his/her legal representative.
- B. The waiver person may be represented by anyone he/she designates. If the person elects to be represented by someone other than a legal representative, he/she must designate the person in writing.
- C. The person has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period is extended if the person can show good cause for not filing within (30) days.
- D. A hearing cannot be scheduled until a written request is received by either the MDRS or the State Division of Medicaid office. If the written request is not received within the thirty (30) days of the NOA, services will be discontinued.
- E. At the local hearing level, MDRS issues a determination within thirty (30) days of the date of the initial request for a hearing.
- F. The person has the right to appeal a local hearing decision by requesting a State hearing; A State hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.
- G. At the State hearing level, the Division of Medicaid issues a determination within ninety (90) days of the date of the receipt initial request for a for a State Fair hearing.
- H. The waiver person or his representative has the following rights in connection with a local or state hearing:
 1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record.

2. The right to have legal representation at the hearing and to bring witnesses.
 3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
 4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.
- I. Services must remain in place during any appeal process, except when there is a threat of harm of the person or the service provider.

Source: 42 C.F.R. Part 431, Subpart E; Miss Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Moved and Revised from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019;
Revised 01/01/2013

Rule 2.13: 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 persons.
 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 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. §§ 37-33-157, 43-13-117, 43-13-121.

History: New rule moved from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019; New rule eff. 01/01/2017.

Rule 2.14: Monitoring Safeguards

- A. Mississippi Department of Rehabilitation Services (MDRS) case managers are required to provide each individual with written information regarding their rights as a waiver person at the initial assessment.
- B. Case managers must provide the person's information at the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect or exploitation is alleged.

Source: Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: New Rule moved from Miss. Admin. Code Part 208, Rule 2.8, eff. 09/01/2019.