Title 23: Division of Medicaid

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

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

Rule 1.1: General

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

B. Beneficiaries enrolled in the E&D Waiver must reside in a private residence that is fully integrated with opportunities for full access to the greater community, and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

C. 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).

D. Beneficiaries enrolled in the E&D Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries enrolled in the E&D Waiver who elect to receive hospice care may not receive waiver services that are duplicative of any services rendered through hospice services. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

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

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

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017.

Rule 1.2: Beneficiary Eligibility

A. In order to qualify as a beneficiary of the Elderly & Disabled (E&D) Waiver Program, individuals must meet the following criteria:

1. Must be twenty-one (21) years of age or older.

2. Must require nursing facility level of care as determined by a comprehensive long-term services and supports (LTSS) assessment.

3. Must meet the criteria in one (1) of the following Categories of Eligibility (COE):

    a) Supplemental Security Income (SSI) eligible under 20 C.F.R. § 416.202, or

    b) 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 to qualify.

B. Beneficiaries enrolled in the E&D Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home.

C. In the event of imminent danger to the beneficiary, caregiver or service provider, the beneficiary may be discharged from the waiver immediately.

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 to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 08/01/2016; Revised eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 1.3: Provider Enrollment

A. Providers of Elderly and Disabled (E&D) Waiver services must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Chapter 4 in addition to the listed provider-type specific requirements as set forth in sections B. and C. below 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 social security numbers for all provider owners 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 provider owners' W-9, and

4. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

5. A copy of business registration with the Mississippi Secretary of State.

B. To participate as a Home and Community-Based Services (HCBS) Elderly & Disabled (E&D) Waiver provider, the provider must, unless exempted in writing by the Division of Medicaid,

at the time of application and at all times thereafter:

1. Attend mandatory orientation, score at least eighty-five (85) on the orientation exam, and submit a completed proposal package to the Office of Long-Term Care for approval by the Division of Medicaid.

2. Once a provider is enrolled, submit any proposed changes to location, supervisory staffing, or organizational contact information, to the Division of Medicaid for approval prior to implementing the requested change.

3. Be established as an agency a business entity and provide the specified service(s) for a minimum of one (1) year prior to application.

4. Be approved for enrollment by Provider Enrollment and enter into a provider agreement with the Division of Medicaid within six (6) months of receiving an approved proposal package letter from the Office of Long-Term Care.

5. Have an advisory committee, representative of the community and beneficiary population, that meets quarterly to assure responsibility and accountability for performance and quality improvement. The advisory committee must maintain an agenda and minutes for each meeting and must provide public notice of the date, time, and location of each meeting at least twenty-four (24) hours in advance of the meeting.

6. Provide proof of financial solvency by:

    a) Establishing and maintaining a business line of credit for business operations from either a financial institution licensed to conduct banking or other Financial Deposit Insurance Corporation (FDIC) or National Credit Union Administration (NCUA) insured financial institutions. The approval amount for the business line of credit must be enough to cover operational costs/expenditures for at least three (3) months at all branch locations.

    b) Providing a copy of the provider's most current filed tax return for the business along with confirmation verifying it was filed. Examples of acceptable forms of confirmation include the following:

        1) 8879 form from a tax preparer, or

        2) 9325 form from the IRS with the submission identification (SID) number.

    c) Providing a copy of the provider's itemized expense report reflecting all income and expenditures for each month for the past twelve (12) months.

7. Establish an office with a physical address in the State of Mississippi that is not located in or on the grounds of a personal residence for a minimum of six (6) months prior to enrollment and maintain an approved physical office until the provider agreement is

terminated. The physical office must:

a) Have appropriate external signage with printed lettering that is visible and readable from the road,

b) Be compliant with applicable federal, state and local building requirements as well as all zoning, fire, OSHA, health codes and ordinances. It must also meet the requirements of the Americans with Disabilities Act (ADA),

c) Maintain an active business privilege tax license,

d) Ensure that beneficiaries and/or family/caregivers have access to a designated private space where they can have confidential discussions with staff and have a reasonable expectation of privacy,

e) Have lockable file storage for the security and maintenance of all files in compliance with HIPAA standards,

f) Maintain regular office hours of Monday through Friday, 8am – 5pm, with the exception of any federal or state holidays, and

g) Have a dedicated office telephone and a means to transmit secure electronic data, i.e., secure email/facsimile, that meets HIPAA standards.

8. Successfully pass a facility inspection by the Division of Medicaid depending on the provider type, as specified in Rule 1.3(c) below.

9. Prior to employment and every two (2) years thereafter, conduct a national criminal background check with fingerprints on all employees and volunteers participating in face-to-face interactions with beneficiaries. Maintain these records in the employee's personnel file.

10. Conduct registry checks before employment and monthly thereafter to ensure that employees or volunteers participating in face-to-face interactions with beneficiaries are not listed on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's Exclusion Database and maintain these records in the employee's personnel file. The provider must not employ individuals whose name appears on the registry list.

11. Not have been nor employ individuals or volunteers participating in face-to-face interactions with beneficiaries who have been convicted of or have 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(h), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, regardless of whether any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

12. Not apply for a Division of Medicaid provider number for the purpose of providing care to friends/family members.

13. Have written criteria for service provision, including procedures for dealing with emergency service requests.

14. Maintain policy and procedure manuals compliant with all state and federal laws and regulations, including Division of Medicaid's regulations.

15. Maintain and ensure responsible personnel management which includes:

    a) Implementing an appropriate policy and process for the recruitment, selection, retention, and termination of employees.

    b) Developing written personnel policies and job descriptions that include educational requirements, work experience, job duties and responsibilities.

    c) Maintaining a current training plan as a component of the policies/procedures that documents 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.

    d) Maintaining a personnel file on every employee and volunteer with required information including, but not limited to, credentialing documentation, training records, and performance reviews. These files must be made available to the Division of Medicaid upon request.

    e) Maintaining an organizational chart that includes the names and job titles of owners, operators, managers, administrators, and other supervisory staff. Any changes in organizational structure including ownership must be reported in writing to the Division of Medicaid within ten (10) business days.

    f) Maintaining an accurate, historical employee listing that captures names, staff identification numbers, tax identification numbers, employment hire dates and employment termination dates.

16. Maintain a roster of qualified personnel necessary to provide authorized services until employment termination. The roster must include the address of the designated workspace for all supervisory staff.

17. Comply with all applicable federal and state regulations including, but not limited to, tax and labor laws.

18. Ensure all protected health information (PHI) and personal identifiable information (PII) is stored, transported and transmitted in a manner consistent with the requirements of the

Health Insurance Portability and Accountability Act of 1996 (HIPAA).

19. At the time of enrollment, not be owned or operated by any individual, organization, or entity currently under investigation by the Division of Medicaid Office of Program Integrity, the Medicaid Fraud Control Unit, or any other government entity. Additionally, the provider must not have been found in violation of the Miss. Admin. Code or the Medicaid Provider Agreement in the eighteen (18) months leading up to their enrollment.

20. In the event a change of ownership occurs, comply with all requirements of Miss. Admin Code, Part 200, Rule 4.3, submit to the Division of Medicaid a proposal packet for review and approval within thirty-five (35) days of the change. The effective date of enrollment is retroactive to the date of the licensure, if licensure applies.

C. E&D providers must satisfy the following criteria, as applicable, to render services.

1. Case Management providers must meet the following requirements:

a) Operate as a statewide network.

b) Have a policies and procedures manual compliant with all state and federal laws and regulations, including Division of Medicaid regulations.

c) Have two (2) person case management teams which consists of Mississippi licensed social workers (LSWs) and/or Mississippi registered nurses (RNs) who meet the following criteria:

1) A Registered Nurse (RN) must:

(a) 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, and

(b) Have a minimum of:

(1) Two (2) years of documented nursing experience in direct care for aged and/or disabled persons, or

(2) At least ninety (90) days of training regarding direction of E&D Waiver services under the supervision of an established E&D Waiver case manager who has two (2) years of E&D Waiver experience.

(c) Be certified to complete the comprehensive long-term services & supports (LTSS) assessment.

2) A Licensed Social Worker (LSW) must:

(a) Have a current and active social work license.

(b) Have a bachelor's degree in social work or other health related field.

(c) Have a minimum of:

(1) Two (2) years of documented experience in direct care services for the aged and/or disabled clients, or

(2) At least ninety (90) days of training regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

(3) Must be certified to complete the comprehensive long-term services & supports (LTSS) assessment.

3) Each team must have an assigned case management supervisor. The case management supervisor cannot carry an active caseload of beneficiaries.

4) All case management supervisors and case managers must successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services. This training course must also be attended annually for each year after hire.

(a) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(b) Person Centered Thinking including Participant Rights and Dignity,

(c) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(d) Crisis Prevention/Intervention and Emergency Preparedness,

(e) Caring for Participants with Cognitive or Behavioral Conditions,

(f) Signs and Symptoms of Illness including Seizures,

(g) HIPAA Compliance and Confidentiality,

(h) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices,

(i) Professional Documentation Practices,

(j) Universal Precautions & Infection Control, and

(k) Medicaid Administrative Code and the E&D Waiver

2. Adult day care (ADC) providers must meet the following requirements:

a) Serve counties as determined and approved by the Division of Medicaid based on location, distance, and time required for travel.

b) Have a sufficient number of employees, who must maintain current and active first aid and cardiopulmonary resuscitation (CPR) certification, with the necessary skills to provide essential administrative and direct care functions to meet the needs of the beneficiaries as follows:

1) There must be at least two (2) persons, with one (1) being a paid employee, at the adult daycare center at all times when there are beneficiaries in attendance.

2) The employee-to-day service attendee ratio must be a minimum of one to six (1:6) in all programs except in programs serving a high percentage of day service attendees who are severely impaired which must maintain an employee ratio of one to four (1:4).

c) All staff /volunteers must receive orientation upon hire and ongoing training which includes at least four (4) in-service training sessions per year to enhance quality of care and job performance.

d) At the time of employment, and annually, each employee must receive training in:

1) The purpose and goals of ADC services,

2) The facility's policies and regulations,

3) The roles and responsibilities of other staff members and how they relate to one another,

4) Beneficiary rights and confidentiality,

5) The needs of the beneficiaries in the facility's target population,

6) Body mechanics/transfer techniques/assistance with Activities of Daily Living (ADLs),

7) Cardiopulmonary resuscitation (CPR), first aid and infection control,

8) Fire, safety, disaster plan, and the facility's emergency plan,

9) Basics of nutritional care, food safety, choking prevention and safe feeding techniques,

10) Mandatory reporting laws of abuse/neglect,

11) Behavioral intervention/acceptance/accommodations,

12) Person-centered thinking, and

13) The purpose and requirements of the Elderly and Disabled (E&D) Waiver.

e) Meet the physical and social needs of each beneficiary and maintain compliance with the state and federal guidelines regarding services provided.

f) Have a well-maintained facility which must have:

1) At least sixty (60) square feet of temperature regulated program space for multi-purpose use for each day service attendee,

2) Restroom(s) which have:

(a) At least one toilet for every ten (10) beneficiaries attending the ADC, at least one of which must be ADA compliant, and no more than forty (40) feet from the activity area and equipped with a call button;

(b) Access to sinks/faucets with water temperature between 100-115 degrees Fahrenheit; and

(c) Supplies including toilet paper, disinfecting soap, and paper towels.

3) Sufficient, adequately lit parking available to accommodate family members, caregivers, visitors, employees and volunteers. In compliance with the Americans with Disabilities Act (ADA) requirements, a minimum of one (1) parking spaces for every twenty-five (25) parking spaces must be identified as parking for those with a disability and one (1) of every six (6) of those spaces must be van accessible,

4) A rest area for beneficiaries that is separate from activity areas, reasonably near a restroom, supervised, equipped with a working call button, and appropriately furnished for safely resting and/or lying down,

5) Private space to permit staff to work and store records without interruption which must include a separate restroom and break space located within the facility,

6) A locked, storage area for all toxic substances including cleaning supplies,

7) At least two (2) well-identified ADA compliant exits with doors that must:

(a) Be either open to the outside or no more than ten (10) feet from an outside exit;

(b) Be side-hinged and swing out in the direction of exit,

(c) Have an operable alarm system, and

(d) Not be locked in a manner that would prevent immediate exit in the event of an emergency.

8) A safe, well-lit environment free from hazards including, but not limited to, obstructed walkways, weapons including knives and firearms, steps more than 7" tall, ramp grades with greater than 8.33% slope, and exposed electrical cords,

9) Sufficient, ADA-accessible safe seating available for all beneficiaries, and

10) A permit to operate a kitchen from the Mississippi State Department of Health (MSDH) if the facility is preparing food onsite, If the food is not prepared on site, the facility must contract with and utilize a food service provider/caterer licensed by MSDH to provide nutritionally well-balanced meals that address the dietary needs of beneficiaries. Home Delivered Meals (HDMs) and other government funded meal programs cannot be served in lieu of one (1) meal and two (2) snacks included as a component of the service.

11) A sufficient number of vehicles to transport beneficiaries between their residences and the facility, and to attend facility outings. Each vehicle must meet the following requirements:

(a) Be accessible to beneficiaries to board and leave from the vehicle without difficulty,

(b) Be equipped with a device for two-way communication or cell phone,

(c) Meet local, state, and federal regulations including applicable ADA vehicle requirements,

(d) Have adequately functioning heating and air-conditioning systems,

(e) Provide seat belts for all passengers and they must be stored off the floor when not in use,

(f) Have at least two (2) seat belt extensions available,

(g) Be equipped with at least one seat belt cutter with a safety blade that is kept within easy reach of the driver for emergency use.

(h) Have an accurate, operating speedometer and odometer,

(i) Have two exterior rear view mirrors, one on each side of the vehicle,

(j) Be equipped with an interior mirror for monitoring the passenger compartment,

(k) Be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease, or litter; or hazardous debris or unsecured items,

(l) Have the ADC provider's business name and telephone number clearly displayed on at least both sides of the exterior of the vehicle,

(m) Not have signage that implies that Medicaid waiver beneficiaries are being transported,

(n) Prominently display the vehicle license number and the ADC local phone number on the interior of each vehicle,

(o) Clearly display complaint procedures and make them available in written format in each vehicle for distribution to beneficiaries upon request,

(p) Prohibit smoking at all times with interior sign that states: "NO SMOKING",

(q) Carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms,

(r) Be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash,

(s) Be equipped with an appropriate working fire extinguisher that must be stored in a safe, secure location within reach of the driver,

(t) Maintain insurance coverage in compliance with state law, and any county or city ordinance,

(u) Be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer,

(v) Be inspected by a certified mechanic prior to application, upon initial use, and bi-annually thereafter following enrollment,

(w) Ensure that records of the ADC scheduled bi-annual vehicle inspections are maintained and made available to the Division of Medicaid upon request, and

(x) Only be driven by authorized employees of the ADC provider who are

compliant with these requirements or with any State or federal regulations.

12) If the facility contracts transportation services, the facility must be able to show current use of the transportation contract from a licensed provider of ADA compliant transportation services. The contracted entity must meet all Division of Medicaid ADC transportation, vehicle, and driver requirements, including the criteria in Rule 1.3(c)(2)(j)(8) below.

g) Have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

h) Have the following employees who must maintain current and active first aid and CPR certification:

1) A full-time administrator, qualified to serve as either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have:

(a) A master's degree and one (1) year supervisory experience, either full-time or an equivalent, in a social or health service setting, or

(b) A bachelor's degree and three (3) years supervisory experience, either full-time or an equivalent, in a social or health service setting; or comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

2) If the Administrator is not on-site full time during operating hours, then an on-site full-time program director responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program.

(a) If required, the program director must have:

(1) A bachelor's degree in health, social services, or a related field and one (1) year supervisory experience, either full-time or an equivalent, or

(2) Comparable technical and human services training with demonstrated competence and experience as a manager in a health or human services setting.

3) A licensed nurse who may be contracted or on staff on-site a minimum of eight (8) hours per week during normal business hours and available on call as needed. The licensed nurse must have a valid state license and a minimum of one (1) year applicable experience, either full-time or the equivalent. The licensed nurse must adhere to the scope of practice pursuant to the Nursing Practice Law and the rules and regulations of the Mississippi Board of Nursing. The service hours must be

tracked on a service log, including date, time in and time out.

4) A full-time, on-site activities coordinator with a bachelor's degree and at least one (1) year of appropriate experience, either full-time or an equivalent, in developing and conducting activities for the type of population to be served, or an associate degree in a related field and at least two (2) years of appropriate experience, either full-time or equivalent.

5) A full-time program assistant with a high school diploma or the equivalent and at least one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served.

6) A ServSafe Certified employee responsible for overseeing the preparation and serving of food, if food is prepared on site.

7) A driverwho meets the following requirements, if transportation is not contracted:

   (a) Must abide by federal, state and local laws,

   (b) Must be eighteen (18) years of age and have a current driver's license to operate the assigned vehicle,

   (c) Must be courteous, patient and helpful to all passengers and be neat and clean in appearance

   (d) Must wear a visible, easily read name tag which identifies the employee and the employer,

   (e) Must provide an appropriate level of assistance to a beneficiary when requested or when necessitated by the beneficiary's mobility status or personal condition, including curb-to-curb, door-to-door, and hand-to-hand assistance, as required,

      (1) The ADC driver must confirm the beneficiary is safely inside the residence or facility before departing the drop-off point, and

      (2) The ADC driver is responsible for properly securing any mobility devices used by the beneficiary.

   (f) Must assist beneficiaries in the process of being seated, confirm all seat belts are fastened properly and all passengers are safely and properly secured,

   (g) Must park the vehicle in a safe location, out of traffic and must notify the facility to request assistance when a passenger's behavior or any other condition impedes the safe operations of the vehicle,

(h) Must park the vehicle in a location that prevents the beneficiary from crossing streets to reach the entrance of their destination when arriving at the intended destination,

(i) Must provide verbal directions to passengers as appropriate,

(j) Must notify the ADC provider immediately of an emergency such as an accident/ incident or vehicle breakdown to arrange for alternative transportation for the beneficiaries on board, and

(k) Must report all accidents/incidents and incidents and breakdowns to the ADC provider as soon as practicable.

8) The ADC Provider must ensure ADC drivers do not:

(a) Leave a beneficiary unattended at any time,

(b) Use alcohol, narcotics, illegal drugs or prescription medications that impair their ability to perform,

(c) Smoke in the vehicle, while assisting a beneficiary or in the presence of a beneficiary or allow beneficiaries or their adult attendant to smoke in the vehicle,

(d) Wear any type of headphones while on duty, except for hands-free headsets for mobile telephones which can only be used for communication with the ADC Provider or to call 911 in an emergency,

(e) Touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance which the ADC driver has been trained, and

(f) Provide services without completing a national and state background check.

9) The ADC Provider must ensure that the ADC driver is removed from service if he/she:

(a) Fails an annual random drug test.

(b) Is convicted of:

(1) Two (2) moving violations or accidents related to transportation in the previous five (5) years as verified by an annual Motor Vehicle Report (MVR), or

(2) Any federal or state crime listed in Miss. Code Ann § 43-13-121.

(c) Has a suspended or revoked driver's license for moving traffic violations in the previous five (5) years as verified by an annual MVR.

i) If the facility utilizes volunteers, they:

1) Must be individuals or groups who desire to work with adult day service beneficiaries.

2) Must successfully complete an orientation/training program.

3) Have responsibilities that are mutually determined by the volunteers and employees and performed under the supervision of facility staff members.

4) Have duties that either supplement required employees in established activities or provide additional services for which the volunteer has special talent/training.

5) Cannot provide services in place of required employees and can only be allowed on a periodic/temporary basis.

6) Must record their hours and activities.

3. Personal care service providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office. If greater than sixty (60) miles driving distance, the provider must ensure that a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by their agency.

b) Employee qualified personal care attendants, qualified personal care service supervisors, and a director/compliance officer.

1) The personal care attendant must meet the following requirements:

(a) Be at least eighteen (18) years of age.

(b) Be a high school graduate or have a General Educational Development (GED) certificate, or must demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits,

(c) Successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services. This training course must also be attended annually for each year after hire.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the E&D Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity and exhibit basic qualities of compassion, responsibility, maturity and be able to respond to beneficiaries and situations in a responsible manner,

(f) Possess a valid state issued identification, and have access to reliable transportation,

(g) Be able to function independently without constant observation and supervision,

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring.

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

(j) Have interest in, and empathy for, persons who are ill, elderly, or disabled,

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people,

(l) Maintain current and active first aid and CPR certification,

(m) Be able to carry out and follow verbal and written instructions, and

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The personal care service supervisor and directors/compliance officers must ensure the requirements of the PCA staff as set forth in Rule 1.3(c)(3)(b)(1) above are met, and must meet the following additional requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

(b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

(c) Satisfy one of the following criteria:

(1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

(2) A licensed RN or Licensed Practical Nurse (LPN) with two (2) years of direct experience working with aged and disabled persons, or

(3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

(a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representative include but are not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

(b) The selected relative must be qualified to provide services as specified in

Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

(c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

(d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

4. In-Home Respite providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office, unless a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by the provider.

b) Employ qualified in-home respite employees and supervisors.

1) In-home respite employees must meet the following requirements:

(a) Be at least eighteen (18) years of age.

(b) Be a high school graduate have a GED or must demonstrate the ability to read the written in-home respite assignment and write adequately to complete and sign required forms and reports of visits.

(c) Successfully complete a curriculum training course upon hire and annually thereafter, covering each of the following topics. They must also pass a scored examination upon hire prior to rendering services.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the Elderly and Disabled Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity, exhibit basic qualities of compassion and maturity, and be able to respond to beneficiaries and situations in a responsible manner,

(f) Possess a valid state issued identification and have access to reliable transportation,

(g) Have the ability to function independently without constant supervision/observation,

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring,

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

(j) Have interest in, and empathy for, individuals who are ill, elderly, and/or disabled,

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people,

(l) Maintain current and active first aid and CPR certification,

(m) Be able to carry out and follow verbal and written instructions, and

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The in-home respite supervisor and directors/compliance officers must ensure the requirements of the IHR staff as set forth in Rule 1.3(c)(4)(b)(1) above are met, and must meet the following additional requirements:

   (a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

   (b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

   (c) Satisfy one of the following criteria:

      (1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

      (2) A licensed RN or Licensed Practical Nurse (LPN) with two (2) years of direct experience working with aged and disabled persons, or

      (3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

   (a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representatives who cannot qualify as a non-legally responsible relative include but are not limited to, spouses, parents/stepparents, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

   (b) The selected relative must be qualified to provide services as specified in Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

   (c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

   (d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services at any time. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

5. Institutional Respite providers must be a Medicaid certified hospital, nursing facility or licensed swing bed facility.

6. Home Delivered Meal providers must meet the following requirements:

   a) Be certified through the Mississippi State Department of Health (MSDH).

   b) Have a qualified person responsible for the day-to-day operation of the service.

   c) Have an adequate number of employees to meet the purpose of the program.

   d) Train all employees in the proper Mississippi Department of Health approved technique of preparing for and/or serving meals to aged and disabled persons including, but not limited to, sanitation procedures, proper cleaning of equipment and utensils, first aid and emergency procedures.

   e) Provide in-service training for all employees.

   f) Submit for approval by the Division of Medicaid written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into Mississippi provider agreement.

   g) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

   h) Provide delivery of meals at times coordinated with the beneficiary or their designated representative.

7. Extended Home Health providers must meet the following qualifications:

   a) Be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

   b) Meet all applicable state and federal laws and regulations,

   c) Provide the Division of Medicaid with a copy of its approved certificate of need (CON), if applicable, and

   d) Ensure direct care providers have a current and active license and/or certification.

8. Physical therapy service providers must meet the following qualifications:

    a) Be certified by the Mississippi Department of Health to participate as a Mississippi Medicaid enrolled home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

    b) Meet all applicable state and federal laws and regulations,

    c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable, and

    d) Employ qualified physical therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and meet the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

9. Speech-Language Pathology providers must meet the following qualifications:

    a) Be certified to participate as a Mississippi Medicaid home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

    b) Meet all applicable state and federal laws and regulations,

    c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable,

    d) Execute a participation agreement with the Division of Medicaid, and

    e) Employ qualified speech therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and meet the state and federal licensing and/or certification requirements to perform speech-language therapy services in the State of Mississippi.

10. Community Transition Service (CTS) providers must meet the following requirements:

    a) Provide documentation to the Division of Medicaid of successfully transitioning individuals into the community for a minimum of two (2) years, and/or working with individuals in the community for a minimum of eight (8) years. For those without two (2) years of successfully transitioning individuals into the community, experience will be considered on an individual basis.

    b) Have documentation of attending the Division of Medicaid's approved person-centered training or another Division of Medicaid approved training relating to person-centered planning.

c) Attend all quarterly and annual CTS trainings administered by the Division of Medicaid with a minimum of one (1) attendee from the provider.

d) Have written procedures for dealing with an after-hour crisis.

e) Each Community Transition Service (CTS) provider must have qualified community navigators and qualified supervisors.

1) The community navigator must meet the following requirements:

(a) Be a(n):

(1) Licensed Social Worker (LSW) with valid Mississippi license and a minimum of one (1) year of relevant work experience,

(2) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),

(3) RN with a valid Mississippi license and a minimum of one (1) year of relevant work experience,

(4) Individual with relevant experience and training with a minimum of a bachelor's degree and (1) year of work experience in a social or health services setting, or

(5) Individual with comparable technical and human service training and five (5) years' experience subject to approval by the Division of Medicaid.

(b) Have documented experience in person-centered planning.

(c) Prior to beginning work, attend an eight (8) hour introductory CTS course that is administered by the Division of Medicaid.

(d) Complete a Person-Centered Plan training course designated by the Division of Medicaid within the one (1) year prior to rendering services, unless excused, in writing, by the Division of Medicaid.

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity.

(f) Exhibit basic qualities of compassion/maturity and be able to respond to persons and situations in a responsible manner.

(g) Attend all CTS trainings administered by the Division of Medicaid unless excused, in writing, by the Division of Medicaid.

(h) Possess a valid Mississippi driver's license.

(i) Be able to function independently without constant observation and supervision.

(j) Have both interest in and empathy for people who are ill, elderly, and/or disabled.

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people.

(l) Be able to carry out and follow verbal and written instructions.

(m) Have training in current information technology systems used by the Division of Medicaid including Long-Term Services and Supports (LTSS) and any other systems utilized for documentation purposes.

2) The community navigator supervisor must have a minimum of two (2) years of supervisory experience in programs dealing with elderly and disabled persons and meet one (1) of the following requirements:

(a) Have a bachelor's degree in social work, Psychology, or related profession with two (2) years of direct experience working with aged and disabled persons transitioning into the community,

(b) Be an RN with a current Mississippi license and two (2) years of direct experience working with aged and disabled persons transitioning into the community, or

(c) Have a high school diploma or GED with seven (7) years of direct experience working with aged and disabled persons with two (2) of the seven (7) years working directly with persons transitioning into the community.

D. The Division of Medicaid may terminate or suspend a provider immediately for failure to comply with the requirements of the E&D waiver program. The Division of Medicaid may also require providers to submit and implement a corrective action plan (CAP) in a timely manner. Failure to submit or comply with a CAP, approved by the Division of Medicaid, may result in a suspension or termination.

Source: 28 C.F.R. Part 36; 42 C.F.R. 455, Subpart E; 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 06/01/2013; Revised eff. 01/01/2013.

Rule 1.4: Freedom of Choice

A. Beneficiaries 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. Freedom of Choice is required of all providers and is monitored by the Division of Medicaid. The case management team must assist the beneficiary by providing them with sufficient information and assistance to make free and informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed by the case manager 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, 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2025; Revised eff. 12/01/2018; Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Elderly and Disabled (E&D) Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. Providers must maintain compliance with all current waiver requirements, rules, regulations and administrative codes as specified by the Division of Medicaid.

1. If an E&D Waiver provider fails to respond to contact attempts timely or respond to requests for documentation/training verification in established timeframes, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the E&D waiver provider establishes contact or demonstrates compliance with the regulatory agency.

2. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the Division of Medicaid.

C. Waiver providers must report:

1. Changes in contact information, administrative staffing, ownership and licensure within ten (10) calendar days to the Division of Medicaid.

2. Critical incidences including all instances of abuse, neglect, and exploitation (including the unauthorized use of restraints, restrictive interventions, and/or seclusion) within twenty (24) hours of the occurrence or knowledge of the occurrence to the Division of Medicaid and other applicable agencies as required by law.

3. Any complaints not resolved within seven (7) days.

D. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

Source: 42 C.F.R. §§ 440.180; 441.302; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

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 services include the identification of resources as well as the coordination and monitoring of resources and services by case managers to ensure the health, social needs, preferences and goals of beneficiaries are met throughout the person centered planning process and service provision. The case management agency is responsible for monitoring and implementation of the Plan of Services and Supports (PSS). Monitoring and implementation of the PSS includes, but is not limited to, on-site review activity in the beneficiary's residence, record reviews, annual recertification reviews, telephone interviews by the Medicaid agency, and other strategies as needed.

   a) The case management team must consist of a Licensed Registered Nurses (RN) and Licensed Social Worker (LSW), and will conduct the following activities.

      1) Conduct face-to-face visits together using the comprehensive long-term services and support (LTSS) assessment instrument at the time of admission and recertification.

         (a) Initial assessments must be conducted face-to-face with the waiver applicant in conjunction with a registered nurse.

         (b) Recertification assessments must be conducted face-to-face with a beneficiary by the case manager, and a registered nurse must be available for consultation

if necessary.

2) Complete face-to-face visits with the beneficiary on a quarterly basis to review the Plan of Services and Supports (PSS).

3) Complete monthly contacts with the beneficiary. Monthly contacts may be completed virtually; however, face-to-face visits for monthly contacts must be completed with beneficiaries if any of the following concerns are identified:

(a) Beneficiary/representative is unable to communicate by phone due to an auditory, speech or cognitive impairment;

(b) Beneficiary has unmet needs that cannot be resolved by phone;

(c) The case management team has identified risks for abuse, neglect or exploitation including the use of restraints or seclusion that require in-person monitoring; or

(d) Beneficiary/representative is unable to be reached by phone.

b) Each case management team must maintain active case load of no more than one hundred and twenty (120) E&D Waiver beneficiaries.

1) If a case management team maintains an average, active case load greater than one hundred and twenty (120), 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 (ADC) Services - ADC services include community-based comprehensive programs 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 be provided in accordance with a beneficiary's approved PSS.

b) ADC services must meet the needs of aged and disabled persons through an individualized service plan (ISP) developed by the ADC through a person-centered process and must include the following:

1) Personal care and supervision,

2) A minimum of one (1) meal and two (2) snacks per day of an adult's daily nutritional requirement as established by state and federal regulations,

3) Provision of limited health care including medications while the beneficiary is at the facility,

4) Round trip transportation from the beneficiary's home to the facility and to center-sponsored activities, and escort service as needed to ensure a beneficiary's safety,

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

6) Information on, and referral to, vocational services.

c) To be eligible for reimbursement, the ADC must:

1) Submits claims billed in fifteen (15) minute increments for the duration of time the services were provided and the provider 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 for that day.

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

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

2) Be open and providing services for at least nine (9) continuous hours per day, Monday through Friday, 8am – 5pm with the exception of any state/federal holidays.

d) ADC settings including outdoor spaces must be safe, clean and physically accessible to the beneficiaries and must:

1) Ensure that beneficiaries receiving Medicaid HCBS have access to the greater community, including opportunities to engage in community life as individuals not receiving Medicaid HCBS.

2) Be selected by the beneficiaries 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 beneficiary's needs and preferences.

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

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

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

6) ADC settings should not restrict a beneficiary within a setting, unless such restriction is documented in the person-centered plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

7) The person-centered service plan should identify and document setting options based on the beneficiary's needs and preferences, including non-disability specific settings, from which the beneficiary can select.

e) ADC 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 beneficiaries receiving Medicaid.

f) Beneficiaries must not be in transportation vehicles for longer than sixty (60) minutes per trip.

3. Personal Care Services - Personal Care Services (PCS) are non-medical support services provided in the home or community of eligible beneficiaries by trained personal care attendants (PCA) to assist the beneficiary 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,

2) Must be provided in accordance with a beneficiary's PSS,

3) Are approved by the Division of Medicaid based upon assessed needs of the beneficiary as set forth in the PSS and require sufficient documentation to substantiate the requested number of hours.

   (a) The frequency cannot duplicate hours rendered or billed 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 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 beneficiaries.

b) PCA responsibilities include:

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

   (a) Mouth and denture care,

   (b) Shaving,

   (c) Finger and toenail 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 beneficiary to take prescribed medication,

   (i) Eating,

   (j) Transferring or changing the beneficiary'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 linens 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 PCAs in an area within sixty (60) miles driving distance of their designated worksite,

2) Ensuring PCA timesheets and any other documents containing protected health or identifying information are securely stored in a manner that prevents unauthorized disclosure while in the PCA or PCA supervisor's possession and returned to the main office location within ten (10) business days,

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

4) Making home visits with PCAs to observe and evaluate job performance, including evaluating the work, skills and job performance of the PCA,

5) Reviewing and approving PCA duties on the approved service plans, revising as needed,

6) Receiving and processing requests for services,

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

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

9) Preparing, submitting or maintaining appropriate records and reports, including supervisory reports and submit monthly activity sheets,

10) Planning, coordinating and recording ongoing in-service PCA training,

11) Performing supervised direct monitoring visits in the beneficiary's home while the PCA staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone while the PCA staff is not on-site, alternating on a bi-weekly basis to assure services and care are provided according to the PSS, and

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

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all applicable state and federal laws, and the CMS approved waiver.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all Office of Inspector General (OIG) and Nursing and Exclusion checks are completed timely and maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately.

6) Ensuring immediate access to all beneficiary and employee records as required for audit purposes.

e) 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 adhere to and support all policies, rules and regulations in the operations of the EVV system.

4. In-Home or Institutional Respite Services - In-Home Respite (IHR) or Institutional Respite Services, either in an institutional or home setting, is covered for beneficiaries unable to

care for themselves in the absence, or need for relief, of the beneficiary'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 beneficiary.

a) In-Home Respite services are non-medical, unskilled services.

    1) IHR services are covered when a beneficiary:

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

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

    2) No more than sixty (60) hours of IHR services per month are allowed. IHR 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 EVV system must adhere to and support all policies, rules and regulations in the operations of the EVV system.

b) IHR staff responsibilities for respite service include, but are not limited to, the following:

    1) The IHR staff providing direct respite care must provide one or more of the following primary activities:

        (a) Companionship,

        (b) Support or general supervision, or

        (c) Feeding and personal care needs.

    2) The provision of these services does not entail hands-on nursing care. Any assistance with activities of daily living is incidental to the care of the individual and are not provided as discrete services.

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

    1) Supervising the IHR staff providing services within sixty (60) miles driving distance of the supervisor's designated worksite,

    2) Ensuring IHR staff timesheets and any other documents containing protected health or identifying information are securely stored while in the possession of the IHR

staff or supervisor in a manner that prevents unauthorized disclosure and are returned to the main office location within ten (10) business days,

3) Supervising no more than twenty (20) full-time IHR staff,

4) Making home visits with IHR staff to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

5) Reviewing and approving IHR duties on the approved service plans,

6) Receiving and processing requests for services,

7) Being accessible to IHR staff and beneficiaries/their representatives for emergencies, case reviews, conferences, and problem solving,

8) Evaluating the work, skills, and job performance of the IHR staff, including the completion of hands-on skills assessments,

9) Interpreting IHR agency policies and procedures relating to the IHR program,

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

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

12) Performing supervised direct monitoring visits in the beneficiary's home while the IHR staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone, while the IHR staff is not on-site, alternating on a biweekly basis to ensure services and care are provided according to the PSS, and

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

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all other state and federal laws, and the CMS approved waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all OIG and Nursing Exclusion checks are completed timely and

maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately if necessary.

6) Ensuring immediate access to all beneficiary and employee records as required for audit purposes.

e) 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 following requirements are met:

a) The beneficiary is unable to leave without assistance and is:

(1) unable to prepare their own meals, and/or

(2) has no responsible caregiver in the home.

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

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

1) Attest 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 beneficiaries 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 beneficiary 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 members and members with limited dexterity or mobility.

8) Ensure all food preparation employees are supervised by a person who is familiar with the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must ensure all hygiene techniques and practices are applied and consult with the service provider dietitian for advice, 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, per beneficiary, and no more than fourteen (14) frozen meals per delivery, per beneficiary.

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

(a) If the beneficiary, or designated caregiver, is not home at time of delivery, the meals must not be delivered.

(b) Meals delivered to anyone other than the beneficiary 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 beneficiary, provided that proper storage and heating facilities are available in the home, and the beneficiary 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:

   a) Extended services have been prior approved by the Division of Medicaid, and are deemed medically necessary by the beneficiary's prescribing primary care provider, 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.

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

7. Physical therapy services are covered when:

   a) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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 (CT) Services provide assistance with initial expenses required for a beneficiary to set up a household. The expenses must be included in the approved PSS, and expenses are limited to those specifically designated by the Division of Medicaid.

a) To qualify for CT services, a beneficiary must meet all of the following criteria:

1) Reside 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 to establish a household,

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 beneficiary 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 beneficiary or the beneficiary's family member,

(b) An apartment with lockable access leased to the transitioning beneficiary which includes living, sleeping, bathing, and cooking areas over which the beneficiary or the beneficiary'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) Have 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 include deposits for telephone, electricity, heating, and water.

(d) May include payment of past due bills which inhibit the beneficiary'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 beneficiary transitioning from the nursing facility and are limited to:

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

(b) Purchased items may only include furniture, window coverings, food preparation items, bed/bath items and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the beneficiary's health and safety, which has a combined limit of two hundred and fifty dollars ($250.00) to ensure that all belongings of the beneficiary located in the institution 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 beneficiary or the beneficiary's family, if they are required by the beneficiary's PSS, are necessary to ensure the beneficiary's health, welfare, and their safety and enable the beneficiary 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 beneficiary, 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 up to ninety (90) consecutive days prior to the date on which an institutionalized beneficiary transitions to the community setting.

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

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

(f) All providers/subcontracted entities rendering HAA 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 manner 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, and leave 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) The modification and/or construction process cannot create any new accessibility barriers.

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

(a) Required by the beneficiary's PSS,

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

(c) It enables the beneficiary 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 beneficiary'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 sixty (260) units, which must occur no earlier than ninety (90) days prior to transition to the community.

(c) Is reimbursed per a 15-minute unit rate up to forty (40) 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) They are clearly identified in the service plan, and

(b) The beneficiary 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, 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 beneficiary is able to transition from the current nursing facility, and

2) Identifying and eliminating any identified obstacles or barriers that could prevent a successful transition to a more independent setting.

10. Environmental Safety Services are provided for the purpose of maintaining a healthy and safe living environment through the performance of tasks in and around the beneficiary's home environment that are beyond the beneficiary's capability to personally perform.

a) Environmental Safety Services must be provided in accordance with a beneficiary's PSS and may include the following services:

1) minor home maintenance and repair.

2) non-routine disposal of garbage posing a threat to the beneficiary's health and welfare.

3) pest control and services to prevent, suppress, eradicate, or remove pests posing a threat to the beneficiary's health and welfare.

b) Environmental Safety services exclude tasks that:

1) are the legal or contractual responsibility of someone other than the beneficiary.

2) can be accomplished through existing informal and formal supports.

3) do not provide a direct or remedial benefit to the beneficiary.

4) are performed or interventions available through the personal care or in-home respite services.

c) Environmental safety services shall not exceed $500.00 per beneficiary per state fiscal year. These services are limited to additional services not otherwise covered under the State Plan, including EPSDT.

d) Environmental Safety Services are coordinated and billed based on actual invoiced cost

to the Division of Medicaid by approved Elderly and Disabled Waiver Case Management providers.

e) Direct services may be contracted out to local vendors. Vendors providing environmental safety services must:

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

2) Ensure the quality of work meets standards that secure the beneficiary's health and welfare.

3) Coordinate with the Case Managers and the beneficiary to ensure that services are rendered in a person-centered manner.

11. Medication Management services are provided to beneficiaries with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications. These services include consultations and follow-up visits with a licensed pharmacist and must be provided in accordance with a beneficiary's approved PSS. Medication management is limited to one initial or annual consultation and fifteen (15) follow-up visits per state fiscal year (SFY). These services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

a) Medication Management includes the following services:

1) Review of all prescription and over-the-counter medications taken by the beneficiary on at least a monthly basis in order to support the beneficiary's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors.

2) Reviews may occur more frequently, on an as needed basis, upon significant change in the beneficiary's condition or immediately following discharge from an acute hospital stay.

3) A comprehensive initial or annual consultation and subsequent follow-up consultations in which the provider will be responsible for collecting a complete medical history and list of current prescribed and over-the-counter medications in order to assess whether:

a) The beneficiary's medication is accurate, valid, non-duplicative and correct for their diagnoses.

b) Therapeutic doses and administration are at an optimal level.

c) Appropriate laboratory monitoring and follow-up are taking place.

d) Drug interactions, drug allergies and contraindications are assessed and prevented.

4) Necessary interventions implemented by the provider including, but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery or reminder 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 to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 08/01/2019; 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.

Rule 1.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive any services through the Elderly and Disabled (E&D) Waiver Program. To obtain approval, the waiver case management provider 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, and

5. Informed Choice.

B. Any request to add or increase services listed on the approved PSS must be submitted to and receive prior approval from the Division of Medicaid and must include documentation substantiating the need for the requested change(s).

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

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.8: Documentation/Record Maintenance

A. Documentation and record maintenance for reimbursement purposes must, at a minimum, meet requirements set forth in the Elderly and Disabled (E&D) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3.]

B. All staff records should include, at a minimum, the following required credentialing and qualification documents:

1. Copy of valid, state issued ID,
2. Job description,
3. Application and date of hire,
4. High school diploma, General Educational Development (GED) certificate, other educational degrees, or proof of ability to read and write accurately,
5. Any licensure and/or certifications as required by the Division of Medicaid for job description,
6. Results of fingerprint-based National Criminal Background check(s),
7. Results of monthly Nurse Aide Abuse Registry checks,
8. Results of monthly Office of Inspector General (OIG) checks,
9. Annual attestation of health,
10. Signed confidentiality agreement that includes social media waiver, and
11. Proof of training/evaluations, required professional certifications, and credentials including CPR and First Aid.

C. Records for beneficiaries receiving Personal Care Services (PCS) & In-Home Respite (IHR) should include, at minimum:

1. Referral form/authorization,
2. Approve Plan of Services and Supports (PSS)
3. Daily activity or time sheets capturing tasks completed and the beneficiary/representative's signature verifying the provision of services, if task and global positioning system (GPS) information is not captured electronically in the state approved electronic visit verification system.

4. Service note indicating the causes of any significant variation in the case management recommended/agreed upon schedule of service provision.

D. Records for PCS/IHR offices should include at minimum:

1. Written criteria for service provision, including procedures for dealing with emergency service requests,

2. Policy and procedure manuals,

3. Records of quarterly advisory committee meetings,

4. Written personnel policies including the process used in the recruitment, selection, retention, and termination of employees,

5. Organizational chart including the names and job titles of owners, operators, managers, administrators, and other supervisory staff., and

6. Current and historical employee listing that captures names, staff/tax id numbers, and employment hire and termination dates.

E. Records for beneficiaries receiving Adult Day Care (ADC) should include, at minimum:

1. Individualized Service Plan (ISP), with documentation of annual review,

2. Approved Plan of Services and Supports (PSS),

3. Daily activity or time sheets capturing service notes and the beneficiary/representative's signature verifying the provision of services,

4. Current photograph,

5. Medical history or medical exam completed within six (6) months of admission,

6. Annual nutritional assessment, and

7. Daily Progress Notes.

F. Activity or time sheets must include:

1. Arrival/service start time and date,

2. Departure/service end time and date,

3. Activities/tasks performed, and

4. The signature of the beneficiary or their legal representative verifying the provision of services.

G. ADC facility records should include, at minimum:

1. Documentation of maintenance and janitorial services including repairs, maintenance and pest control,

2. Documentation of quarterly drills for fire and inclement weather,

3. Annual fire safety inspection reports conducted by the fire department,

4. Records of quarterly advisory committee meetings,

5. Written criteria for service provision, including procedures for detailing with emergency service requests,

6. Policy and procedure manuals,

7. Written personnel policies including the process used in the recruitment, selection, training, retention, and termination of employees,

8. Current and historical organizational charts including the names and job titles of owners, operators, managers, administrators, and other supervisory staff,

9. Current and historical employee listing that captures names, staff/tax id numbers, employment hire and termination dates, and

10. Service records of licensed nurses which includes dates in the facility, arrival and departure times, services performed, and signature of administrator or program director.

Source: 42 C.F.R. §§ 440.180, 441.303; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121; 43-13-129.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.9: Reserved

Rule 1.10: Reimbursement

A. Claims must be based on services that have been rendered to beneficiaries 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 beneficiary 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 beneficiary's approved PSS.

E. Records documenting the provision of services must be maintained by the providers of waiver services for a minimum of five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

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

G. Providers must bill for Elderly and Disabled (E&D) Waiver services no sooner than the first (1st) day of the month following the month in which services were rendered for the following services:

1. Case Management,

2. Adult Day Care (ADC) Services,

3. Institutional Respite, and

4. Home delivered meals.

H. All providers of Personal Care Services (PCS) and In-Home Respite must utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system for the submission of claims unless an exception is approved, in writing by the Division of Medicaid. Requirements for the use of the EVV system are outlined in Miss. Admin. Code Part 200.

I. The Division of Medicaid reimburses for extended Home Health services, physical therapy services and speech therapy services in accordance with statewide uniform fee schedule.

Source: 42 C.F.R. §§ 440.180, 440.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025.

Rule 1.11: Due Process Protection

A. The Division of Medicaid and the case management agencies are responsible for operating a

dispute resolution process 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 waiver services.

2. At the initial assessment, the case management agency must provide written notice to inform the beneficiary/representative of the specific criteria for the dispute, complaint/grievance, and hearing processes.

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

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. Notice of Action

1. The case management agency must provide the beneficiary with a Notice of Action (NOA) via certified mail as required in 42 C.F.R. §431.210.

2. The NOA must include:

a) A description of the action the provider has taken or intends to take,

b) An explanation for the action,

c) Notification that the person/representative has the right to file an appeal,

d) Procedures for filing an appeal,

e) Notification of person/representative's right to request a Fair Hearing,

f) Notice the person/representative has the right to have benefits continued pending the resolution of the appeal, and

g) 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. §§ 431.210, 440.180, 441.301, 441.307; 42 CFR; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.12: Hearings and Appeals

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

Source: 42 C.F.R. 431, Subpart E; 42 C.F.R. §§ 440.180, 441.308; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.13: Person Centered Planning (PCP)

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

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

2. Include people chosen by the beneficiary.

3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary.

5. Reflect cultural considerations of the beneficiary 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 beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, 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 beneficiaries must be provided with a clear and accessible alternative dispute resolution process which ensures the beneficiary's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

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

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

a) Chosen by the beneficiary and/or their representative,

b) Integrated in, and supports full access of beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries with disabilities and who are limited English proficient so as to be understandable to the beneficiary receiving services and supports, and the individuals important in supporting the beneficiary.

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

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

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

11. Identify those services, the purpose or control of which the beneficiary 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 content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least twelve (12) months have lapsed since the provider's last review,

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

E. All changes to the PSS require documented consent from the beneficiary either via current signature/date or via verbal consent with a witness's signature/date on a change request.

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

History: Revised eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; New rule eff. 01/01/2017.

Rule 1.15: Grievances and Complaints

A. The Division of Medicaid is responsible for investigating and documenting all grievances/complaints regarding all E&D Waiver programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format or email.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. 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 the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved E&D Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

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

History: New rule eff. 06/01/2025.

Title 23: Division of Medicaid

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

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

Rule 1.1: General

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

B. Beneficiaries enrolled in the E&D Waiver must reside in a private residence that is fully integrated with opportunities for full access to the greater community, and meets the requirements of a Home and Community-Based (HCB) setting in 42 C.F.R. § 441.301(c)(4) and (5).

C. 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).

D. Beneficiaries enrolled in the E&D Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries enrolled in the E&D Waiver who elect to receive hospice care may not receive waiver services that are duplicative of any services rendered through hospice services. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

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

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

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2017.

Rule 1.2: Beneficiary Eligibility

A. In order to qualify as a beneficiary of the Elderly & Disabled (E&D) Waiver Program, individuals must meet the following criteria:

1. Must be twenty-one (21) years of age or older.

2. Must require nursing facility level of care as determined by a comprehensive long-term services and supports (LTSS) assessment.

3. Must meet the criteria in one (1) of the following Categories of Eligibility (COE):

   a) Supplemental Security Income (SSI) eligible under 20 C.F.R. § 416.202, or

   b) 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 to qualify.

B. Beneficiaries enrolled in the E&D Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home.

C. In the event of imminent danger to the beneficiary, caregiver or service provider, the beneficiary may be discharged from the waiver immediately.

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 to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 08/01/2016; Revised eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 1.3: Provider Enrollment

A. Providers of Elderly and Disabled (E&D) Waiver services must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Chapter 4 in addition to the listed provider-type specific requirements as set forth in sections B. and C. below 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 social security numbers for all provider owners 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 provider owners' W-9, and

   4. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

   5. A copy of business registration with the Mississippi Secretary of State.

B. To participate as a Home and Community-Based Services (HCBS) Elderly & Disabled (E&D) Waiver provider, the provider must, unless exempted in writing by the Division of Medicaid,

at the time of application and at all times thereafter:

1. Attend mandatory orientation, score at least eighty-five (85) on the orientation exam, and submit a completed proposal package to the Office of Long-Term Care for approval by the Division of Medicaid.

2. Once a provider is enrolled, submit any proposed changes to location, supervisory staffing, or organizational contact information, to the Division of Medicaid for approval prior to implementing the requested change.

3. Be established as an agency a business entity and provide the specified service(s) for a minimum of one (1) year prior to application.

4. Be approved for enrollment by Provider Enrollment and enter into a provider agreement with the Division of Medicaid within six (6) months of receiving an approved proposal package letter from the Office of Long-Term Care.

5. Have an advisory committee, representative of the community and ~~participant~~ beneficiary population, that meets quarterly to assure responsibility and accountability for performance and quality improvement. The advisory committee must maintain an agenda and minutes for each meeting and must provide public notice of the date, time, and location of each meeting at least twenty-four (24) hours in advance of the meeting.

6. Provide proof of financial solvency by:

    a) Establishing and maintaining a business line of credit for business operations from either a financial institution licensed to conduct banking or other Financial Deposit Insurance Corporation (FDIC) or National Credit Union Administration (NCUA) insured financial institutions. The approval amount for the business line of credit must be enough to cover operational costs/expenditures for at least three (3) months at all branch locations.

    b) Providing a copy of the provider's most current filed tax return for the business along with confirmation verifying it was filed. Examples of acceptable forms of confirmation include the following:

        1) 8879 form from a tax preparer, or

        2) 9325 form from the IRS with the submission identification (SID) number.

    c) Providing a copy of the provider's itemized expense report reflecting all income and expenditures for each month for the past twelve (12) months.

7. Establish an office with a physical address in the State of Mississippi that is not located in or on the grounds of a personal residence for a minimum of six (6) months prior to enrollment and maintain an approved physical office until the provider agreement is

terminated. The physical office must:

a) Have appropriate external signage with printed lettering that is visible and readable from the road,

b) Be compliant with applicable federal, state and local building requirements as well as all zoning, fire, OSHA, health codes and ordinances. It must also meet the requirements of the Americans with Disabilities Act (ADA),

c) Maintain an active business privilege tax license,

d) Ensure that ~~participants~~ beneficiaries and/or family/caregivers have access to a designated private space where they can have confidential discussions with staff and have a reasonable expectation of privacy,

e) Have lockable file storage for the security and maintenance of all files in compliance with HIPAA standards,

f) Maintain regular office hours of Monday through Friday, 8am – 5pm, with the exception of any federal or state holidays, and

g) Have a dedicated office telephone and a means to transmit secure electronic data, i.e., secure email/facsimile, that meets HIPAA standards.

8. Successfully pass a facility inspection by the Division of Medicaid depending on the provider type, as specified in Rule 1.3(c) below.

9. Prior to employment and every two (2) years thereafter, conduct a national criminal background check with fingerprints on all employees and volunteers participating in face-to-face interactions with beneficiaries. Maintain these records in the employee's personnel file.

10. Conduct registry checks before employment and monthly thereafter to ensure that employees or volunteers participating in face-to-face interactions with beneficiaries are not listed on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's Exclusion Database and maintain these records in the employee's personnel file. The provider must not employ individuals whose name appears on the registry list.

11. Not have been nor employ individuals or volunteers participating in face-to-face interactions with beneficiaries who have been convicted of or have 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(h)-, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, regardless of whether any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

12. Not apply for a Division of Medicaid provider number for the purpose of providing care to friends/family members.

13. Have written criteria for service provision, including procedures for dealing with emergency service requests.

14. Maintain policy and procedure manuals compliant with all state and federal laws and regulations, including Division of Medicaid's regulations.

15. Maintain and ensure responsible personnel management which includes:

    a) Implementing an appropriate policy and process for the recruitment, selection, retention, and termination of employees.

    b) Developing written personnel policies and job descriptions that include educational requirements, work experience, job duties and responsibilities.

    c) Maintaining a current training plan as a component of the policies/procedures that documents 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.

    d) Maintaining a personnel file on every employee and volunteer with required information including, but not limited to, credentialing documentation, training records, and performance reviews. These files must be made available to the Division of Medicaid upon request.

    e) Maintaining an organizational chart that includes the names and job titles of owners, operators, managers, administrators, and other supervisory staff. Any changes in organizational structure including ownership must be reported in writing to the Division of Medicaid within ten (10) business days.

    f) Maintaining an accurate, historical employee listing that captures names, staff identification numbers, tax identification numbers, employment hire dates and employment termination dates.

16. Maintain a roster of qualified personnel necessary to provide authorized services until employment termination. The roster must include the address of the designated workspace for all supervisory staff.

17. Comply with all applicable federal and state regulations including, but not limited to, tax and labor laws.

18. Ensure all protected health information (PHI) and personal identifiable information (PII) is stored, transported and transmitted in a manner consistent with the requirements of the

Health Insurance Portability and Accountability Act of 1996 (HIPAA).

19. At the time of enrollment, not be owned or operated by any individual, organization, or entity currently under investigation by the Division of Medicaid Office of Program Integrity, the Medicaid Fraud Control Unit, or any other government entity. Additionally, the provider must not have been found in violation of the Miss. Admin. Code or the Medicaid Provider Agreement in the eighteen (18) months leading up to their enrollment.

20. In the event a change of ownership occurs, comply with all requirements of Miss. Admin Code, Part 200, Rule 4.3, submit to the Division of Medicaid a proposal packet for review and approval within thirty-five (35) days of the change. The effective date of enrollment is retroactive to the date of the licensure, if licensure applies.

C. E&D providers must satisfy the following criteria, as applicable, to render services.

1. Case Management providers must meet the following requirements:

a) Operate as a statewide network.

b) Have a policies and procedures manual compliant with all state and federal laws and regulations, including Division of Medicaid regulations.

c) Have two (2) person case management teams which consists of Mississippi licensed social workers (LSWs) and/or Mississippi registered nurses (RNs) who meet the following criteria:

1) A Registered Nurse (RN) must:

(a) 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, and

(b) Have a minimum of:

(1) Two (2) years of documented nursing experience in direct care for aged and/or disabled persons, or

(2) At least ninety (90) days of training regarding direction of E&D Waiver services under the supervision of an established E&D Waiver case manager who has two (2) years of E&D Waiver experience.

(c) Be certified to complete the comprehensive long-term services & supports (LTSS) assessment.

2) A Licensed Social Worker (LSW) must:

(a) Have a current and active social work license.

(b) Have a bachelor's degree in social work or other health related field.

(c) Have a minimum of:

(1) Two (2) years of documented experience in direct care services for the aged and/or disabled clients, or

(2) At least ninety (90) days of training regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

(3) Must be certified to complete the comprehensive long-term services & supports (LTSS) assessment.

3) Each team must have an assigned case management supervisor. The case management supervisor cannot carry an active caseload of ~~persons~~beneficiaries.

4) All case management supervisors and case managers must successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services. This training course must also be attended annually for each year after hire.

(a) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(b) Person Centered Thinking including Participant Rights and Dignity,

(c) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(d) Crisis Prevention/Intervention and Emergency Preparedness,

(e) Caring for Participants with Cognitive or Behavioral Conditions,

(f) Signs and Symptoms of Illness including Seizures,

(g) HIPAA Compliance and Confidentiality,

(h) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices,

(i) Professional Documentation Practices,

(j) Universal Precautions & Infection Control, and

(k) Medicaid Administrative Code and the E&D Waiver

2. Adult day care (ADC) providers must meet the following requirements:

   a) Serve counties as determined and approved by the Division of Medicaid based on location, distance, and time required for travel.

   b) Have a sufficient number of employees, who must maintain current and active first aid and cardiopulmonary resuscitation (CPR) certification, with the necessary skills to provide essential administrative and direct care functions to meet the needs of the beneficiaries as follows:

      1) There must be at least two (2) persons, with one (1) being a paid employee, at the adult daycare center at all times when there are beneficiaries in attendance.

      2) The employee-to-day service attendee ratio must be a minimum of one to six (1:6) in all programs except in programs serving a high percentage of day service attendees who are severely impaired which must maintain an employee ratio of one to four (1:4).

   c) All staff /volunteers must receive orientation upon hire and ongoing training which includes at least four (4) in-service training sessions per year to enhance quality of care and job performance.

   d) At the time of employment, and annually, each employee must receive training in:

      1) The purpose and goals of ADC services,

      2) The facility's policies and regulations,

      3) The roles and responsibilities of other staff members and how they relate to one another,

      4) Beneficiary rights and confidentiality,

      5) The needs of the beneficiaries in the facility's target population,

      6) Body mechanics/transfer techniques/assistance with Activities of Daily Living (ADLs),

      7) Cardiopulmonary resuscitation (CPR), first aid and infection control,

      8) Fire, safety, disaster plan, and the facility's emergency plan,

      9) Basics of nutritional care, food safety, choking prevention and safe feeding techniques,

10) Mandatory reporting laws of abuse/neglect,

11) Behavioral intervention/acceptance/accommodations,

12) Person-centered thinking, and

13) The purpose and requirements of the Elderly and Disabled (E&D) Waiver.

e) Meet the physical and social needs of each beneficiary and maintain compliance with the state and federal guidelines regarding services provided.

f) Have a well-maintained facility which must have:

1) At least sixty (60) square feet of temperature regulated program space for multi-purpose use for each day service attendee,

2) Restroom(s) which have:

(a) At least one toilet for every ten (10) beneficiaries attending the ADC, at least one of which must be ADA compliant, and no more than forty (40) feet from the activity area and equipped with a call button;

(b) Access to sinks/faucets with water temperature between 100-115 degrees Fahrenheit; and

(c) Supplies including toilet paper, disinfecting soap, and paper towels.

3) Sufficient, adequately lit parking available to accommodate family members, caregivers, visitors, employees and volunteers. In compliance with the Americans with Disabilities Act (ADA) requirements, a minimum of one (1) parking spaces for every twenty-five (25) parking spaces must be identified as parking for those with a disability and one (1) of every six (6) of those spaces must be van accessible,

4) A rest area for beneficiaries that is separate from activity areas, reasonably near a restroom, supervised, equipped with a working call button, and appropriately furnished for safely resting and/or lying down,

5) Private space to permit staff to work and store records without interruption which must include a separate restroom and break space located within the facility,

6) A locked, storage area for all toxic substances including cleaning supplies,

7) At least two (2) well-identified ADA compliant exits with doors that must:

(a) Be either open to the outside or no more than ten (10) feet from an outside exit;

(b) Be side-hinged and swing out in the direction of exit,

(c) Have an operable alarm system, and

(d) Not be locked in a manner that would prevent immediate exit in the event of an emergency.

8) A safe, well-lit environment free from hazards including, but not limited to, obstructed walkways, weapons including knives and firearms, steps more than 7" tall, ramp grades with greater than 8.33% slope, and exposed electrical cords,

9) Sufficient, ADA-accessible safe seating available for all beneficiaries, and

10) A permit to operate a kitchen from the Mississippi State Department of Health (MSDH) if the facility is preparing food onsite, If the food is not prepared on site, the facility must contract with and utilize a food service provider/caterer licensed by MSDH to provide nutritionally well-balanced meals that address the dietary needs of beneficiaries. Home Delivered Meals (HDMs) and other government funded meal programs cannot be served in lieu of one (1) meal and two (2) snacks included as a component of the service.

11) A sufficient number of vehicles to transport beneficiaries between their residences and the facility, and to attend facility outings. Each vehicle must meet the following requirements:

(a) Be accessible to beneficiaries to board and leave from the vehicle without difficulty,

(b) Be equipped with a device for two-way communication or cell phone,

(c) Meet local, state, and federal regulations including applicable ADA vehicle requirements,

(d) Have adequately functioning heating and air-conditioning systems,

(e) Provide seat belts for all passengers and they must be stored off the floor when not in use,

(f) Have at least two (2) seat belt extensions available,

(g) Be equipped with at least one seat belt cutter with a safety blade that is kept within easy reach of the driver for emergency use.

(h) Have an accurate, operating speedometer and odometer,

(i) Have two exterior rear view mirrors, one on each side of the vehicle,

(j) Be equipped with an interior mirror for monitoring the passenger compartment,

(k) Be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease, or litter; or hazardous debris or unsecured items,

(l) Have the ADC provider's business name and telephone number clearly displayed on at least both sides of the exterior of the vehicle,

(m) Not have signage that implies that Medicaid waiver beneficiaries are being transported,

(n) Prominently display the vehicle license number and the ADC local phone number on the interior of each vehicle,

(o) Clearly display complaint procedures and make them available in written format in each vehicle for distribution to ~~participants~~ beneficiaries upon request,

(p) Prohibit smoking at all times with interior sign that states: "NO SMOKING",

(q) Carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms,

(r) Be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash,

(s) Be equipped with an appropriate working fire extinguisher that must be stored in a safe, secure location within reach of the driver,

(t) Maintain insurance coverage in compliance with state law, and any county or city ordinance,

(u) Be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer,

(v) Be inspected by a certified mechanic prior to application, upon initial use, and bi-annually thereafter following enrollment,

(w) Ensure that records of the ADC scheduled bi-annual vehicle inspections are maintained and made available to the Division of Medicaid upon request, and

(x) Only be driven by authorized employees of the ADC provider who are compliant with these requirements or with any State or federal regulations.

12) If the facility contracts transportation services, the facility must be able to show current use of the transportation contract from a licensed provider of ADA compliant transportation services. The contracted entity must meet all Division of Medicaid ADC transportation, vehicle, and driver requirements, including the criteria in Rule 1.3(c)(2)(j)(8) below.

g) Have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

h) Have the following employees who must maintain current and active first aid and CPR certification:

1) A full-time administrator, qualified to serve as either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have:

(a) A master's degree and one (1) year supervisory experience, either full-time or an equivalent, in a social or health service setting, or

(b) A bachelor's degree and three (3) years supervisory experience, either full-time or an equivalent, in a social or health service setting; or comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

2) If the Administrator is not on-site full time during operating hours, then an on-site full-time program director responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program.

(a) If required, the program director must have:

(1) A bachelor's degree in health, social services, or a related field and one (1) year supervisory experience, either full-time or an equivalent, or

(2) Comparable technical and human services training with demonstrated competence and experience as a manager in a health or human services setting.

3) A licensed nurse who may be contracted or on staff on-site a minimum of eight (8) hours per week during normal business hours and available on call as needed. The licensed nurse must have a valid state license and a minimum of one (1) year applicable experience, either full-time or the equivalent. The licensed nurse must adhere to the scope of practice pursuant to the Nursing Practice Law and the rules

and regulations of the Mississippi Board of Nursing. The service hours must be tracked on a service log, including date, time in and time out.

4) A full-time, on-site activities coordinator with a bachelor's degree and at least one (1) year of appropriate experience, either full-time or an equivalent, in developing and conducting activities for the type of population to be served, or an associate degree in a related field and at least two (2) years of appropriate experience, either full-time or equivalent.

5) A full-time program assistant with a high school diploma or the equivalent and at least one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served.

6) A ServSafe Certified employee responsible for overseeing the preparation and serving of food, if food is prepared on site.

7) A driver~~, must meet the~~ who meets the following requirements, if transportation is not contracted:

   (a) Must abide by federal, state and local laws,

   (b) Must be eighteen (18) years of age and have a current driver's license to operate the assigned vehicle,

   (c) Must be courteous, patient and helpful to all passengers and be neat and clean in appearance

   (d) Must wear a visible, easily read name tag which identifies the employee and the employer,

   (e) Must provide an appropriate level of assistance to a beneficiary when requested or when necessitated by the beneficiary's mobility status or personal condition, including curb-to-curb, door-to-door, and hand-to-hand assistance, as required,

      (1) The ADC driver must confirm the beneficiary is safely inside the residence or facility before departing the drop-off point, and

      (2) The ADC driver is responsible for properly securing any mobility devices used by the beneficiary.

   (f) Must assist beneficiaries in the process of being seated, confirm all seat belts are fastened properly and all passengers are safely and properly secured,

   (g) Must park the vehicle in a safe location, out of traffic and must notify the facility

to request assistance when a passenger's behavior or any other condition impedes the safe operations of the vehicle,

(h) Must park the vehicle in a location that prevents the beneficiary from crossing streets to reach the entrance of their destination when arriving at the intended destination,

(i) Must provide verbal directions to passengers as appropriate,

(j) Must notify the ADC provider immediately of an emergency such as an accident/ incident or vehicle breakdown to arrange for alternative transportation for the beneficiaries on board, and

(k) Must report all accidents/incidents and incidents and breakdowns to the ADC provider as soon as practicable.

8) The ADC Provider must ensure ADC drivers do not:

(a) Leave a beneficiary unattended at any time,

(b) Use alcohol, narcotics, illegal drugs or prescription medications that impair their ability to perform,

(c) Smoke in the vehicle, while assisting a beneficiary or in the presence of a beneficiary or allow beneficiaries or their adult attendant to smoke in the vehicle,

(d) Wear any type of headphones while on duty, except for hands-free headsets for mobile ~~telephoned~~ telephones which can only be used for communication with the ADC Provider or to call 911 in an emergency,

(e) Touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance which the ADC driver has been trained, and

(f) Provide services without completing a national and state background check.

9) The ADC Provider must ensure that the ADC driver is removed from service if he/she:

(a) Fails an annual random drug test.

(b) Is convicted of:

(1) Two (2) moving violations or accidents related to transportation in the previous five (5) years as verified by an annual Motor Vehicle Report

(MVR), or

(2) Any federal or state crime listed in Miss. Code Ann § 43-13-121.

(c) Has a suspended or revoked driver's license for moving traffic violations in the previous five (5) years as verified by an annual MVR.

i) If the facility utilizes volunteers, they:

1) Must be individuals or groups who desire to work with adult day service beneficiaries.

2) Must successfully complete an orientation/training program.

3) Have responsibilities that are mutually determined by the volunteers and employees and performed under the supervision of facility staff members.

4) Have duties that either supplement required employees in established activities or provide additional services for which the volunteer has special talent/training.

5) Cannot provide services in place of required employees and can only be allowed on a periodic/temporary basis.

6) Must record their hours and activities.

3. Personal care service providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office. If greater than sixty (60) miles driving distance, the provider must ensure that a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by their agency.

b) Employee qualified personal care attendants, qualified personal care service supervisors, and a director/compliance officer.

1) The personal care attendant must meet the following requirements:

(a) Be at least eighteen (18) years of age.

(b) Be a high school graduate or have a General Educational Development (GED) certificate, or must demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits,

(c) Successfully complete a mandatory training course upon hire covering each of the following topics and pass a scored examination prior to rendering services.

This training course must also be attended annually for each year after hire.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the E&D Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity and exhibit basic qualities of compassion, responsibility, maturity and be able to respond to beneficiaries and situations in a responsible manner,

(f) Possess a valid state issued identification, and have access to reliable transportation,

(g) Be able to function independently without constant observation and supervision,

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring.

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

(j) Have interest in, and empathy for, persons who are ill, elderly, or disabled,

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people,

(l) Maintain current and active first aid and CPR certification,

(m) Be able to carry out and follow verbal and written instructions, and

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The personal care service supervisor and directors/compliance officers must ensure the requirements of the PCA staff as set forth in Rule 1.3(c)(3)(b)(1) above are met, and must meet the following additional requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

(b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

(c) Satisfy one of the following criteria:

(1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

(2) A licensed RN or Licensed Practical Nurse (LPN) with two (2) years of direct experience working with aged and disabled persons, or

(3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

(a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representative include but are not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

(b) The selected relative must be qualified to provide services as specified in Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

(c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

(d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours., ~~and~~

~~(e) The service provided must not be a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.~~

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

4. In-Home Respite providers must meet the following requirements:

a) Serve counties no more than sixty (60) miles driving distance from the physical office, unless a supervisor has a designated worksite within sixty (60) miles driving distance of any beneficiaries served by the provider.

b) Employ qualified in-home respite employees and supervisors.

1) In-home respite employees must meet the following requirements:

(a) Be at least eighteen (18) years of age.

(b) Be a high school graduate have a GED or must demonstrate the ability to read the written in-home respite assignment and write adequately to complete and sign required forms and reports of visits.

(c) Successfully complete a curriculum training course upon hire and annually thereafter, covering each of the following topics. They must also pass a scored examination upon hire prior to rendering services.

(1) Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse Neglect & Exploitation,

(2) Person Centered Thinking including Participant Rights and Dignity,

(3) Assisting with Activities of Daily Living (ADLs) and Instrumental

Activities of Daily Living (IADLs),

(4) Crisis Prevention/Intervention and Emergency Preparedness

(5) Caring for Participants with Cognitive or Behavioral Conditions

(6) Signs and Symptoms of Illness including Seizures

(7) HIPAA Compliance and Confidentiality

(8) Safety including Preventing and Reporting of Accidents/Incidents and the Operation of Assistive Devices

(9) Professional Documentation Practices

(10) Universal Precautions & Infection Control

(11) Medicaid Administrative Code and the Elderly and Disabled Waiver

(d) Pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity, exhibit basic qualities of compassion and maturity, and be able to respond to beneficiaries and situations in a responsible manner,

(f) Possess a valid state issued identification and have access to reliable transportation,

(g) Have the ability to function independently without constant supervision/observation,

(h) Be physically and mentally able to perform the job tasks required including lifting and transferring,

(i) Attest that communicable diseases of major public health concern are not present on an annual basis using the Health Self Attestation Form,

(j) Have interest in, and empathy for, individuals who are ill, elderly, and/or disabled,

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people,

(l) Maintain current and active first aid and CPR certification,

(m) Be able to carry out and follow verbal and written instructions, and

(n) Be able to issue verbal and written instructions that are understandable by others.

2) The in-home respite supervisor and directors/compliance officers must ensure the requirements of the IHR staff as set forth in Rule 1.3(c)(4)(b)(1) above are met, and must meet the following additional requirements:

(a) Have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals, and

(b) Have a designated workspace within sixty (60) miles driving distance of the service area, as verified, and documented by the compliance officer, and

(c) Satisfy one of the following criteria:

(1) Have a bachelor's degree in social work, home economics, or a related profession with two (2) years of direct experience working with aged and disabled persons, or

(2) A licensed RN or Licensed Practical Nurse (LPN) with two (2) years of direct experience working with aged and disabled persons, or

(3) Be a high school graduate with diploma, or have a General Educational Development (GED) certificate, and four (4) years of direct experience working with aged and disabled persons.

3) The Division of Medicaid may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:

(a) For the purposes of this requirement, a non-legally responsible relative is defined as any individual related by blood or marriage to the beneficiary who is not a legal guardian or legal representative. Legal guardians or representatives who cannot qualify as a non-legally responsible relative include but are not limited to, spouses, parents/stepparents, conservators, guardians, individuals who hold the beneficiary's power of attorney, or those designated as the representative payee for Social Security benefits.

(b) The selected relative must be qualified to provide services as specified in Appendix C-1/C-3 of the CMS approved waiver application, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

(c) The beneficiary or a designated representative must sign a verification that services were rendered by the selected relative, and

(d) The selected relative must agree in writing, signed prior to providing services, to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.~~, and~~

~~(e) The service provided must not be a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.~~

4) The Division of Medicaid reserves the right to remove a selected relative from the provision of services at any time. If the Division of Medicaid removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

5. Institutional Respite providers must be a Medicaid certified hospital, nursing facility or licensed swing bed facility.

6. Home Delivered Meal providers must meet the following requirements:

a) Be certified through the Mississippi State Department of Health (MSDH).

b) Have a qualified person responsible for the day-to-day operation of the service.

c) Have an adequate number of employees to meet the purpose of the program.

d) Train all employees in the proper Mississippi Department of Health approved technique of preparing for and/or serving meals to aged and disabled persons including, but not limited to, sanitation procedures, proper cleaning of equipment and utensils, first aid and emergency procedures.

e) Provide in-service training for all employees.

f) Submit for approval by the Division of Medicaid written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into Mississippi provider agreement.

g) Provide written documentation to the Division of Medicaid stating how the required standards are to be met.

h) Provide delivery of meals at times coordinated with the beneficiary or their designated representative.

7. Extended Home Health providers must meet the following qualifications:

a) Be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its approved certificate of need (CON), if applicable, and

d) Ensure direct care providers have a current and active license and/or certification.

8. Physical therapy service providers must meet the following qualifications:

a) Be certified by the Mississippi Department of Health to participate as a Mississippi Medicaid enrolled home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable, and

d) Employ qualified physical therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and meet the state and federal licensing and/or certification requirements to perform physical therapy services in the State of Mississippi.

9. Speech-Language Pathology providers must meet the following qualifications:

a) Be certified to participate as a Mississippi Medicaid home health agency under Title XVIII (Medicare) of the Social Security Act. The Agency must furnish the Division of Medicaid with a copy of its current State license certification and/or recertification,

b) Meet all applicable state and federal laws and regulations,

c) Provide the Division of Medicaid with a copy of its certificate of need (CON) approval when applicable,

d) Execute a participation agreement with the Division of Medicaid, and

e) Employ qualified speech therapists who have a non-restrictive current Mississippi license issued by the appropriate licensing agency to practice in the State of Mississippi and meet the state and federal licensing and/or certification requirements to perform speech-language therapy services in the State of Mississippi.

10. Community Transition Service (CTS) providers must meet the following requirements:

a) Provide documentation to the Division of Medicaid of successfully transitioning

individuals into the community for a minimum of two (2) years, and/or working with individuals in the community for a minimum of eight (8) years. For those without two (2) years of successfully transitioning individuals into the community, experience will be considered on an individual basis.

b) Have documentation of attending the Division of Medicaid's approved person-centered training or another Division of Medicaid approved training relating to person-centered planning.

c) Attend all quarterly and annual CTS trainings administered by the Division of Medicaid with a minimum of one (1) attendee from the provider.

d) Have written procedures for dealing with an after-hour crisis.

e) Each Community Transition Service (CTS) provider must have qualified community navigators and qualified supervisors.

1) The community navigator must meet the following requirements:

(a) Be a(n):

(1) Licensed Social Worker (LSW) with valid Mississippi license and a minimum of one (1) year of relevant work experience,

(2) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),

(3) RN with a valid Mississippi license and a minimum of one (1) year of relevant work experience,

(4) Individual with relevant experience and training with a minimum of a bachelor's degree and (1) year of work experience in a social or health services setting, or

(5) Individual with comparable technical and human service training and five (5) years' experience subject to approval by the Division of Medicaid.

(b) Have documented experience in person-centered planning.

(c) Prior to beginning work, attend an eight (8) hour introductory CTS course that is administered by the Division of Medicaid.

(d) Complete a Person-Centered Plan training course designated by the Division of Medicaid within the one (1) year prior to rendering services, unless excused, in writing, by the Division of Medicaid.

(e) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity.

(f) Exhibit basic qualities of compassion/maturity and be able to respond to persons and situations in a responsible manner.

(g) Attend all CTS trainings administered by the Division of Medicaid unless excused, in writing, by the Division of Medicaid.

(h) Possess a valid Mississippi driver's license.

(i) Be able to function independently without constant observation and supervision.

(j) Have both interest in and empathy for people who are ill, elderly, and/or disabled.

(k) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people.

(l) Be able to carry out and follow verbal and written instructions.

(m) Have training in current information technology systems used by the Division of Medicaid including Long-Term Services and Supports (LTSS) and any other systems utilized for documentation purposes.

2) The community navigator supervisor must have a minimum of two (2) years of supervisory experience in programs dealing with elderly and disabled persons and meet one (1) of the following requirements:

(a) Have a bachelor's degree in social work, Psychology, or related profession with two (2) years of direct experience working with aged and disabled persons transitioning into the community,

(b) Be an RN with a current Mississippi license and two (2) years of direct experience working with aged and disabled persons transitioning into the community, or

(c) Have a high school diploma or GED with seven (7) years of direct experience working with aged and disabled persons with two (2) of the seven (7) years working directly with persons transitioning into the community.

D. The Division of Medicaid may terminate or suspend a provider immediately for failure to comply with the requirements of the E&D waiver program. The Division of Medicaid may also require providers to submit and implement a corrective action plan (CAP) in a timely manner. Failure to submit or comply with a CAP, approved by the Division of Medicaid, may

result in a suspension or termination.

Source: 28 C.F.R. Part 36; 42 C.F.R. 455, Subpart E; 42 C.F.R. §§ 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 06/01/2013; Revised eff. 01/01/2013.

Rule 1.4: Freedom of Choice

A. Beneficiaries 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. Freedom of Choice is required of all providers and is monitored by the Division of Medicaid. The case management team must assist the beneficiary by providing them with sufficient information and assistance to make free and informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed by the case manager 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, 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2025; Revised eff. 12/01/2018; Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Elderly and Disabled (E&D) Waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Waiver is available on the Division of Medicaid's website, www.medicaid.ms.gov.

B. Providers must maintain compliance with all current waiver requirements, rules, regulations and administrative codes as specified by the Division of Medicaid.

1. If an E&D Waiver provider fails to respond to contact attempts timely or respond to requests for documentation/training verification in established timeframes, the Division of

Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the E&D waiver provider establishes contact or demonstrates compliance with the regulatory agency.

2. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the Division of Medicaid.

C. Waiver providers must report:

1. Changes in contact information, administrative staffing, ownership and licensure within ten (10) calendar days to the Division of Medicaid.

2. Critical incidences including all instances of abuse, neglect, and exploitation (including the unauthorized use of restraints, restrictive interventions, and/or seclusion) within twenty (24) hours of the occurrence or knowledge of the occurrence to the Division of Medicaid and other applicable agencies as required by law.

3. Any complaints not resolved within seven (7) days.

D. A provider may not rely on any interpretation or exception to the Medicaid rules if it's not provided, in writing, by the Division of Medicaid.

Source: 42 C.F.R. §§ 440.180; 441.302; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

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 services include the identification of resources as well as the coordination and monitoring of resources and services by case managers to ensure the health, social needs, preferences and goals of beneficiaries are met throughout the person centered planning process and service provision. The case management agency is responsible for monitoring and implementation of the Plan of Services and Supports (PSS). Monitoring and implementation of the PSS includes, but is not limited to, on-site review activity in the beneficiary's residence, record reviews, annual recertification reviews, telephone interviews by the Medicaid agency, and other strategies as needed.

a) The case management team must consist of a Licensed Registered Nurses (RN) and Licensed Social Worker (LSW), and will conduct the following activities.

1) Conduct face-to-face visits together using the comprehensive long-term services

and support (LTSS) assessment instrument at the time of admission and recertification.

(a) Initial assessments must be conducted face-to-face with the waiver applicant in conjunction with a registered nurse.

(b) Recertification assessments must be conducted face-to-face with a beneficiary by the case manager, and a registered nurse must be available for consultation if necessary.

2) Complete face-to-face visits with the beneficiary on a quarterly basis to review the Plan of Services and Supports (PSS).

3) Complete monthly contacts with the beneficiary. Monthly contacts may be completed virtually; however, face-to-face visits for monthly contacts must be completed with beneficiaries if any of the following concerns are identified:

(a) Beneficiary/representative is unable to communicate by phone due to an auditory, speech or cognitive impairment;

(b) Beneficiary has unmet needs that cannot be resolved by phone;

(c) The case management team has identified risks for abuse, neglect or exploitation including the use of restraints or seclusion that require in-person monitoring; or

(d) Beneficiary/representative is unable to be reached by phone.

b) Each case management team must maintain active case load of no more than one hundred and twenty (~~100~~120) E&D Waiver beneficiaries.

1) If a case management team maintains an average, active case load greater than one hundred and twenty (~~100~~120), 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 (ADC) Services - ADC services include community-based comprehensive programs 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 be provided in accordance with a beneficiary's approved PSS.

b) ADC services must meet the needs of aged and disabled persons through an individualized service plan (ISP) developed by the ADC through a person-centered process and must include the following:

1) Personal care and supervision,

2) A minimum of one (1) meal and two (2) snacks per day of an adult's daily nutritional requirement as established by state and federal regulations,

3) Provision of limited health care including medications while the beneficiary is at the facility,

4) Round trip transportation from the beneficiary's home to the facility and to center-sponsored activities, and escort service as needed to ensure a beneficiary's safety,

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

6) Information on, and referral to, vocational services.

c) To be eligible for reimbursement, the ADC must:

1) Submits claims billed in fifteen (15) minute increments for the duration of time the services were provided and the provider 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 for that day.

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

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

2) Be open and providing services for at least nine (9) continuous hours per day, Monday through Friday, 8am – 5pm with the exception of any state/federal holidays.

d) ADC settings including outdoor spaces must be safe, clean and physically accessible to the beneficiaries and must:

1) Ensure that beneficiaries receiving Medicaid HCBS have access to the greater community, including opportunities to engage in community life as individuals not receiving Medicaid HCBS.

2) Be selected by the beneficiaries 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 beneficiary's needs and preferences.

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

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

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

6) ADC settings should not restrict a beneficiary within a setting, unless such restriction is documented in the person-centered plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

7) The person-centered service plan should identify and document setting options based on the beneficiary's needs and preferences, including non-disability specific settings, from which the beneficiary can select.

e) ADC 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 beneficiaries receiving Medicaid.

f) Beneficiaries must not be in transportation vehicles for longer than sixty (60) minutes per trip.

3. Personal Care Services - Personal Care Services (PCS) are non-medical support services provided in the home or community of eligible beneficiaries by trained personal care

attendants (PCA) to assist the beneficiary 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,

2) Must be provided in accordance with a beneficiary's PSS,

3) Are approved by the Division of Medicaid based upon assessed needs of the beneficiary as set forth in the PSS and require sufficient documentation to substantiate the requested number of hours.

(a) The frequency cannot duplicate hours rendered or billed 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 beneficiaries.

b) PCA responsibilities include:

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

(a) Mouth and denture care,

(b) Shaving,

(c) Finger and toenail 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 beneficiary to take prescribed medication,

(i) Eating,

(j) Transferring or changing the beneficiary'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 linens 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 PCAs in an area within sixty (60) miles driving distance of their designated worksite,

2) Ensuring PCA timesheets and any other documents containing protected health or identifying information are securely stored in a manner that prevents unauthorized disclosure while in the PCA or PCA supervisor's possession and returned to the main office location within ten (10) business days,

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

4) Making home visits with PCAs to observe and evaluate job performance, including evaluating the work, skills and job performance of the PCA,

5) Reviewing and approving PCA duties on the approved service plans, revising as needed,

6) Receiving and processing requests for services,

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

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

9) Preparing, submitting or maintaining appropriate records and reports, including supervisory reports and submit monthly activity sheets,

10) Planning, coordinating and recording ongoing in-service PCA training,

11) Performing supervised direct monitoring visits in the beneficiary's home while the PCA staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone while the PCA staff is not on-site, alternating on a bi-weekly basis to assure services and care are provided according to the PSS, and

12) Reporting directly to the ~~PSC~~ PCS agency's Director and in the absence of the Director, being responsible for the regular, routine activities of the PCS program.

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all applicable state and federal laws, and the CMS approved waiver.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all Office of Inspector General (OIG) and Nursing and Exclusion checks are completed timely and maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately.

6) Ensuring immediate access to all ~~participant~~ beneficiary and employee records as required for audit purposes.

e) 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 adhere to and support all policies, rules and regulations in the operations of the EVV system.

4. In-Home or Institutional Respite Services - In-Home Respite (IHR) or Institutional Respite Services, either in an institutional or home setting, is covered for beneficiaries unable to care for themselves in the absence, or need for relief, of the beneficiary'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 beneficiary.

a) In-Home Respite ~~(IHR)~~ services are non-medical, unskilled services.

1) IHR services are covered when a beneficiary:

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

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

2) No more than sixty (60) hours of IHR services per month are allowed. IHR 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 EVV system must adhere to and support all policies, rules and regulations in the operations of the EVV system.

b) IHR ~~Staff~~ staff responsibilities for respite service include, but are not limited to, the following:

1) The IHR staff providing direct respite care must provide one or more of the following primary activities:

(a) -Companionship,

(b) Support or general supervision, or

(c) Feeding and personal care needs.

2) The provision of these services does not entail hands-on nursing care. Any assistance with activities of daily living is incidental to the care of the individual and are not provided as discrete services.

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

1) Supervising the IHR staff providing services within sixty (60) miles driving distance of the supervisor's designated worksite,

2) Ensuring IHR staff timesheets and any other documents containing protected health or identifying information are securely stored while in the possession of the IHR staff or supervisor in a manner that prevents unauthorized disclosure and are returned to the main office location within ten (10) business days,

3) Supervising no more than twenty (20) full-time IHR staff,

4) Making home visits with IHR staff to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

5) Reviewing and approving IHR duties on the approved service plans,

6) Receiving and processing requests for services,

7) Being accessible to IHR staff and beneficiaries/their representatives for emergencies, case reviews, conferences, and problem solving,

8) Evaluating the work, skills, and job performance of the IHR staff, including the completion of hands-on skills assessments,

9) Interpreting IHR agency policies and procedures relating to the IHR program,

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

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

12) Performing supervised direct monitoring visits in the beneficiary's home while the IHR staff is on-site and unsupervised indirect monitoring visits, which may be performed in the beneficiary's home or by phone, while the IHR staff is not on-site, alternating on a biweekly basis to ensure services and care are provided according to the PSS, and

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

d) Director/Compliance Officer responsibilities include, but are not limited to, the following:

1) Ensuring continuing compliance with the Medicaid Administrative Code, Medicaid provider agreement, all other state and federal laws, and the CMS approved waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

2) Ensuring all mandatory training and certifications are completed timely.

3) Ensuring all background checks are completed timely and maintained appropriately.

4) Ensuring all OIG and Nursing Exclusion checks are completed timely and maintained appropriately.

5) Ensuring all Corrective Action Plans are implemented appropriately if necessary.

6) Ensuring immediate access to all beneficiary and employee records as required for audit purposes.

e) 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 following requirements are met:

a) The beneficiary is unable to leave without assistance and is:

(1) unable to prepare their own meals, and/or

(2) has no responsible caregiver in the home.

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

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

1) Attest 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 beneficiaries 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 beneficiary 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 members and members with limited dexterity or mobility.

8) Ensure all food preparation employees are supervised by a person who is familiar with the application of hygienic techniques and practices in food handling, preparation and services. This supervisory employee must ensure all hygiene techniques and practices are applied and consult with the service provider dietitian for advice, 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, per beneficiary, and no more than fourteen (14) frozen meals per delivery, per beneficiary.

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

(a) If the beneficiary, or designated caregiver, is not home at time of delivery, the meals must not be delivered.

(b) Meals delivered to anyone other than the beneficiary 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 beneficiary, provided that proper storage and heating facilities are available in the home, and the beneficiary 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:

a) Extended services have been prior approved by the Division of Medicaid, and are deemed medically necessary by the beneficiary's prescribing primary care provider, 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.

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

7. Physical therapy services are covered when:

a) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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. ~~Provided in accordance with Miss. Admin. Code Title 23, Part 213.8.8.~~ Speech therapy services are covered when:

a) Services must be provided by an enrolled Mississippi Medicaid home health provider utilizing 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 (CT) Services provide assistance with initial expenses required for a beneficiary to set up a household. The expenses must be included in the approved PSS, and expenses are limited to those specifically designated by the Division of Medicaid.

a) To qualify for CT services, a beneficiary must meet all of the following criteria:

1) Reside 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 to establish a household,

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 beneficiary 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 beneficiary or the beneficiary's family member,

(b) An apartment with lockable access leased to the transitioning beneficiary which includes living, sleeping, bathing, and cooking areas over which the beneficiary or the beneficiary'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) Have 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 include deposits for telephone, electricity, heating, and water.

(d) May include payment of past due bills which inhibit the beneficiary'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 beneficiary transitioning from the nursing facility and are limited to:

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

(b) Purchased items may only include furniture, window coverings, food preparation items, bed/bath items and cleaning supplies.

3) Moving expenses and a one (1) time cleaning and pest eradication, as necessary for the beneficiary's health and safety, which has a combined limit of two hundred and fifty dollars ($250.00) to ensure that all belongings of the beneficiary located in the institution 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 beneficiary or the beneficiary's family, if they are required by the beneficiary's PSS, are necessary to ensure the beneficiary's health, welfare, and their safety and enable the beneficiary 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 beneficiary, 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 up to ninety (90) consecutive days prior to the date on which an institutionalized beneficiary transitions to the community setting.

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

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

(f) All providers/subcontracted entities rendering HAA 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 manner 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, and leave 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) The modification and/or construction process cannot create any new accessibility barriers.

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

(a) Required by the beneficiary's PSS,

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

(c) It enables the beneficiary 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 beneficiary'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 sixty (260) units, which must occur no earlier than ninety (90) days prior to transition to the community.

(c) Is reimbursed per a 15-minute unit rate up to forty (40) 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) They are clearly identified in the service plan, and

(b) The beneficiary 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, 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 beneficiary is able to transition from the current nursing facility, and

2) Identifying and eliminating any identified obstacles or barriers that could prevent a successful transition to a more independent setting.

10. Environmental Safety Services are provided for the purpose of maintaining a healthy and safe living environment through the performance of tasks in and around the beneficiary's home environment that are beyond the beneficiary's capability to personally perform.

a) Environmental Safety Services must be provided in accordance with a beneficiary's PSS and may include the following services:

1) minor home maintenance and repair.

2) non-routine disposal of garbage posing a threat to the beneficiary's health and welfare.

3) pest control and services to prevent, suppress, eradicate, or remove pests posing a threat to the beneficiary's health and welfare.

b) Environmental Safety services exclude tasks that:

1) are the legal or contractual responsibility of someone other than the beneficiary.

2) can be accomplished through existing informal and formal supports.

3) do not provide a direct or remedial benefit to the beneficiary.

4) are performed or interventions available through the personal care or in-home

respite services.

c) Environmental safety services shall not exceed $500.00 per beneficiary per state fiscal year. These services are limited to additional services not otherwise covered under the State Plan, including EPSDT.

d) Environmental Safety Services are coordinated and billed based on actual invoiced cost to the Division of Medicaid by approved Elderly and Disabled Waiver Case Management providers.

e) Direct services may be contracted out to local vendors. Vendors providing environmental safety services must:

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

2) Ensure the quality of work meets standards that secure the beneficiary's health and welfare.

3) Coordinate with the Case Managers and the beneficiary to ensure that services are rendered in a person-centered manner.

11. Medication Management services are provided to beneficiaries with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications. These services include consultations and ~~follow up~~follow-up visits with a licensed pharmacist and must be provided in accordance with a beneficiary's approved PSS. Medication management is limited to one initial or annual consultation and fifteen (15) follow-up visits per state fiscal year (SFY). These services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

a) Medication Management includes the following services:

1) Review of all prescription and over-the-counter medications taken by the beneficiary on at least a monthly basis in order to support the beneficiary's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors.

2) Reviews may occur more frequently, on an as needed basis, upon significant change in the beneficiary's condition or immediately following discharge from an acute hospital stay.

3) A comprehensive initial or annual consultation and subsequent follow-up consultations in which the provider will be responsible for collecting a complete medical history and list of current prescribed and over-the-counter medications in

order to assess whether:

a) The beneficiary's medication is accurate, valid, non-duplicative and correct for their diagnoses.

b) Therapeutic doses and administration are at an optimal level.

c) Appropriate laboratory monitoring and follow-up are taking place.

d) Drug interactions, drug allergies and contraindications are assessed and prevented.

4) Necessary interventions implemented by the provider including, but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery or reminder 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 to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 08/01/2019; 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.

Rule 1.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive any services through the Elderly and Disabled (E&D) Waiver Program. To obtain approval, the waiver case management provider 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, and

5. Informed Choice.

B. Any request to add or increase services listed on the approved PSS must be submitted to and receive prior approval from the Division of Medicaid and must include documentation substantiating the need for the requested change(s).

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

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.8: Documentation/Record Maintenance

A. Documentation and record maintenance for reimbursement purposes must, at a minimum, meet requirements set forth in the Elderly and Disabled (E&D) Waiver. [Refer to Miss. Admin. Code Part 200, Rule 1.3.]

B. All staff records should include, at a minimum, the following required credentialing and qualification documents:

1. Copy of valid, state issued ID,
2. Job description,
3. Application and date of hire,
4. High school diploma, General Educational Development (GED) certificate, other educational degrees, or proof of ability to read and write accurately,
5. Any licensure and/or certifications as required by the Division of Medicaid for job description,
6. Results of fingerprint-based National Criminal Background check(s),
7. Results of monthly Nurse Aide Abuse Registry checks,
8. Results of monthly Office of Inspector General (OIG) checks,
9. Annual attestation of health,
10. Signed confidentiality agreement that includes social media waiver, and
11. Proof of training/evaluations, required professional certifications, and credentials including CPR and First Aid.

C. Records for beneficiaries receiving Personal Care Services (PCS) & In-Home Respite (IHR) should include, at minimum:

1. Referral form/authorization,
2. Approve Plan of Services and Supports (PSS)

3. Daily activity or time sheets capturing tasks completed and the beneficiary/representative's signature verifying the provision of services, if task and global positioning system (GPS) information is not captured electronically in the state approved electronic visit verification system.

4. Service note indicating the causes of any significant variation in the case management recommended/agreed upon schedule of service provision.

D. Records for PCS/IHR offices should include at minimum:

1. Written criteria for service provision, including procedures for dealing with emergency service requests,

2. Policy and procedure manuals,

3. Records of quarterly advisory committee meetings,

4. Written personnel policies including the process used in the recruitment, selection, retention, and termination of employees,

5. Organizational chart including the names and job titles of owners, operators, managers, administrators, and other supervisory staff., and

6. Current and historical employee listing that captures names, staff/tax id numbers, and employment hire and termination dates.

E. Records for beneficiaries receiving Adult Day Care (ADC) should include, at minimum:

1. Individualized Service Plan (ISP), with documentation of annual review,

2. Approved Plan of Services and Supports (PSS),

3. Daily activity or time sheets capturing service notes and the beneficiary/representative's signature verifying the provision of services,

4. Current photograph,

5. Medical history or medical exam completed within six (6) months of admission,

6. Annual nutritional assessment, and

7. Daily Progress Notes.

F. Activity or time sheets must include:

1. Arrival/service start time and date,

2. Departure/service end time and date,

3. Activities/tasks performed, and

4. The signature of the beneficiary or their legal representative verifying the provision of services.

G. ADC facility records should include, at minimum:

1. Documentation of maintenance and janitorial services including repairs, maintenance and pest control,

2. Documentation of quarterly drills for fire and inclement weather,

3. Annual fire safety inspection reports conducted by the fire department,

4. Records of quarterly advisory committee meetings,

5. Written criteria for service provision, including procedures for detailing with emergency service requests,

6. Policy and procedure manuals,

7. Written personnel policies including the process used in the recruitment, selection, training, retention, and termination of employees,

8. Current and historical organizational charts including the names and job titles of owners, operators, managers, administrators, and other supervisory staff,

9. Current and historical employee listing that captures names, staff/tax id numbers, employment hire and termination dates, and

10. Service records of licensed nurses which includes dates in the facility, arrival and departure times, services performed, and signature of administrator or program director.

Source: 42 C.F.R. §§ 440.180, 441.303; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121; 43-13-129.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.9: Reserved

Rule 1.10: Reimbursement

A. Claims must be based on services that have been rendered to beneficiaries 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 beneficiary 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 beneficiary's approved PSS.

E. Records documenting the provision of services must be maintained by the providers of waiver services for a minimum of five (5) years. If, at the conclusion of the five-year period, there is ongoing litigation or an open audit, the provider must maintain these records until the litigation or audit is concluded.

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

G. Providers must bill for Elderly and Disabled (E&D) Waiver services no sooner than the first (1st) day of the month following the month in which services were rendered for the following services:

1. Case Management,

2. Adult Day Care (ADC) Services,

3. Institutional Respite, and

4. Home delivered meals.

H. All providers of Personal Care Services (PCS) and In-Home Respite must utilize the Mississippi Medicaid Electronic Visit Verification (EVV) system for the submission of claims unless an exception is approved, in writing by the Division of Medicaid. Requirements for the use of the EVV system are outlined in Miss. Admin. Code Part 200.

I. The Division of Medicaid reimburses for extended Home Health services, physical therapy services and speech therapy services in accordance with statewide uniform fee schedule.

Source: 42 C.F.R. §§ 440.180, 440.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025.

Rule 1.11: Due Process Protection

A. The Division of Medicaid and the case management agencies are responsible for operating a dispute resolution process 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 waiver services.

    2. At the initial assessment, the case management agency must provide written notice to inform the beneficiary/representative of the specific criteria for the dispute, complaint/grievance, and hearing processes.

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

    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. Notice of Action

    1. The case management agency must provide the beneficiary with a Notice of Action (NOA) via certified mail as required in 42 C.F.R. §431.210.

    2. The NOA must include:

        a) A description of the action the provider has taken or intends to take,

        b) An explanation for the action,

        c) Notification that the person/representative has the right to file an appeal,

        d) Procedures for filing an appeal,

        e) Notification of person/representative's right to request a Fair Hearing,

        f) Notice the person/representative has the right to have benefits continued pending the resolution of the appeal, and

g) 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. §§ 431.210, 440.180, 441.301, 441.307; 42 CFR; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.12: Hearings and Appeals

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed in accordance with Miss. Admin. Code Part 300.

Source: 42 C.F.R. 431, Subpart E; 42 C.F.R. §§ 440.180, 441.308; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the E&D Waiver renewal (eff. 07/01/2023) eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; Revised eff. 01/01/2013.

Rule 1.13: Person Centered Planning (PCP)

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

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

2. Include people chosen by the beneficiary.

3. Provide the necessary information and support to ensure that the beneficiary 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 beneficiary.

5. Reflect cultural considerations of the beneficiary 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 beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary, 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 beneficiaries must be provided with a clear and accessible alternative dispute resolution process which ensures the beneficiary's rights to privacy, dignity, respect, and freedom from coercion and restraint.

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

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

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

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

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

    a) Chosen by the beneficiary and/or their representative,

    b) Integrated in, and supports full access of beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries with disabilities and who are limited English proficient so as to be understandable to the beneficiary receiving services and supports, and the individuals important in supporting the beneficiary.

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

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

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

11. Identify those services, the purpose or control of which the beneficiary 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 content:

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

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

3. The services and supports needed by the beneficiary 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 beneficiary, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Each provider identified in the PSS must review and revise the PSS when any of the following occur:

1. At least twelve (12) months have lapsed since the provider's last review,

2. The beneficiary's circumstances or needs change significantly, or

3. When requested by the beneficiary.

E. All changes to the PSS require documented consent from the beneficiary either via current signature/date or via verbal consent with a witness's signature/date on a change request.

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

History: Revised eff. 06/01/2025; Revised to correspond with the E&D Waiver renewal (eff. 07/01/2017) eff. 12/01/2018; New rule eff. 01/01/2017.

Rule 1.15: Grievances and Complaints

A. The Division of Medicaid is responsible for investigating and documenting all grievances/complaints regarding all E&D Waiver programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format or email.

B. Personnel issues are not considered as grievances or complaints within the scope or purview of the Division of Medicaid.

C. The Division of Medicaid's toll-free Helpline is available at (800) 421-2408. 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 the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved E&D Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

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

History: New rule eff. 06/01/2025.