Title 23: Division of Medicaid

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

Part 208 Chapter 2: Home and Community-Based Services (HCBS) Independent Living Waiver

Rule 2.1: General

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

B. Beneficiaries enrolled in the IL Waiver must reside in a private residence, 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 IL Waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

D. IL Waiver Beneficiaries are prohibited from receiving additional Medicaid services through another waiver program.

E. IL Waiver Beneficiaries who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

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

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

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

Source: 42 U.S.C. § 1396n; 42 C.F.R. §§ 440.180, 441.710(a)(1)(i), 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 09/01/2019; Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.2: Eligibility

A. In order to qualify as a beneficiary of the IL Waiver Program, an individual must meet the following criteria:

1. Must be age sixteen (16) or older;

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

3. Must exhibit severe orthopedic and/or neurological impairments that render them dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living;

4. Must be able to express ideas and wants either verbally or nonverbally with caregivers, direct care workers, case managers or others involved in their care;

5. Must be certified as medically stable by a physician or nurse practitioner. The Division of Medicaid defines medical stability as the absence of all of the following:

   a) An active, life-threatening condition requiring systematic therapeutic measures;

   b) Intravenous drip to control or support blood pressure; and

   c) Intracranial pressure or arterial monitoring.

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

   a) Supplemental Security Income (SSI);

   b) Parents and Other Caretaker Relatives Program;

   c) Katie Beckett COE;

   d) Children under age nineteen (19) who meet the applicable income requirements;

   e) Disabled Adult Child;

f) Protected Foster Care Adolescents;

g) Child Protection Services (CPS) Foster Children and Adoption Assistance Children;

h) IV-E Foster Children and Adoption Assistance Children;

i) An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify; or

j) Working Disabled.

B. IL Waiver beneficiaries 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. An IL Waiver 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 IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 2.2.E. eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 2.3: Provider Enrollment

A. The Mississippi Department of Rehabilitation Services (MDRS), as the provider of Independent Living (IL) Waiver services, must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Chapter 4.

B. To participate as a Home and Community-Based Services (HCBS) IL Waiver provider, MDRS must:

1. Conduct a national criminal background check with fingerprints on case managers, nurses, and direct care workers (DCW) that provide personal care and transition services prior to employment and every two (2) years thereafter and maintain the record in the employee's personnel file;

2. Conduct registry checks, prior to employment and monthly thereafter, to ensure individuals providing case management and personal care services or transition services are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record in the employee's personnel file. The provider must not employ individuals whose name appears on either the registry or the database;

3. Not have employed or currently employ individuals or volunteers who have been convicted of, pleaded guilty to, or pleaded nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or any other crime of violence. Any conviction or plea which was reversed on appeal or for which a pardon was granted shall not be considered;

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

5. Be compliant with all federal and state regulations; and6. Have responsible personnel management including:

    a) Appropriate processes used in the recruitment, selection, retention, and termination of employees;

    b) Maintain current written personnel policies and job descriptions;

    c) Maintain a current training plan as a component of the policies/procedures documenting the method for the completion of required training. The training plan must require all employees to meet training requirements as designated by the Division of Medicaid upon hire, and annually thereafter; and

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

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

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

    a) The Registered Nurse must:

        1) Have a current and active unencumbered RN license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license; and

        2) Have at least one (1) year of experience with the aged and/or individuals with

disabilities.

b) The Case Manager must:

1) Possess at a minimum a bachelor's degree in Rehabilitation Counseling or other related field; and

2) Have one (1) year of experience working with the aged and/or individuals with disabilities.

c) Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Case Manager.

d) MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken against any nurse providing services under the IL waiver.

e) MDRS must verify provider qualifications upon hire and at least annually and maintain documentation of that verification in the employee file.

2. Personal care Services must be provided by a DCW who must meet the following qualifications:

a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCW;

b) Must meet basic competencies that include both educational and functional requirements;

c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements;

d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with providing personal care services for the beneficiary.

1) The educational program must be personalized with participation of the beneficiary to ensure his/her specific needs are met.

2) The cost of training/instruction time for DCWs cannot be reimbursed by the Division under the waiver.

3) The individual must demonstrate competency in performing each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering

any IL waiver service.

4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary/representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

(a) DCW training must be conducted by the Case Manager, or an agency permitted by law to train nurse aides, must be tailored to the personal care required for the person, and must include:

(1) The purpose and philosophy of self-directed services by the disabled;

(2) Disability awareness;

(3) Employee-employer relationships;

(4) The need for respect for the beneficiary's privacy and property;

(5) Basic elements of body functions;

(6) Infection control procedures;

(7) Maintaining a clean and safe environment;

(8) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance; and

(9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities is deemed to meet the classroom training requirements. Competency certification for these personal care providers by the beneficiary/representative and Case Manager is required. A DCW that has satisfactorily provided personal care services to the beneficiary for four (4) weeks prior to coverage under the IL waiver program, with such service certified by and verified by the beneficiary/representative and Case Manager, is deemed meeting the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but 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 beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division of Medicaid under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the Division under the waiver when the following criteria are met:

1) There is documentation that there are no other willing/qualified providers available for selection;

2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the IL Waiver;

3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative;

4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours; and

5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The Division of Medicaid and/or the Department of Rehabilitation reserves the right to remove a selected relative from the provision of services at any time if there is a reasonable suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports (PSS). If the state removes a selected relative from the provision of services, the IL Waiver beneficiary will be asked to select an alternate qualified provider.

h) The direct care worker must meet the following requirements:

1) Be at least eighteen (18) years of age;

2) Be a high school graduate, 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;

3) Be able to follow verbal and written instructions;

4) Have no physical/mental impairment to prevent lifting, transferring, or providing

any other assistance to IL Waiver beneficiary;

5) Be certified as meeting the training and competence requirement by the IL Waiver beneficiary and the Case Manager; and

6) Be able to communicate effectively and carry out directions.

i) MDRS must verify the competency for all DCWs as needed.

3. Specialized Medical Equipment and Supplies must be provided by entities who meet the following qualifications:

a) Have a permanent local address and phone number;

b) Have a State of Mississippi sales tax number;

c) Have Federal identification number or social security number;

d) Have liability insurance;

e) Must honor the manufacturer's guarantee or warranty as published;

f) Must provide repair capability for products; and

g) Must meet the following additional standards if providing custom in-house seating systems, powered mobility, three-wheel scooters, and high-tech systems:

1) Must provide documented proof of attendance of training with seating and positioning;

2) Maintain a current list of power chair manufacturers represented;

3) Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer;

4) Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above;

5) Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting;

6) Must have and present at purchase all necessary manuals and written warranties;

7) Must be able to provide instruction in proper use and care of equipment;

8) Must be capable of providing training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price; and

9) Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.

4. Transition Assistance services must be provided by a Registered Nurse and/or Case Manager.

5. Environmental Accessibility Adaptation services must be provided by entities who meet the following:

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

b) Provide services in accordance with applicable state housing and local building codes;

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

1) All work must be done in a fashion that exhibits good craftsmanship;

2) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions;

3) The contractor must obtain all permits required by local governmental bodies;

4) All non-salvaged supplies and/or materials must be new and of best quality, without defects;

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

6) All work must be accomplished in compliance with applicable codes, ordinances, regulations, and laws;

7) The specifications and drawings cannot be modified without a written change order from the case manager; and

8) No accessibility barriers can be created by the modification and/or construction process;

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

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff. 09/01/2019.

Rule 2.4: 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. The freedom of choice requirement is monitored by the operating agency and Division of Medicaid. The case management team must assist the beneficiary by providing them with sufficient information and assistance to make a free and informed choice regarding services and supports, taking into account risks that may be involved for that beneficiary.

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, 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Moved and revised from Miss. Admin. Code Part 208, Rule 2.5 eff. 09/01/2019. Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Independent Living (IL) 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 IL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the IL Waiver provider 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 and/or contractors must report:

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

2. Critical incidences of abuse, neglect, and exploitation (including the unauthorized use of restraints, restrictive interventions, and/or seclusion) within twenty-four (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 to MDRS and within fourteen (14) days to the Division of Medicaid.

D. Quality Management Strategy for the waiver must be implemented in accordance with Appendix H of the CMS approved waiver application.

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

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.6 eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.6: Covered Services

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

1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver services and other services, including but not limited to medical, social and educational services, regardless of the funding source for the services.

a) Case Management services, as an administrative activity, must be provided by

Mississippi Department of Rehabilitation Services (MDRS) case managers/registered nurses who meet minimum qualifications listed in the waiver and Miss. Admin. Code Part 208, Rule 2.3.

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

1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care. Initial assessments must be conducted in person in conjunction with a registered nurse. Annual recertification assessments must be conducted in person by the case manager and a registered nurse must be available for consultation if necessary;

2) Provide ongoing monitoring of the services included in the beneficiary's Plan of Services and Supports (PSS);

3) Develop, review, and revise the PSS at intervals specified in the waiver;

4) Conduct quarterly in person visits with the beneficiary;

5) Complete monthly contacts with the beneficiary. Monthly contacts may be completed telephonically or virtually; however, in person 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 or virtual electronic device due to an auditory, speech or cognitive impairment;

(b) Beneficiary has unmet needs that cannot be resolved by phone or virtual electronic device;

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

(d) Beneficiary/representative is unable to be reached by phone or virtual electronic device.

6) Document all contacts, progress, needs, and activities carried out on behalf of the beneficiary; and

7) Ensure that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e., infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e., bathing, transferring, skin care, dressing, and bowel and bladder programs).

2. Personal care services are non-medical, hands-on care of both a supportive and health-related nature. Personal care services are provided to meet daily living needs to ensure

adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

a) Personal care services must be provided in accordance with the approved PSS, cannot be purely diversional in nature, and may include:

1) Support for activities of daily living such as, but not limited to, bathing (sponge/ tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation;

2) Assistance with housekeeping that is directly related to the beneficiary's disability, and which is necessary for the health and well-being of the beneficiary such as, but not limited to, changing bed linens, straightening area used by the beneficiary, doing the personal laundry of the beneficiary, preparation of meals for the beneficiary, cleaning the beneficiary's equipment such as wheelchairs or walkers;

3) Food shopping, meal preparation, and assistance with eating; however, the cost of food, groceries, and meals is not reimbursed by the Division of Medicaid.

4) Support for community participation by accompanying and assisting the beneficiary as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities; however, the cost of any such activity is not reimbursed by the Division of Medicaid.

b) If the beneficiary/representative has not located or chosen a DCW within six months after admission to the waiver, or after being without a DCW for six (6) consecutive months, the beneficiary is reevaluated to determine if the waiver can meet the needs of the beneficiary.

3. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the PSS, which enable beneficiaries to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

a) The need for use of such items must be documented in the assessment/case file, ordered by a physician, and approved on the PSS.

b) Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. The cost of items which do not have a direct medical or remedial benefit to the beneficiary is not reimbursed by the Division of Medicaid.

c) Specialized medical equipment and supplies must meet the applicable standards of manufacture, design, and installation.

d) Requests for specialized medical equipment and supplies must be evaluated by the Mississippi Department of Rehabilitation Services (MDRS) case manager or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for specialized medical equipment and/or supplies for approval.

e) Medicaid waiver funds are utilized as the payor of last resort.

4. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the IL Waiver program.

a) Transition Assistance services include the following:

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

2) Essential furnishings required to occupy and use a community domicile. Television or cable TV access are not essential furnishings;

3) Moving expenses;

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

5) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

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

c) To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

1) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid,

2) Have no other source to fund or obtain the necessary items/supports,

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

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

d) Transition Assistance must be completed by the day the beneficiary relocates from the institution.

e) Beneficiaries whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

5. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's PSS, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

   a) Environmental accessibility adaptations must be included in the approved PSS.

   b) Environmental accessibility adaptations may include the following:

      1) Installation of ramps and grab bars;

      2) Widening of doorways;

      3) Modification of bathroom facilities;

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

   c) Environmental accessibility adaptations exclude the following:

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

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

   d) Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for environmental accessibility adaptation.

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

Source: 42 U.S.C. 1396n; 42 C.F.R. §§ 431.53, 440.170, 440.180 and 441.302; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and revised from Miss. Admin. Code Part 208, Rule 2.3 eff. 09/01/2019; Revised 01/01/2013.

Rule 2.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Independent Living (IL) Waiver program. To obtain approval, the Mississippi Department of Rehabilitation Services (MDRS) must complete and submit the current Division of Medicaid approved forms as follows:

1. Long Term Services and Supports (LTSS) Assessment;

2. Bill of Rights;

3. Plan of Services and Supports (PSS);

4. Emergency Preparedness Plan;

5. Informed Choice Form;

6. Physician or Nurse Practitioner Certification of Medical Stability and Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM or MDRS; and

7. Other supportive documentation as needed including, but not limited to, prescriptions and assistive technology recommendations.

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).

C. MDRS is responsible for implementation of the PSS. The Division of Medicaid and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

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

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; Revised 01/01/2013.

Rule 2.8: Documentation/Record Maintenance

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

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 descriptions or DCW Certification;

3. Application and date of hire;

4. High School Diploma, General Educational Development (GED) diploma, other educational degrees, or proof of ability to read and write accurately;

5. Any licensure and/or certifications as required 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. Attestation of health at hire;

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 should include, at minimum:

1. Referral form/authorization;

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

3. Service Notes documenting monthly and quarterly case management oversight of the DCW which includes the causes of any significant variation in the recommended schedule of services provision; and

4. Daily activity or Service Notes 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.

D. Activity or time sheets, if needed, must include:

1. Arrival/service time and date;

2. Departure/service time and date;

3. Activities/tasks performed; and

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

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

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 09/01/2019; Revised eff. 01/01/2013.

Rule 2.9: [Reserved]

Rule 2.10: Reimbursement

A. Claims must be based on services that have been rendered to waiver 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 waiver 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 operating agency (if applicable) and 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. All providers of personal care services 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.

Source: 42 CFR §§ 440.180, 441.30; Miss Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised 09/01/2019; Revised 01/01/2013.

Rule 2.11: Due Process Protection

A. The Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating 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. MDRS must inform the beneficiary/representative at the initial assessment of the specific criteria for the dispute, complaint/grievance and hearing processes.

3. MDRS must inform the beneficiary/representative of their rights which address disputes, complaints/ grievances and hearings.

4. A beneficiary participating in the IL waiver or their representative may engage the dispute resolution process by notifying MDRS or DOM of their concern either by phone or in writing.

5. The Division of Medicaid has the final authority over any dispute.

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 (NOA) requirements:

1. MDRS must provide the beneficiary with a Notice of Action (NOA) via certified mail as required in 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 beneficiary/representative has the right to file an appeal;

d) Procedures for filing an appeal;

e) Notification of beneficiary/representative's right to request a Fair Hearing;

f) Notice that the beneficiary/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.

D. A person applying for or participating in the IL waiver has any additional rights to an appeal and/or hearing which are provided for in Title 23, Mississippi Administrative Code, Part 300.

Source: 42 C.F.R. §§ 431.210, 440.180, 441.301, 441.308; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 09/01/2019.

Rule 2.12: 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. Part 431, Subpart E; Miss Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Moved and Revised from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019; Revised 01/01/2013

Rule 2.13: Person Centered Planning (PCP)

A. Person Centered Planning (PCP) as 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 person 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 person 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. Include 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; and

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 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. § 441.301; Miss. Code Ann. §§ 37-33-157, 43-13-117, 43-13-121.

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; New rule moved from Miss. Admin. Code Part 208, Rule 2.12 eff. 09/01/2019; New rule eff. 01/01/2017.

Rule 2.14: Monitoring Safeguards

A. Mississippi Department of Rehabilitation Services (MDRS) case managers are required to provide each waiver person with written information regarding their rights as a waiver person at the initial assessment.

B. Case managers must provide the persons information during the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect, or exploitation is alleged.

C. All IL providers and their employees must immediately report in writing to the Division of Medicaid Office of Long-Term Care, the Mississippi Department of Human Services (MDHS), and any other entity required by federal or state law, all suspected, alleged, or reported instances the following:

1. Abuse,

2. Neglect,

3. Exploitation,

4. Suspicious death, or

5. Unauthorized use of restraints, seclusion, or restrictive interventions.

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

History: Revised to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; New Rule moved from Miss. Admin. Code Part 208, Rule 2.8, eff. 09/01/2019.

Rule 2.15 Grievances and Complaints

A. The Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format, or email. The Division of Medicaid has the final authority over any complaint or grievance.

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. MDRS case managers are required to provide the toll-free number at initial assessment and annually at recertification.

D. The Department of Rehabilitation Services must cooperate with the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved IL Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

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

History: New Rule to correspond with the IL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Part 208 Chapter 3: Home and Community-Based Services (HCBS) Assisted Living Waiver

Rule 3.1: General

A. The Division of Medicaid covers certain Home and Community Based Services (HCBS) services as an alternative to institutionalization in a nursing facility through the Assisted Living (AL) Waiver.

B. Beneficiaries enrolled in the AL Waiver must reside in a licensed assisted living facility which 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 AL Waiver services to persons in 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 AL Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries enrolled in the Assisted Living Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

F. The AL Waiver is administered and operated by the Division of Medicaid.

Source: Social Security Act 1915(c); 42 CFR § 440.180; Miss. Ann. Code § 43-13-117.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.2: Eligibility

A. In order to qualify as a beneficiary of the Assisted Living Waiver, 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 service and supports (LTSS) assessment.

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

a) Supplemental Security Income (SSI), 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 in order to qualify.

B. Beneficiaries enrolled in the AL Waiver cannot reside in a nursing facility or unlicensed personal care home.

C. In the event of imminent danger to the beneficiary, facility residents, or service providers, the beneficiary may be discharged from the waiver immediately.

D. To be eligible for care in a Traumatic Brain Injury Residential facility a beneficiary must:

1. Meet all the requirements in Miss. Admin. Code Part 208, Rule 3.2.A.,

2. Have a diagnosis of an acquired traumatic brain injury defined by the Division of Medicaid as a non-degenerative structural brain damage excluding a brain injury that is congenital or due to injuries induced by birth trauma,

3. Have completed acute rehabilitation treatment,

4. Be in a crisis/high stress environment with behavioral needs which place the beneficiary at high risk for institutionalization.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 08/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.C. eff. 06/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.B. to correspond with the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.3: Provider Enrollment

A. Providers of Assisted Living (AL) Waiver services must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Rule 4.8 in addition to the listed provider-type specific requirements and provide to the Division of Medicaid.

1. A National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. A copy of the provider's current license or permit, if applicable,

3. Verification of a social security number using a social security card, driver's license with a social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification document must match the name noted on the W-9, and

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

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

B. To participate as a Home and Community-Based Services (HCBS) Assisted Living (AL) 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 eight-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 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 within the facility. The facility 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 3.3(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 employed or currently 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, felonious abuse and/or battery of a vulnerable adult, regardless of whether any such conviction or plea which was reversed on appeal or for the conviction or plea.

12. Not applying 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 document 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 and transported 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 or organization currently under investigation based on a credible allegation of fraud or abuse by the Division of Medicaid Office of Program Integrity, the Medicaid Fraud Control Unit or any other government entity, or that has been found in violation of the Miss. Admin. Code or the Medicaid Provider Agreement within the eighteen (18) months leading up to their

enrollment.

20. In the event a change of ownership occurs, and complies 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. AL providers must satisfy the following training requirements, as applicable, to render services:

1. Assisted Living service providers must provide all staff, excluding any RN, LPN, or CNA who maintains an active and current unencumbered license to practice in the state of Mississippi or a privilege to practice in Mississippi with a compact license, with training upon hire prior to rendering services and annually thereafter in the following areas:

   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,

   k) Medication Assistance, and

   l) Medicaid Administrative Code and the Assisted Living Waiver

2. TBI Residential Waiver providers must provide training to all staff which consists of all topics listed in the Miss. Admin. Code, Part 208, Rule 3.3(C)(1) as well as the following areas:

a) Stress Reduction,

b) Behavior Programs, and

c) Rational/Behavioral Therapy.

3. All staff must pass a facility-administered initial hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately,

4. All staff must maintain current and active first aid and cardiopulmonary resuscitation (CPR) certification.

5. Each TBI residential provider must have a program manager who is nationally certified as a Brain Injury Specialist.

E. AL Waiver providers must provide a licensed nurse at the facility for a minimum of eight (8) hours a day to assist the beneficiaries with medication administration or oversight. If the facility employs a licensed practical nurse (LPN), the LPN must have direct supervision by either a registered nurse, nurse practitioner, or a physician. Additionally, the facility must not aide or abet a licensed nurse to practice outside of their scope of practice or to violate the Nursing Practice Law or Administrative Code in any manner.

F. If the facility utilizes volunteers, they:

1. Must be individuals or groups who desire to work with Assisted Living waiver 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.

G. The Division of Medicaid may terminate or suspend a provider immediately for failure to comply with the requirements of the AL 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: 42 CFR Part 455, Subpart E; Miss. Code Ann. §§ 43-13-5; 43-11-13; 43-11-121.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised Miss. Admin. Code, Part 208, Rule 3.3.B. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.4: Freedom of Choice

A. Beneficiaries enrolled in a Medicaid Waiver have the right to freedom of choice of approved Medicaid providers for services. [Refer to Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.]

B. Freedom of Choice is required of all providers and is monitored by the Division of Medicaid. The Division of Medicaid case manager 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 and 441.302; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 01/01/2017.

Rule 3.5: Quality Management

A. Waiver providers must follow applicable service specifications as referenced in the Assisted Living (AL) 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, regulatory rules and regulations and administrative codes as specified by the licensing agency.

1. If an AL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the AL Waiver provider 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 of abuse, neglect and exploitation (including the unauthorized use of restraints, restrictive interventions, and/or seclusion) within twenty-four (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 CFR §§ 440.180, 441.302; Miss. Code Ann. § 43-13-121.

History: Revised and renamed to correspond with the AL Waiver Renewal (eff. 07/01/2023), eff. 08/01/2026. Revised Miss. Admin. Code Part 208, Rule 3.7.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.6: Covered Services

A. The Division of Medicaid covers the following services through the Assisted Living 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 Division of Medicaid case manager is responsible for implementation of the PSS. The Division of Medicaid is responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

    a) Case Management services are provided by a social worker licensed to practice in the State of Mississippi with at least two (2) years of full-time experience in direct services to elderly and disabled individuals. Case managers will conduct the following activities.

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

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

3) Complete monthly contacts with the participant. Monthly contacts may be completed telephonically or virtually; however, in person 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) Beneficiary has identified risks for Abuse, Neglect, or Exploitation including the use of restraints or seclusion that require in person monitoring.

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

B. AL Services include the following:

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

2. Homemaker services,

3. Attendant care services,

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

5. Therapeutic, social, and recreational programming services,

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

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

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

7. Medication Assistance is defined as any form of delivering medication which has been prescribed, but is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing. Medication assistance is monitored by the licensed nurse and all facility staff are required to receive training upon hire prior to rendering services.

8. Transportation services may be provided through the Division of Medicaid's Non-Emergency Transportation (NET) program if the waiver person has not reached the maximum NET service limits. The AL Waiver provider must provide transportation to all waiver beneficiaries who have reached the maximum NET service limits or who choose not to use the NET program.

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

    a) Is available to waiver beneficiaries who are:

        1) At risk of falling,

        2) At risk of becoming disoriented, or

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

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

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

C. AL Waiver providers must provide:

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

    a) A nursing facility,

    b) An institution for mental diseases,

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

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

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

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

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

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

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

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

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

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

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

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

      2) The option to share living units only at the choice of the beneficiary. The beneficiary choosing cohabitation per room removes the reasonable expectation of privacy.

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

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

5. Protection of a beneficiary's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint,

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

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

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

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

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

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

    a. Attend religious and other activities of their choice,

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

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

    d. Send and receive mail or packages unopened or in compliance with the facility policy,

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

    f. Retain and use personal clothing and possessions as space permits, unless doing so infringes upon the rights or health and safety of other residents,

    g. Voice grievances and recommend changes in licensed facility policies and services without the fear of discrimination or reprisal,

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

    i. Free from physical and/or chemical restraints,

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

    k. Decide his or her own sleep schedule,

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

    m. Allows the person to eat at non-traditional times or outside regular scheduled mealtime consistent with the beneficiary's plan of care,

    n. Have snacks that adhere to the federal government's Dietary Guidelines for Americans available at all times, and

    o. Use the dining room for congregate meals and socialization at the person's choosing.

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

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 01/01/2017; Revised Miss. Admin. Code Part 208, Rule 3.6.B. and added Miss. Admin. Code Part 208, Rule 3.6.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Assisted Living (AL) Waiver program. To obtain approval, the waiver case manager must complete and submit the current Division of Medicaid approved forms as follows:

   1. Long-Term Services and Supports (LTSS) Assessment,

   2. Bill of Rights,

   3. Plan of Services and Supports (PSS),

   4. Emergency Preparedness Plan,

   5. Informed Choice, and

   6. Physician or Nurse Practitioner Certification of Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM.

B. All requests for increases and decreases in services must be submitted to the Division of Medicaid and must include documentation to substantiate the need for the change. Any request to add or increase services listed on the approved PSS must receive prior approval.

Source: 42 CFR § 441.301 (b)(1)(i); Miss. Code Ann. § 43-13-121.

History: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised Miss. Admin. Code, Part 208, Rule 3.5.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.8: Documentation/ Record Maintenance

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

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

   1. Copy of valid, state issued ID,

2. Job descriptions,

3. Application and date of hire,

4. High school diploma, General Educational Development (GED) diploma, 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 cardiopulmonary resuscitation (CPR) and First Aid.

C. Records for beneficiaries receiving AL Waiver services should include, at minimum:

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

2. Daily activity logs documenting the services rendered and billed under the program, including when a beneficiary is out of the facility and the reason why,

3. Current photograph,

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

5. Annual nutritional assessment and,

6. Daily progress notes.

D. Assisted Living facility records should include, at minimum:

1. Documentation of monthly 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 dealing 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. Organizational chart including the names and job titles of owners, operators, managers, administrators, etc.,

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

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

11. Statistical and financial data supporting a cost report for at least five (5) years from the date of the cost report or amended cost report or appeals submitted to the Division of Medicaid.

12. Records of medication administration and medication allergies of waiver beneficiaries.

13. A current, signed, and dated copy of the Division of Medicaid-approved admission agreement for each waiver beneficiary which includes, at a minimum:

    a) Basic charges agreed upon separating costs for room and board and personal care services,

    b) Period to be covered,

    c) List of itemized charges, and

    d) Agreement regarding refunds for payments.

E. AL Waiver providers are required to submit, within three (3) business days of the occurrence, the disposition form to the respective case manager anytime a person leaves the facility for a period of twenty-four (24) hours or longer. The disposition form should be submitted when the beneficiary leaves another one indicating their return if applicable.

Source: 42 CFR § 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 AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Added Miss. Admin. Code Part 208, Rule 3.8.A.6 and 3.8.A.7 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.9: [Reserved]

Rule 3.10: 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 Assisted Living (AL) Waiver services no sooner than the first (1st) day of the month following the month in which services were rendered.

H. Transportation is an integral part of AL Waiver provider services and is not reimbursed separately.

Source: Miss. Code Ann. § 43-13-17, 121.

History: Revised to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.11: Due Process Protection

A. The Division of Medicaid is responsible for operating the dispute mechanism for waiver beneficiaries 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 manager must 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 (NOA) must include:

1. A description of the action the provider has taken or intends to take,

2. An explanation for the action,

3. Notification that the beneficiary/representative has the right to file an appeal,

4. Procedures for filing an appeal,

5. Notification of beneficiary/representative's right to request a Fair Hearing,

6. Notice the beneficiary/representative has the right to have benefits continued pending the resolution of the appeal, and

7. The specific regulations or the change in Federal or State law that support or require the action.

Source: 42 C.F.R. §§ 431.210, 440.180, 441.301, 441.308; 42 CFR; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.12: 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 CFR §§ 431.210; 441.308; 441.307; Miss. Code Ann. § 43-13-121.

History: Revised and renamed to correspond with AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.13: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as 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 person 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 Plan of Services and Supports (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 for the beneficiary. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

8. Offer informed choices to the 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 and must:

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

   a) Chosen by the beneficiary,

   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 individual in lieu of 1915(c) HCBS waiver services and supports.

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

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

8. Identify the beneficiary 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. Include 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 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.

Source: 42 C.F.R. § 441.301.

History: Revised and renamed to correspond with AL Waiver (eff. 7/01/2023) eff. 08/01/2026. New rule eff. 01/01/2017.

Rule 3.14: Monitoring Safeguards

A. Case managers are required to provide each waiver person with written information regarding their rights as a waiver person during the initial assessment.

B. Case managers must provide the person's information during the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect or exploitation is alleged.

C. All Assisted Living (AL) providers and their employees must immediately report orally or telephonically, within twenty-four (24) hours of discovery excluding Saturdays, Sundays and legal holidays, and in writing within seventy-two (72) hours of discovery, to the State Department of Health, the Medicaid Fraud Control Unit of the Attorney General's office, the Division of Medicaid Office of Long Term Care, and any other entity required by federal or state law any suspected, alleged or reported instances of the following:

1. Abuse,

2. Neglect,

3. Exploitation,

4. Suspicious death, or

5. Unauthorized use of restraints, seclusion or restrictive interventions.

Source: 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann §§ 43-13-117, 43-13-121, 43-47-1 - 43-47-39.

History: Revised and renamed to correspond with the AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 3.15: Grievances and Complaints

A. The Division of Medicaid is responsible for investigating and documenting all grievances/complaints regarding all Assisted Living 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 facility.

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 Assisted Living Waiver, which is available on the Division of Medicaid's website,

www.medicaid.ms.gov.

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

History: Revised and renamed to correspond with AL Waiver (eff. 7/01/2023) eff. 08/01/2026.

Rule 3.16 Disaster Preparedness

A. Assisted Living (AL) Waiver providers must have disaster preparedness and management procedures to ensure that waiver beneficiary's care, safety, and well-being are maintained during and following instances of natural disasters, disease outbreaks, or similar situations.

B. In the event of termination of an AL Waiver provider agreement, the Division of Medicaid, the beneficiary and their designated representatives, and the licensing agency will work collaboratively to arrange for appropriate transfer of waiver participants to other Medicaid approved providers.

Source: 42 CFR §§ 431.210; Miss. Code Ann. § 43-13-121.

History: New rule, renamed and revised to correspond with AL Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Part 208 Chapter 4: Home and Community-Based Services (HCBS) Traumatic Brain Injury/Spinal Cord Injury Waiver

Rule 4.1: General

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

B. Beneficiaries enrolled in the TBI/SCI Waiver must reside in a private residence which 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 TBI/SCI waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

D. Beneficiaries enrolled in the TBI/SCI Waiver are prohibited from receiving additional Medicaid services through another waiver program.

E. Beneficiaries enrolled in the TBI/SCI Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Beneficiaries may receive non-duplicative waiver services in coordination with hospice services.

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

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

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

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

History: Revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 01/01/2017.

Rule 4.2: Eligibility

A. In order to qualify as a beneficiary of the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver Program, individuals must meet the following criteria:

1. Persons must be diagnosed with one (1) of the following disease(s) or condition(s):

   a) Traumatic brain injury which the Division of Medicaid defines as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

   b) Spinal cord injury which the Division of Medicaid defines as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two (2) of the above three (3) deficits.

2. The extent of injury must be certified by the physician.

3. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

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

5. Must be certified as medically stable by a physician or nurse practitioner. The Division of Medicaid defines medically stable as the absence of all of the following:

    a) An active, life-threatening condition requiring systematic therapeutic measures.

    b) Intravenous drip to control or support blood pressure.

    c) Intracranial pressure or arterial monitoring.

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

    a) Supplemental Security Income (SSI),

    b) Parents and Other Caretaker Relatives Program,

    c) Katie Beckett,

    d) Children under age nineteen (19) who meet the applicable income requirements,

    e) Disabled Adult Child,

    f) Protected Foster Care Adolescents,

    g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

    h) IV-E Foster Children and Adoption Assistance Children, or

    i) An aged, blind, or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify, or

    j) Working Disabled

B. Beneficiaries enrolled in the TBI/SCI 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 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised to correspond with the TBI/SCI Waiver Renewal (eff. 07/01/2023) eff. 08/01/2026. Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 4.2.F. eff. 06/01/2016.

Rule 4.3: Provider Enrollment

A. The Mississippi Department of Rehabilitation Services (MDRS), as the provider of Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver services, must satisfy all requirements set forth in Title 23 Miss. Admin. Code Part 200, Rule 4.8 in addition to the listed provider-type specific requirements and provide to the Division of Medicaid.

1. A National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. A copy of the provider's current license or permit, if applicable.

3. Verification of a social security number using a social security card, driver's license with a social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification document must match the name noted on the W-9, and

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

B. To participate as a Home and Community-Based Services (HCBS) TBI/SCI Waiver provider, MDRS must:

1. Conduct a national criminal background check with fingerprints on case managers, nurses, and direct care workers (DCW) personal care or transition services prior to employment and every two (2) years thereafter, and maintain the record in the employee's personnel file;

2. Conduct registry checks, prior to employment and monthly thereafter, to ensure individuals providing case management, personal care services, or transition services are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's (OIG) Exclusion Database and maintain the record in the employee's personal file. The provider must not employ individuals whose name appears on registry or database;

3. Not have been, or employed or currently employ individuals or volunteers who have been, convicted of, pleaded guilty to, or pleased nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense defined in Miss. Code Ann. § 45-33-239(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or any other crime of violence. Any such conviction or plea which was reversed on appeal or for which a pardon was granted shall not be considered;

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

5. Be compliant with all federal and state regulations; and

6. Have responsible personnel management including:

    a) Appropriate processes used in the recruitment, selection, retention, and termination of employees,

    b) Maintain written personnel policies and job descriptions,

    c) Maintain a current training plan as a component of the policies/procedures documenting the method for the completion of required training. The training plan must require all employees to meet training requirements as designated by the Division of Medicaid upon hire, and annually thereafter, and

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

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

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

    a) The Registered Nurse must:

        1) Have a current and active unencumbered RN license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license, and

        2) Have at least one (1) year of experience with the aged and/or individuals with disabilities.

    b) The Case Manager must:

        1) Possess at a minimum a bachelor's degree in Rehabilitation Counseling or other related field, and

        2) Have one (1) year of experience working with aged and/or individuals with

disabilities.

c) Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Case Manager.

d) MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken against any nurse providing services under the TBI/SCI waiver.

e) MDRS must verify provider qualifications upon hire and at least annually and maintain documentation of that verification in the employee file.

2. Personal Care Services (PCS) must be provided by a Direct Care Worker (DCW) who must meet the following qualifications:

a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCW.

b) Must meet basic competencies that include both educational and functional requirements.

c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements.

d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with the Personal Care Services program.

1) The educational program must be personalized with participation of the beneficiary to ensure his/her specific needs are met.

2) The cost of training/instruction time for personal care attendants cannot be reimbursed by the Division under the waiver.

3) The individual must demonstrate competency to perform each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering any Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver service.

4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary /representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

(a) DCW training must be conducted by the Case Manager, or an agency permitted by law to train nurse aides, must be tailored to the personal care required for the beneficiary, and must include:

(1) The purpose and philosophy of self-directed services by the disabled,

(2) Disability awareness,

(3) Employee-employer relationships,

(4) The need for respect for the beneficiary's privacy and property,

(5) Basic elements of body functions,

(6) Infection control procedures,

(7) Maintaining a clean and safe environment,

(8) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance, and

(9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities is deemed to meet the training requirements. Competency certification for these personal care providers by the beneficiary/representative and Case Manager is required. A DCW that has satisfactorily provided personal care services for four (4) weeks prior to coverage under the TBI/SCI waiver program, with such service certified by and verified by the beneficiary/representative and Case Manager, is deemed to meet the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but 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 beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the

Division under the waiver when the following criteria are met:

1) There is documentation that there are no other willing/qualified providers available for selection.

2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the TBI/SCI Waiver.

3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative.

4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The Division of Medicaid reserves the right to remove a selected relative from the provision of services at any time if there is a reasonable suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

h) The direct care worker must meet the following requirements:

1) Be at least eighteen (18) years of age,

2) Be a high school graduate, have a General Education 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,

3) Be able to follow verbal and written instructions,

4) Have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to beneficiary,

5) Be certified as meeting the training and competence requirement by the beneficiary and the Case Manager, and

6) Be able to communicate effectively and carry out directions.

i) MDRS must verify the competency for all PCAs as needed.

3. In-home respite (IHR) services must be provided by a DCW who must meet the following qualifications:

   a) Be chosen by the beneficiary/representative as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified DCWs.

   b) Must meet basic competencies that include both educational and functional requirements.

   c) Be certified by MDRS Case Managers which includes documentation that the DCW meets the requirements.

   d) Must have completed training/instruction that covers the purpose, functions, and tasks associated with the In-Home Respite Services program.

      1) The educational program must be personalized with participation of the beneficiary to ensure his/her specific needs are met.

      2) The cost of training/instruction of direct care workers cannot be reimbursed under the waiver.

      3) The individual must demonstrate competency to perform each activity of daily living task to the beneficiary/representative and Case Manager prior to rendering any TBI/SCI waiver service.

      4) In addition to the technical skills required, the DCW must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the beneficiary/representative and Case Manager to be adequate in fulfilling the responsibilities of personal care.

         (a) DCW training must be conducted by the beneficiary/representative and the Case Manager, or an agency permitted by law to train nurse aides, and must include:

            (1) The purpose and philosophy of self-directed services by the disabled,

            (2) Disability awareness,

            (3) Employee-employer relationships,

(4) The need for respect for the beneficiary's privacy and property

(5) Basic elements of body functions,

(6) Infection control procedures,

(7) Maintaining a clean and safe environment,

(8) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.

(9) Meal preparation and menus that provide a balanced, nutritional diet.

e) A prospective DCW who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities is deemed to meet the classroom training requirements. Competency certification for these personal care providers by the person/representative and Case Manager is required. A DCW that has satisfactorily provided In Home Respite services for four (4) weeks prior to coverage under the TBI/SCI waiver program, with such service certified by and verified by the person/representative and Case Manager, is deemed to meet the training requirement.

f) Waiver services provided by legal guardians or legal representatives, including but 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 beneficiary's representative payee for Social Security benefits cannot be reimbursed by the Division under the waiver. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the beneficiary. Waiver services provided by non-legally responsible relatives may be reimbursed by the Division under the waiver when the following criteria are met:

1) There is documentation that there are no other willing/qualified providers available for selection.

2) The selected relative is qualified to provide services as specified in the Appendix C-1/C-3 of the TBI/SCI Waiver.

3) The beneficiary or another designated representative is available to sign verifying that services were rendered by the selected relative.

4) The selected relative agrees to render services in accordance with the scope, limitations, and professional requirements of the service during their designated hours.

5) The service provided is not a function that a relative or housemate was providing for the beneficiary without payment prior to waiver enrollment.

g) The state reserves the right to remove a selected relative from the provision of services at any time if there is suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the beneficiary will be asked to select an alternate qualified provider.

h) Minimum requirements include:

1) Be at least eighteen (18) years of age,

2) Be a high school graduate, have a GED certificate, or must demonstrate the ability to read the written in-home respite services assignment and write adequately to complete forms and reports of visits,

3) Be able to follow verbal and written instructions,

4) Have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to beneficiary,

5) Be certified as meeting the training and competence requirement by the beneficiary and the Case Manager, and

6) Be able to communicate effectively and carry out directions,

7) Must be a registered nurse or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations, if providing in-home nursing respite, and

i) MDRS must verify the competency for all DCWs as needed.

4. Institutional Respite must be provided in a Medicaid certified hospital, nursing facility or licensed swing bed facility.

5. Specialized Medical Equipment and Supplies must be provided by entities who meet the following qualifications:

a) Have a permanent local address and phone number,

b) Have a State of Mississippi sales tax number,

c) Have Federal identification number or social security number,

d) Have liability insurance,

e) Must honor the manufacturer's guarantee or warranty as published,

f) Must provide repair capability for products, and

g) Meet the following additional standards if providing custom in-house seating systems, powered mobility, three-wheel scooters, and high-tech systems:

    1) Must provide documented proof of attendance of training with seating and positioning,

    2) Maintain a current list of power chair manufacturers represented,

    3) Have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer,

    4) Maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above,

    5) Must be able to deliver and assemble all equipment to be ready for final adjustment and fitting,

    6) Must have and present at purchase all necessary manuals and written warranties,

    7) Must be able to provide instruction in proper use and care of equipment,

    8) Must be capable of providing training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price, and

    9) Must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current

technical service bulletins.

6. Transition Assistance services must be provided by a Registered Nurse and/or Case Manager.

7. Environmental Accessibility Adaptation services must be provided by entities who meet the following:

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

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

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

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

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

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

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

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

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

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

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

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; Social Security Act §1915(c); 42 C.F.R §441.302.

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.4: 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. The freedom of choice is required of all providers and is monitored by the operating agency and Division of Medicaid. The case manager must assist the beneficiary by providing them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that beneficiary.

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 including non-disability specific setting options.

Source: 42 C.F.R. §§ 431.51 and 441.302; Miss. Code Ann. § 43-13-121; §43-13-117; §1915(c) of the Social Security Act.

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.5: Quality Management

A. Waiver providers must meet applicable service specifications as referenced in the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) 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, and regulations, and administrative codes as specified by the Division of Medicaid.

1. If a TBI/SCI Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the TBI/SCI Waiver provider 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 and/or contractors must report:

1. Changes in contact information, administrative staffing, ownership, and licensure within

ten (10) calendar days to the Mississippi Department of Rehabilitation Services (MDRS) and the Division of Medicaid.

2. Critical incidences of abuse neglect and exploitation, (including the unauthorized use of restraints, restrictive interventions and/or seclusion) within twenty-four (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 to MDRS and within fourteen (14) days to the Division of Medicaid.

D. Quality Management Strategy for the waiver must be implemented in accordance with Appendix H of the CMS approved waiver application.

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

History: Renamed and revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026

Rule 4.6: Covered Services

A. The Division of Medicaid covers the following through the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver services:

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

a) Case Management services, as an administrative activity, must be provided by Mississippi Department of Rehabilitation Services (MDRS) case managers/registered nurses who meet minimum qualifications listed in the waiver and Miss. Admin. Code Part 208, Rule 4.3.

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

1) Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care. Initial and readmission assessments must be conducted in person in conjunction with a registered nurse. Annual recertification assessments must be conducted in person by the case manager, and a registered nurse must be available for consultation if necessary.

2) Provide ongoing monitoring of the services included in the beneficiary's Plan of

Services and Supports (PSS).

3) Develop, review, and revise the PSS at intervals specified in the waiver.

4) Conduct quarterly in person visits with the person.

5) Complete monthly contacts with the beneficiary. Monthly contacts may be completed telephonically or virtually; however, in person 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 or virtual electronic device due to an auditory, speech or cognitive impairment

   (b) Beneficiary has unmet needs that cannot be resolved by phone or virtual electronic device.

   (c) Beneficiary has identified risks for Abuse, Neglect, or Exploitation including the use of restraints or seclusion that require in person monitoring.

   (d) Beneficiary/representative is unable to be reached by phone or virtual electronic device.

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

7) Ensure that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e., infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).

2. Personal Care Services (PCS) are non-medical, hands-on care of both a supportive and health-related nature. PCS services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

   a) PCS services must be provided in accordance with the approved PSS, cannot be purely diversional in nature, and may include:

      1) Support for activities of daily living such as, but not limited to, bathing (sponge/ tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.

      2) Assistance with housekeeping that is directly related to the beneficiary's disability, and which is necessary for the health and well-being of the beneficiary such as, but not limited to, changing bed linens, straightening area used by the beneficiary,

doing the personal laundry of the beneficiary, preparation of meals for the beneficiary, cleaning the beneficiary's equipment such as wheelchairs or walkers.

3) Food shopping, meal preparation and assistance with eating; however, the cost of food, groceries, and meals is not reimbursed by the Division.

4) Support for community participation by accompanying and assisting the beneficiary as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities; however, the cost of any such activity is not reimbursed by the Division.

b) If the beneficiary/representative has not located or chosen a DCW within six (6) months after admission to the waiver, or after being without a DCW for six (6) consecutive months, the beneficiary is reevaluated to determine if the waiver can meet the needs of the beneficiary.

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

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

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

4. Specialized Medical Equipment and Supplies include devices, controls, or appliances specified in the PSS, enable beneficiaries to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

a) The need for/use of such items must be documented in the assessment/case file, ordered by a physician and approved on the PSS.

b) Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under the Medicaid State Plan. Items not of direct medical or remedial benefit to the person are not covered under the waiver and cannot be reimbursed by the Division.

c) Specialized medical equipment and supplies must meet the applicable standards of manufacture, design, and installation.

d) Requests for specialized medical equipment and supplies must be evaluated by the Mississippi Department of Rehabilitation Services (MDRS) case manager or the

Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for specialized medical equipment and/or supplies for approval.

e) Medicaid waiver funds are utilized as the payor of last resort.

5. Transition Assistance services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the TBI/SCI Waiver program.

   a) Transition Assistance services include the following:

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

      2) Essential furnishings required to occupy and use a community domicile. Televisions or cable TV access are not essential furnishings.

      3) Moving expenses.

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

      5) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

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

   c) To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

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

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

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

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

   d) Transition Assistance must be completed by the day the beneficiary relocates from the institution.

   e) Beneficiaries whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this

service.

6. Environmental Accessibility Adaptation are physical adaptations to the home, required by the individual's PSS, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

   a) Environmental accessibility adaptations must be included in the approved PSS.

   b) Environmental accessibility adaptations include the following:

      1) Installation of ramps and grab bars.

      2) Widening of doorways.

      3) Modification of bathroom facilities.

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

   c) Environmental accessibility adaptations exclude the following:

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

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

   d) Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the PSS and the request for environmental accessibility adaptation.

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

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

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026; Revised eff. 01/01/2017.

Rule 4.7: Prior Approval

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. To obtain approval, the Mississippi Department of Rehabilitation Services (MDRS) must complete and submit the current Division of Medicaid approved forms as follows:

1. Long Term Services and Supports (LTSS) Assessment,

2. Bill of Rights,

3. Plan of Services and Supports (PSS),

4. Emergency Preparedness Plan,

5. Informed Choice Form,

6. Physician or Nurse Practitioner Certification of Medical Stability and Nursing Facility Level of Care at initial certification, readmission certification, and as required by DOM or MDRS, and

7. Other supportive documentation as needed including, but not limited to, prescriptions and assistive technology recommendations.

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).

C. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. An individual whose brain or spinal cord injury is due to a degenerative or congenital condition, or that resulted, intentionally or unintentionally, from medical intervention is not eligible to receive services through the HCB waiver program.

D. MDRS is responsible for implementation of the PSS. The Division of Medicaid and MDRS are jointly responsible for monitoring the PSS and the health and welfare of the participants. The Division of Medicaid, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for PSS implementation. Monitoring the implementation of the PSS includes on site review activity, record reviews, annual recertification reviews, beneficiary phone calls from the Medicaid agency, and other strategies as needed.

Source: 42 CFR §§ 440.180, 441.301 (b)(1); Miss. Code Ann. § 43-13-121

History: Renamed and revised to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.8: Documentation/ Record Maintenance

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth for applicable waiver quality assurance standards. Refer to Maintenance of Records Part 200, Rule 1.3.

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

1. Copy of valid, state issued ID,

2. Job descriptions or DCW Certification,

3. Application and date of hire,

4. High School Diploma, General Educational Development (GED) diploma, other educational degrees, or proof of ability to read and write accurately,

5. Any licensure and/or certifications as required 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. Attestation of health at hire,

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) and In-Home Respite (IHR) services should include, at minimum:

1. Referral form/authorization,

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

3. Service Notes documenting monthly and quarterly case management documenting oversight of the DCW, and

4. Daily activity or service notes 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.

D. Activity or service notes, if needed must include:

1. Arrival/service time and date,

2. Departure/service time and date,

3. Activities/tasks performed, and

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

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

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.9: Reserved

Rule 4.10: Reimbursement

A. Claims must be based on services that have been rendered to waiver 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 waiver 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 operating agency (if applicable) and 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. 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.

Source: Miss. Code Ann. § 43-13-121

History: Revised and renamed to correspond with the TBI/SCI waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.11: Due Process Protection

A. The Division of Medicaid and Mississippi Department of Rehabilitation Services (MDRS) 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 their waiver services.

2. MDRS must inform the beneficiary/representative at the initial assessment of the specific criteria for the dispute, complaint/grievance and hearing processes.

3. MDRS must inform the beneficiary/representative of their rights which address disputes, complaints/ grievances and hearings.

4. A beneficiary participating in the TBI/SCI waiver or their representative may engage the dispute resolution process by notifying MDRS or DOM of their concern either by phone or in writing.

5. The Division of Medicaid has the final authority over any dispute.

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 (NOA)

1. MDRS must provide the beneficiary with a Notice of Action via certified mail as required in 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 beneficiary/representative has the right to file an appeal,

d) Procedures for filing an appeal,

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

f) Notice that the beneficiary/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.

D. A person applying for or participating in the TBI/SCI waiver has any additional rights to an appeal and/or hearing which are provided for in Title 23, Mississippi Administrative Code, Part 300.

Source: 42 CFR § 431.210; Miss. Code Ann. § 43-13-121

History: Moved from Rule 4.10 eff. to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.12: 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 CFR §§ 431.210, 441.307 and 441.308; Miss. Code Ann. § 43-13-121;

History: Revised and renamed to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.13: 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 person 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 person 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. Include 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 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 every 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 CFR § 441.301; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.14: Monitoring Safeguards

A. Mississippi Department of Rehabilitation Services (MDRS) case managers are required to provide each waiver person with written information regarding their rights as a waiver person at the initial assessment.

B. Case managers must provide the persons information during the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect, or exploitation is alleged.

C. All TBI/SCI providers and their employees must immediately report in writing to the Division of Medicaid Office of Long-Term Care, the Mississippi Department of Human Services (MDHS), and any other entity required by federal or state law, all suspected, alleged or reported instances the following:

1. Abuse,

2. Neglect,

3. Exploitation,

4. Suspicious death, or

5. Unauthorized use of restraints, seclusion, or restrictive interventions.

Source: 42 C.F.R. §§ 440.180, 441.302; Miss. Code Ann §§ 43-13-117, 43-13-121, 43-47-1 - 43-47-39.

History: New rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Rule 4.15 Grievances and Complaints

A. The Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by the Division of Medicaid. Grievances may be made via phone, written letter format, or email. The Division of Medicaid has the final authority over any complaint or grievance.

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. MDRS case managers are required to provide the toll-free number at initial assessment and annually at recertification.

D. The Department of Rehabilitation Services must cooperate with the Division of Medicaid to resolve grievances/complaints in accordance with the requirements in the CMS-approved TBI/SCI Waiver, which is available on the Division of Medicaid's website, www.medicaid.ms.gov.

Source: 42 CFR § 441.301; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with the TBI/SCI Waiver renewal (eff. 07/01/2023) eff. 08/01/2026.

Part 208 Chapter 6: [Reserved]