

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.01 Pages: 1 Cross Reference:</b>	
<b>Subject: Introduction</b>		

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. HCBS waivers offer broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid Plan may be addressed.

Home and Community-Based Service programs are an optional benefit under the state's Medicaid program. If individuals are not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for individuals if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may **not** bill beneficiaries for these services.

The Division of Medicaid (DOM) and the Mississippi Department of Mental Health, Bureau of Intellectual and Developmental Disabilities (DMH/BIDD) maintain joint responsibility for the ID/DD Waiver program. DOM formulates all DOM policies, rules, and regulations related to the Waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DMH/BIDD is responsible for the operational functions of the Waiver. DMH is responsible for incorporating the following into the provision of covered services: DOM policies, rules and regulations; provisions of the HCBS ID/DD Waiver approved by the Centers for Medicare and Medicaid Services (CMS); and the Mississippi Department of Mental Health Standards. DOM maintains ultimate authority and responsibility for the administration of the Waiver by exercising oversight over the performance of the Waiver functions by other State and local/regional non-State (if appropriate) and contracted entities. DOM will ensure financial audits of ID/DD Waiver providers are conducted. In the event of any conflict between DOM policies, rules and regulations and the policies, rules and regulations of any other State agency, DOM's policies, rules and regulations shall control for the purpose of determining reimbursement from DOM.

**Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.**

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<b>Subject: Eligibility</b>		

The Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver provides services to individuals who, but for the provision of such services, would require the level of care found in an intermediate care facility for the mentally retarded (ICF/MR).

### **Eligibility Requirements**

Eligibility requirements for the ID/DD Waiver include the following:

- Applicant must have an intellectual disability, a developmental disability, or autism, **AND**
- Applicant must require a level of care found in an ICF/MR, **AND**
- Applicant must currently qualify for full Medicaid benefits in one of the following categories:
  - SSI – COE -001
  - Low Income Families and Children Program – COE-085
  - Disabled Child Living at Home Program – COE-019
  - Working Disabled – COE-025
  - Children Under Age 19 Under 100% of Poverty – COE-091
  - Protected Foster Care Adolescents – COE-007
  - CWS Foster Children and Adoption Assistance Children – COE-026
  - IV-E Foster Children and Adoption Assistance Children – COE-003
  - Child under Age 6 at 133% Federal Poverty Level – COE-087

**OR** an aged, blind, or disabled individual who meets all factors of eligibility can qualify if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible. COE-064 denotes eligibility in the ID/DD Waiver.

ID/DD Waiver services are available statewide. The Waiver carries no age restrictions. **A beneficiary may be enrolled in only one DOM HCBS Waiver program at a time.**

Applicants for the ID/DD Waiver must go through the same initial evaluation process as someone applying for admission to an ICF/MR. Refer to Provider Policy Manual Section 16.06 for Participant Certification/Recertification policy.

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In order to meet clinical eligibility requirements, an individual must have a diagnosis of mental retardation, developmental disability, or autism as defined below:

### **Criteria for Evaluation/Re-evaluation of Clinical Eligibility for Services**

#### **Intellectual Disability**

Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The condition is manifested prior to age eighteen (18). Intellectual disability is the preferred term for the disability historically referred to as mental retardation.

The term intellectual disability covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type, and duration of the disability and the need for individuals with this disability to receive individualized services and supports. Every individual who is or was eligible for the diagnosis of mental retardation is eligible for a diagnosis of intellectual disability. The low IQ score alone is insufficient for a diagnosis of intellectual disability. It must co-exist with limitations in adaptive behavior. Adaptive behavior refers to those social and practical skills used to effectively function in daily life. Skills include, but are not limited to, communication, social interaction, self-care, money management, and use of transportation. An accurate diagnosis of intellectual disability requires three (3) components: an IQ score of approximately seventy (70) or below, a determination of deficits in adaptive behavior, and manifestation of disability prior to age eighteen (18).

#### **Developmental Disability**

In general, the term developmental disability is defined as a severe, chronic disability that is attributable to a mental and/or physical impairment. The condition is manifested before age twenty-two (22) and is likely to continue indefinitely. It results in substantial functional limitations in three (3) or more areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. The individual requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of extended duration.

An individual from birth to age nine (9) who has a substantial developmental delay or specific congenital or acquired condition, may be considered developmentally disabled without meeting all of the criteria described in the previous paragraph if, without services and supports, there is a high probability of meeting those criteria later in life.

#### **Severe, Chronic Disability**

Severe, chronic disability is defined as a condition attributable to cerebral palsy or epilepsy or any other condition other than mental illness found to be closely related to mental retardation, because it results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires similar treatment/services. The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely. The condition results in substantial functional limitations in three (3) or more of the follow major life activities: self-care, understanding and use of language, learning, mobility, self direction, and capacity for independent living (42 CFR 435.1010).

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## Autism

### DSM IV-TR Diagnostic Criteria for Autistic Disorder

A diagnosis of autistic disorder is made when the following criteria from A, B, and C are all met.

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
  1. Qualitative impairment in social interaction, as manifested by at least two of the following:
    - a. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
    - b. Failure to develop peer relationships appropriate to developmental level.
    - c. A lack of spontaneous seeking to share enjoyment, interests, or achievements with others (e.g., by a lack of showing, bringing, or pointing out objects of interest).
    - d. Lack of social or emotional reciprocity.
  2. Qualitative impairments in communication as manifested by at least one of the following:
    - a. Delay in or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).
    - b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.
    - c. Stereotyped and repetitive use of language or idiosyncratic language.
    - d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
  3. Restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, as manifested by at least one of the following:
    - a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
    - b. Apparently inflexible adherence to specific, nonfunctional routines or rituals.
    - c. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements).
    - d. Persistent preoccupation with parts of objects.
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age three (3) years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

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<b>Subject: Provider Enrollment</b>		

Providers interested in enrolling as a DOM ID/DD Waiver provider must **first** apply and be certified by the Mississippi Department of Mental Health, Bureau of Intellectual Disabilities and Developmental Disabilities (DMH/BIDD). DMH/BIDD Certification is dependent upon compliance with the Mississippi Department of Mental Health Standards. Standards may be accessed at <http://www.dmh.state.ms.us>.

All providers must be employed/contracted with an agency. **The only exceptions to this requirement are the following providers:**

- Occupational therapist (OT)
- Speech-language therapist (ST)
- Physical therapist (PT)
- Durable Medical Equipment (DME)

Providers of occupational therapy (OT), speech-language therapy (ST), physical therapy (PT), and durable medical equipment (DME) are not required to apply through DMH/BIDD. These providers must, however, comply with all other policies and standards related to the applicable Waiver services, and they must have or apply for a current Mississippi Medicaid provider number. These providers must also adhere to applicable state and federal regulations related to their license.

**All** providers must meet DOM enrollment criteria. Providers may not begin providing services to ID/DD Waiver participants until receiving a Medicaid provider number. Refer to Provider Policy Manual Sections 4.09 for All Providers policy and Section 4.21 for HCBS Waiver for People with Intellectual Disabilities or Developmental Disabilities policy.

All providers must comply with the CMS approved ID/DD Waiver. The document may be accessed at <http://domweb.gov/MentalHealthServices.aspx>.

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<b>Subject: Freedom of Choice</b>		

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that “any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required.”

As provided in 42 CFR 441.302 (d), when it is determined that a beneficiary is likely to require a level of care provided in the Waiver, the beneficiary/legal representative will be informed of alternatives under the Waiver, and the beneficiary/legal guardian will be given the choice of either institutional or home and community-based services.

The choice made by the beneficiary/legal representative will be documented on the appropriate form. The form must be signed by the beneficiary/legal representative and must be maintained in the ID/DD Waiver Support Coordinator’s case record.

The ID/DD Waiver will not restrict a beneficiary’s/legal representative’s freedom to choose providers. ID/DD Waiver Support Coordinators will provide the beneficiary/legal representative with a list of qualified providers for approved services. When requested, ID/DD Waiver Support Coordinators will assist the beneficiary/legal representative with making arrangements to tour services sites and meeting/interviewing agency representatives. The ID/DD Waiver Support Coordinator will document the beneficiary’s/legal representative’s choice of providers in the case record and on the Plan of Care. The beneficiary/legal representative may request modification and/or cancellation of services at any time by contacting the ID/DD Waiver Support Coordinator.

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<b>Subject: Level of Care (LOC) Evaluation/Reevaluation</b>	<b>Eligibility 16.02</b>	

All level of care (LOC) evaluations and reevaluations are conducted by one of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the Department of Mental Health's five (5) comprehensive regional centers (Ellisville State School, Boswell Regional Center, Hudspeth Regional Center, North Mississippi Regional Center, or South Mississippi Regional Center). All members of the teams are state employees and meet the Mississippi State Personnel Board's minimum requirements for hire.

### **Evaluator Qualifications**

#### **Initial Evaluation:**

The educational/professional qualifications for evaluators are the same for ID/DD Waiver and ICF/MR services. Initial evaluations are conducted in an interdisciplinary team format. Team members must include a psychologist, psychometrist, speech pathologist, and social worker. Other disciplines (i.e. nutrition, nursing) participate as needed based on the applicant's needs. All team members are appropriately licensed/certified under State law for their respective disciplines.

#### **Reevaluation:**

Reevaluations of level of care are conducted at least annually by the ID/DD Waiver Support Coordinators. Each ID/DD Waiver Support Coordinator is a state employee who meets the Mississippi State Personnel Board's minimum requirements for hire. All reevaluations are reviewed by ID/DD Waiver Support Coordination Directors, who are required to have a Master's degree in a field related to intellectual/developmental disabilities and at least three (3) years of supervision experience, prior to submission to DMH/BIDD for review and approval or denial.

### **Level of Care (LOC) Criteria**

Applicants for ID/DD waiver services must meet eligibility criteria. Refer to Provider Policy Manual Section 16.02 for Eligibility policy.

### **Evaluation/Reevaluation Process**

#### **Initial Evaluation:**

The initial LOC evaluation for both ID/DD Waiver and institutionalized individuals is through a common Pre-Admission Screening (PAS) system. The evaluations for both programs are conducted by the D&E teams at each of the DMH comprehensive regional centers. The specific battery of standardized diagnostic and assessment instruments chosen for initial evaluations are based on each individual, depending on such factors as communication, motor skills, etc. Evaluators choose instruments which, in their professional opinion, will most accurately assess the individual's level of function in all areas of development. There is not a single instrument/tool used to determine if an individual meets the requirements for ICF/MR level of care.

As part of the initial evaluation process, the D&E team also completes the Inventory for Client and Agency Planning (ICAP) to establish a general baseline for reevaluations.

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**Reevaluation:**

The reevaluation differs from the initial evaluation in that a battery of standardized assessments is not administered. The continuing need for ID/DD Waiver services is verified by (1) conducting a new ICAP and comparing the scores from year to year, and (2) ongoing evaluation of the individual's needs and use of ID/DD Waiver services.

Reevaluation of LOC is done annually by the ID/DD Waiver Support Coordinator. If there is a significant change in the ICAP scores, the D&E team conducts a review to determine if the individual's level of care needs have changed.

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<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.06 Pages: 2 Cross Reference: Level of Care Evaluation/Reevaluation 16.05 Covered Services 16.07</b>	
<b>Subject: Participant Certification/Recertification</b>		

All participants must be initially certified as needing ICF/MR level of care before services provided through the ID/DD Waiver can begin. Participants must be recertified at least every twelve (12) months thereafter to continue receiving ID/DD Waiver services. ID/DD Support Coordinators are responsible for coordinating the certification/recertification process and for forwarding the information/documents outlined in the DMH/BIDD Record Guide to DMH/BIDD. DMH/BIDD approves/disapproves all requests for certification and recertification. All documentation is submitted to DOM.

### **Evaluation Summary and Interdisciplinary Recommendations Report**

The initial level of care evaluation for both ID/DD Waiver applicants and ICF/MR applicants is the same. Educational/professional qualifications for evaluators are the same for ID/DD Waiver applicants and applicants for ICF/MR facilities. Evaluations are conducted at one of the Mississippi Department of Mental Health's five (5) comprehensive regional centers (Ellisville State School, Boswell Regional Center, Hudspeth Regional Center, North Mississippi Regional Center, or South Mississippi Regional Center), depending on where the applicant lives. When the evaluation is complete, the Diagnostic Services Department prepares the Evaluation Summary and Interdisciplinary Recommendations Report. The results of the evaluation determine whether the applicant meets ICF/MR level of care. The applicant must require ICF/MR level of care to be eligible for Waiver services. Refer to Provider Policy Manual Section 16.05 for Level of Care Evaluation/Reevaluation policy.

### **ID/DD Waiver HCBS Certification of ICF/MR Level of Care (DOM-260-HCBS-ID/DD Form)**

The ID/DD Waiver HCBS Certification of ICF/MR Level of care form may not be dated more than ninety (90) days prior to the lock-in end date for a recertification. Waiver Support Coordinators **may** submit a recertification to the DMH/BIDD beginning 60 days prior to the current lock-in end date, but **must** submit them at least 45 days prior to the current lock-in end date. The participant must be recertified on an annual basis, prior to the current lock-in end date. The ID/DD Waiver HCBS Certification of ICF/MR Level of care form is valid for 364 days. The form, regardless if it is an initial or recertification request, is dated and signed by the Waiver Support Coordinator and the Waiver Support Coordinator Director certifying the participant meets the criteria for ICF/MR level of care. Recertification requests are submitted to DMH/BIDD for approval/denial.

### **Plan of Care (HCBS-ID/DD Waiver Individual Plan of Care Form)**

The Plan of Care (POC) contains objectives, the types of services to be provided, frequency of services and current providers of each approved service. This form is completed by the ID/DD Waiver Support Coordinator. Refer to Provider Policy Manual Section 16.07 for Covered Services policy.

The formal comprehensive evaluation conducted by the Diagnostic and Evaluation (D&E) Team is used to identify strengths, needs, preferences and health status. The ID/DD Waiver Support Coordinator meets with the beneficiary and/or legal representative (as appropriate) and anyone else the beneficiary would like to have present, to discuss items identified in the D&E Team's evaluation in addition to anything else the beneficiary might identify. The beneficiary and ID/DD Waiver Support Coordinator list, arrange, and prioritize all items and areas to be addressed before developing the POC.

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After the initial POC is developed, it becomes a “living” document which is reviewed at least quarterly by the ID/DD Waiver Support Coordinator and beneficiary/legal representative. Beneficiaries/legal representatives may request modification and/or cancellation of services at any time. If the beneficiary/legal representative desires a modification and or cancellation of services between quarterly visits, the beneficiary/legal representative may contact the ID/DD Waiver Support Coordinator to request changes to the POC. Request for modifications and/or cancellations are submitted to DMH/BIDD by the ID/DD Waiver Support Coordinator. When a decision is rendered by DMH/BIDD, the ID/DD Waiver Support Coordinator is notified. The ID/DD Waiver Support Coordinator will make any revisions to the POC, including updating start and end dates.

#### **ID/DD Waiver Lock-in Request Form (MHP105)**

The ID/DD Waiver Lock-in Request Form (MHP105) is used to notify DOM of an admission, discharge, or recertification of a beneficiary enrolled in the HCBS waiver program. The form is also used to inform DOM when a beneficiary enrolled in the ID/DD Waiver is transferred to the catchment area of another Regional Center. DOM/BMHP staff updates the lock in segment in MMIS system based on information on the MHP105.

#### **Submission of Participant Certification/Re-certification File**

The Support Coordinator submits a copy of all applicable forms and information to DMH/BIDD. After DMH/BIDD staff takes action, if needed, applicable forms and supporting documentation are submitted to DOM/BMHP. DOM/BMHP staff updates the MMIS system, if needed, and sends a copy to the appropriate Support Coordinator. The Support Coordinator will retain all original forms as part of the on-site case record. All documents must be readily available for review by DOM/BMHP staff when requested.

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<b>Subject: Covered Services</b>		

Services may only be provided to participants when approved by the DMH/BIDD and authorized by the ID/DD Waiver Support Coordinator as part of the approved Plan of Care (POC).

The ID/DD Waiver offers the following services:

- Support Coordination (Case Management)
- Respite Care (In-Home, Community and ICF/MR)
- Residential Habilitation
- Day Services-Adults (previously Day Habilitation)
- Prevocational Services
- Supported Employment
- Home and Community Supports (replaces Attendant Care and/or Supported Residential Habilitation)
- Behavior Support/Interventions
- Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Therapy)
- Specialized Medical Supplies

### **Support Coordination**

ID/DD Waiver Support Coordination is defined as services designed to assist participants in accessing needed Waiver and other State Plan services, as well as needed medical, social, educational, or other services, regardless of the funding source for the services. The service is provided by ID/DD Waiver Support Coordinators. ID/DD Waiver Support Coordinators are responsible for the following activities:

- Developing (along with the participant), reviewing, and revising the participant's POC as necessary.
- Providing participants with information about qualified providers for the services on the approved POC.
- Forwarding required information to DMH/BIDD for review and approval/denial.
- Notifying applicants of approval/denial of initial enrollment as well as requests for additional services, increases in services, recertification, reductions in services, termination of services, and/or discharge from the waiver.

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- Ongoing monitoring and documentation of whether the participant's health and welfare is being assured by evaluating the effectiveness of services, waived and non-waived, and participant/legal representative satisfaction with services during phone contacts and face-to-face visits.
  - Submitting requests for changes in services on the POC identified during phone contacts and face-to-face visits to DMH/BIDD for approval/disapproval along with supporting documentation. When the POC is returned, the ID/DD Waiver Support Coordinator sends a Notice of Determination to the beneficiary/legal representative within ten (10) days.
  - Notifying providers of changes to the POC by sending Service Authorizations within ten (10) days of receipt of determination by DMH/BIDD. If a beneficiary decides to appeal, the provider is notified in writing to continue services that were in place prior to the changes specified in the Service Authorization. The provider will be notified in writing of approved services resulting from the final appeal decision.
  - Ongoing assessment of the beneficiary and his/her situation based on information obtained during phone contacts, observations/interactions with the participant during quarterly face-to-face visits, contacts with providers, contacts with family/caregivers, and information acquired for the annual LOC re-evaluation.
  - Ongoing monitoring of all services on the POC to ensure they are appropriate/adequate to meet identified needs.
  - Ensuring that all services, regardless of funding source, are coordinated to maximize the benefit and to prevent duplication of services.
  - Performing all functions necessary for the recertification process.
  - Reviewing reports provided by DOM/BMHP to monitor waiver services on the Plan of Care.

### **Respite Care**

Respite Care is defined as services that provide temporary, periodic relief to those persons normally providing the care for an eligible participant who is unable to provide the care themselves. The respite worker provides the care the caregiver would normally provide during that time and may accompany the participant on short outings such as those for exercise, recreation or shopping. Respite services are also available when the usual caregiver is absent or incapacitated due to hospitalization, illness, injury, or death. Respite is designed to be provided on a short-term basis.

Respite services can be provided in the participant's home or private place of residence, a DMH certified community site, or a Medicaid certified ICF/MR.

### **In-Home Respite**

In-home respite services are provided in the participant's home by a Certified Nursing Assistant (CNA), a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).

If services are provided to more than one participant in the same residence, both participants must be immediately related (example: siblings, parent/sibling). The provider must bill separately for each participant.

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### **Types of In-Home Respite:**

- In-Home Respite services may be provided in the beneficiary's home by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN). The need for respite provided by a nurse is dependent upon whether or not the beneficiary requires nursing care in the absence of the primary care giver. Nurses must be licensed according to state law and practice in compliance with the Mississippi Nurse Practice Act and current nursing laws and regulations. Nurses must be employed by an agency certified by MDMH and enrolled as an ID/DD Waiver provider.
- In-Home Respite services may be provided in the beneficiary's home by a Certified Nurse's Aide (CNA). CNA's must be employed by an agency certified by MDMH and enrolled as an ID/DD Waiver provider. CNA's must be supervised by an RN.

Exclusions: The provider may not run personal errands while caring for the participant. Services may not be provided in the home of the respite worker, only in the home of the individual receiving the services.

### **Community Respite**

Community Respite services are provided in a community setting. Community respite is designed to provide primary caregivers a break from constant care giving as well as provide the participant with a safe place to go that will provide scheduled activities to address beneficiary preferences/requirements.

Exclusions: Community Respite cannot be provided overnight and cannot be provided in a private residence. Community Respite cannot be used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adults, or Prevocational Services.

### **ICF/MR Respite**

ICF/MR Respite services are provided in a state-licensed ICF/MR facility. ICF/MR respite services may be provided up to thirty (30) days per certification period.

### **General Guidelines for Respite**

- In-home and community respite participants may receive other ID/DD Waiver services on the same day of services, but not during the same time period. Participants may receive Day Service-Adults, Prevocational, Supported Employment, Home and Community Supports, PT/OT/ST and/or Behavior Support Intervention.
- Residential habilitation participants are not eligible to receive in-home and community respite services.
- In-home and community respite services include medication administration and other medical treatments to the extent permitted by State law.
- Training is not provided as a component part of in-home and community respite.
- Participants who live in a group home or staffed residence or who live alone cannot receive in-home or community respite.

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- In-home and community respite cannot be provided to someone who is an in-patient of a hospital, nursing facility, or ICF/MR when the in-patient facility is billing Medicare, Medicaid and/or private insurance.

### **Residential Habilitation**

Residential Habilitation is defined as services designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community inclusion, transportation and leisure skill development. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect that of daily living.

General guidelines for Residential Habilitation include the following:

- Residential Habilitation dwellings may be (1) rented, leased or owned by the provider or (2) rented, leased or owned by the participant.
- Staff must be available on site twenty-four (24) hours per day seven (7) days per week. Staff must be able to respond to requests for assistance within five (5) minutes.
- The provider is responsible for providing an appropriate level of services and supports twenty-four (24) hours a day during the hours the participant is not receiving day services or is not at work.
- The provider is responsible for overseeing the participant's health care needs by assisting with (1) making doctor/dentist/optical appointments, (2) transporting and accompanying the participant to appointments, and (3) talking with medical professionals if the participant gives permission to do so.
- Residential Habilitation is available to participants who are no longer eligible for educational services based on graduation and/or receipt of a diploma/equivalency certificate or permanent discontinuation of the educational services.
- Transportation service is a component part of Residential Habilitation and is included in the reimbursement rate. Services include transportation to and from job sites, transportation for shopping or other community activities, transportation to leisure events, and transportation to appointments. Providers should not bill separately for transportation services and should not charge participants for these services.
- Participants receiving Residential Habilitation may not receive home and community supports, in-home respite, or community respite services.
- Participants receiving Residential Habilitation may receive Prevocational Services, Day Services-Adult, Supported Employment, Behavior Support/intervention, therapy (OT, PT, and ST) services, and/or Specialized Medical supplies.

### **Day Services-Adults**

Day Services for adults is defined as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies listed if included on the POC. Activities include those that foster the

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acquisition of skills, greater independence and personal choice.

Day Services for adults take place in a nonresidential setting, separate from the home or facility in which the participant resides. Services are furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the participant's POC. Services are limited to a maximum of one hundred thirty (130) hours per month.

General guidelines for Day Services for adults include the following:

- Meals provided as part of this service do not constitute a "full nutritional regimen" (i.e., three meals per day), but the program must provide a mid-morning snack, a nutritious noon meal, an afternoon snack, and offer choices of food and drink.
- Participants with degenerative conditions and/or those who have chosen to retire may receive services that include supports designed to maintain skills and prevent or slow regression.
- Participants receiving Day Services for adults may also receive educational, Supported Employment, Prevocational services, In-home respite, Community respite, ICF/MR respite, Home and Community Supports, Behavior Support/intervention services, and/or PT/OT/ST if these services are included in the approved POC. None of these services may be received during the same time period, but participants may receive multiple services on the same day.
- Services may be provided in DMH certified sites and/or in community settings.

Transportation between the participant's place of residence and the service site for community outings is provided as a component part of Day Services for adults. The cost of transportation is included in the rate paid to providers. Providers cannot bill for transportation time to and from the participant's residence but can bill for transportation provided to access the community during the provision of Day Services for adults.

### **Prevocational Services**

Prevocational Services prepare a participant for paid employment. Services address underlying habilitative goals (e.g., attention span, motor skills) which are associated with performing compensated work. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented, but instead, are aimed at a generalized result. Services are reflected in the participant's Prevocational Service Plan and are directed to habilitative rather than explicit employment objectives. Services are limited to a maximum of one hundred thirty (130) hours per month

In Mississippi, Prevocational Services are not otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17).

General guidelines for Prevocational Services include the following:

- The program is not required to provide meals but must have procedures to ensure food/drink is available to anyone who might forget lunch/snacks.
- Personal care/assistance may be a component of Prevocational Services, but it may not comprise the entirety of the service.

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- Participants who receive Prevocational Services may be compensated in accordance with applicable federal laws and regulations.
  - When a participant earns more than fifty percent (50%) of the minimum wage, the participant, appropriate staff and the ID/DD Waiver Support Coordinator must review the necessity and appropriateness of the services.
  - Participants receiving Prevocational Services may also receive educational, Supported Employment and/or Day Services for adults.
  - Transportation between the participant's place of residence and the Prevocational Services site and to the sites in the community is provided as a component part of Prevocational Services. The cost of this transportation is included in the rate paid to providers of Prevocational Services. Providers should not bill separately for transportation services and should not charge participants for these services.

### **Supported Employment**

Supported Employment services are intensive, ongoing supports which enable participants for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of disabilities, require supports to perform in a regular work setting. Supported Employment may include assisting the participant to locate a job or developing a job on the participant's behalf.

Supported Employment also includes services and supports to assist the participant in achieving self-employment. Assistance with self-employments includes the following:

- Aiding the participant in identifying potential business opportunities
- Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business
- Identifying supports necessary for the participant to successfully operate the business
- On-going assistance, counseling and guidance once the business has launched

Supported Employment services are provided only at work sites where persons without disabilities are employed. When Supported Employment services are provided at a work site where persons without disabilities are also employed, payment will be made only for the adaptations, supervision, and training required by participants receiving ID/DD Waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment services are not available under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

General guidelines for Supported Employment include the following:

- Personal care/assistance may be a component of Supported Employment, but it may not comprise the entirety of the service.
- Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities.

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- Medicaid funds will not be used to defray the expenses associated with starting or operating a business.
  - Participants receiving Supported Employment may also receive educational, Prevocational, Day Services for adults, In-home Respite, Community Respite, ICF/MR Respite, Home and Community Supports, Behavior Support/Intervention services, and/or PT/OT/ST if the services are included in the approved POC. None of these services may be received during the same time period but a participant can receive multiple services on the same day. Exception: Behavior Support/Intervention services may be provided simultaneously with Supported Employment.

Transportation between the participant's residence and/or other habilitation sites and the employment site is a component part of Supported Employment. The cost of transportation is included in the rate paid to the provider. Providers should not bill separately for transportation services and should not charge participants for these services.

### **Home and Community Supports**

Home and Community Supports (HCS) are a range of services for participants who require assistance to meet their daily living needs. Services ensure the participant can function adequately both in the home and in the community. Services also provide safe access to the community. HCS may be provided in a participant's private residence (own home or family home) and/or community settings.

Services include the following:

- Hands-on assistance or cuing/prompting the participant to perform a task.
- Accompanying and assisting the participant in accessing community resources and participating in community activities.
- Medication administration and other medical treatments to the extent permitted by current State law.
- Supervision and monitoring in the participant's home, during transportation, and in the community setting.
- Provision for and/or assistance with housekeeping that is directly related to the participant's disability and is necessary for the health and well being of the participant (this may not comprise the entirety of the service).
- Assistance with money management, but not receiving or disbursing funds on behalf of the participant.
- Grocery shopping, meal preparation and assistance with feeding not to include the cost of meals themselves.

General guidelines for Home and Community Supports include the following:

- HCS cannot be provided in school or be used as a substitute for educational services.
- HCS may be provided on an episodic or regularly scheduled basis.
- HCS cannot be provided to a participant who lives in a residential setting or who is an inpatient of

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- a hospital, nursing facility, or ICF/MR if the facility is billing Medicaid, Medicare, and/or private insurance.
  - Participants receiving HCS may also receive educational, Prevocational, Day Services for adults, In-Home Respite, Community Respite, ICF/MR Respite, Behavior Support/Intervention services, and/or PT/OT/ST if the services are included in the approved POC. Even though a participant may receive multiple services on the same day, services **may not** be received during the same time period. Services provided during the same time period will be considered duplication of services. If duplication of services is discovered, all providers involved will be subject to investigation by DOM Bureau of Program Integrity. Providers will make all records that will disclose services rendered and/or billed under the program, upon request, available to representatives of CMS, DOM, the Attorney General Medicaid Fraud Control Unit, or DHHS in substantiation of any and all claims.
  - Providers are not required to transport participants to the community. However, community integration is a component part of home and community supports and transportation is allowable as part of the service.

### **Behavior Support/Intervention**

Behavior Support/Intervention is provided for beneficiaries who exhibit behavior problems that prevent them from benefiting from other services being provided or cause them to be so disruptive in their environment(s) that there is imminent danger of removal or dismissal. The provider works directly with the beneficiary and trains staff and family members to assist in the implementation of specific behavior support/intervention programs. Services are limited to a maximum of ten (10) hours per year for evaluation and eight hundred (800) hours per year for direct services.

Services may be provided in the home, in a habilitation setting, or the provider's office. **Services cannot be provided in a public school setting.** The provider may observe the beneficiary in the school setting to gather information, but may not function as an assistant in the classroom by providing direct services.

Behavior Support/Intervention is not available under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or through the Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Behavior Support/Intervention services may include the following:

- Assessing the beneficiary's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for the behaviors, and in turn how these particular behaviors impact the beneficiary's environment and life
- Developing a behavior support plan, implementing the plan, collecting the data, measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan
- Providing therapy services to the beneficiary to assist him/her in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavior support plan
- Communication with medical and ancillary therapy providers to promote coherent and coordinated services addressing behavioral issues in order to limit the need for psychotherapeutic medications

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### **Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Therapy)**

Therapy services (physical therapy, occupational therapy, and speech-language pathology) will be covered under the State Plan until the participant reaches maximum health care goals or no longer meets medical necessity criteria for prior authorization/pre-certification from the Utilization Management and Quality Improvement Organization (UM/QIO) for DOM.

Therapy services provided through the waiver begin at the termination of State Plan services. ID/DD Waiver therapy services are not available under the Individuals with Disabilities Education Act(20 U.S.C. 1401 et seq.) or through EPSDT/Expanded EPSDT and are in excess of those covered under the State Plan, either in amount, duration or scope. Services are considered to be both cost-effective and necessary to prevent institutionalization. Services are limited as follows:

- Speech-language pathology: maximum of three (3) hours per week
- Physical therapy: maximum of three (3) hours per week
- Occupational therapy: Maximum of two (2) hours per week

Therapy providers (individual and/or facility) must meet state and federal licensing/certification requirements.

### **Specialized Medical Supplies**

Specialized Medical Supplies are those supplies available under the waiver to beneficiaries who are not covered for such supplies under regular State Plan benefits. Refer to Provider Policy Manual Section 10.0 for Durable Medical Equipment policy.

When specialized medical supplies are not available or have been exhausted under the regular State Plan services, they may be covered through the ID/DD Waiver **if** they are on the participant's current approved POC. The following list includes supplies covered under the waiver, if they are on the approved POC:

- Specified types of catheters
- Diapers
- Under pads

DME providers must meet state and federal licensing/certification requirements.

**All ID/DD Waiver services and supplies must be included in the participant's Plan of Care.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.08 Pages: 3 Cross Reference: Covered Services 16.07 Critical Events/Incidents 16.10</b>	
<b>Subject: Quality Management Strategy (QMS)</b>		

Under Section 1915(c) of the Social Security Act and 42 CFR 441.302, the State is required to make assurances concerning the protection of participant health and welfare, financial accountability, and other elements of Waiver operation.

Discovery, remediation and improvement strategies for the ID/DD Waiver center primarily on the implementation of the Mississippi Department of Mental Health Standards. DMH standards outline the process providers must follow to become certified DMH providers and define the minimum staff qualification for each type of provider/position in every DMH certified service. All providers must meet DMH standards for administration/operation of programs, personnel, training, grievance and compliant procedures, environment and safety, reporting of serious incidents, knowing and protecting the rights of individuals receiving services, confidentiality, record management, medication administration, and transportation. DMH provides specific standards for each service except PT/OT/ST and DME. Standards must be implemented and are monitored by DMH/BIDD. A web copy of the Mississippi Department of Mental Health Standards may be found at <http://www.dmh.state.ms.us>. Click on the link for online documents.

Functions performed by DMH/BIDD staff include, but are not limited to, the following:

- Conduct on-site monitoring visits at least two (2) times each year to make assurances concerning the protection of participant health and welfare, financial accountability, and other elements of Waiver operation.
- Track deficiencies to evaluate trends and patterns and use outcomes to improve program performance.
- Monitor ID/DD Support Coordinators to ensure compliance with all requirements set forth in the CMS approved Waiver and DOM policy.
- Monitor the number of individuals enrolled in the Waiver to ensure the number does not exceed that approved by CMS.
- Approve/disapprove all requests for Waiver participant initial and recertification for ID/DD Waiver services (based on documentation submitted by Support Coordinators).
- Approve/disapprove all requests for additional services/increases in services (beyond the approved POC).
- Manage the waiting list and make it readily available to DOM/BMHP.
- Train ID/DD Support Coordinators and ID/DD Support Coordinator Directors.
- Participate in DMH/BMR Division of Accreditation and Licensure monitoring visits for ID/DD Waiver service providers.

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## **Quality Assurance Performance Measurement**

### **Level of Care Assurances**

- Waiver applicants for whom there is a reasonable indication that services may be needed are provided an individual Level of Care evaluation.
- Enrolled participants are reevaluated at least annually to verify they still require ICF/MR level of care.
- The process and the standardized diagnostic and assessment instruments are applied in Level of Care determinations.
- DMH/BIDD monitors LOC determinations and takes action to address inappropriate LOC determinations.

### **Individualized Plans of Care**

The Plan of Care is designed to ensure the following:

- The participant's assessed Waiver and non-Waiver needs (including health, safety, and risk factors) and personal goals are addressed in the POC.
- The POC is updated/revised at least annually and/or when warranted by changes in the participants needs (refer to Provider Policy Manual Section 16.07 for Covered Services policy).
- Participants are afforded the choice between Waiver services and institutional care.
- Participants are afforded a choice between/among services and providers.
- Services are delivered in accordance with the POC, including the type, scope, amount, duration and frequency specified in the POC.

### **Qualified Providers**

Assurances include the following:

- Providers must meet required certification standards prior to providing Waiver services.
- Providers must maintain compliance with licensure and/or certification standards on an on-going basis.
- Non-licensed/non-certified providers cannot participate in the Waiver.
- Training is provided in accordance with DMH/BIDD and DOM requirements for the approved Waiver.

### **Health and Welfare**

Assurances include the following:

There is continuous, ongoing monitoring of the health and welfare of individuals served through

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the Waiver and remediation action is initiated when appropriate. When instances of suspected abuse, neglect and exploitation are discovered, appropriate reports are submitted. Refer to Provider Policy Manual Section 16.10 for Critical Events/Incidents, Abuse/Neglect/Exploitation policy.

- Waiver participants are encouraged to receive an annual preventative physical. Waiver participants are informed that annual preventative physicals (wellness visits) do not count against allowed regular office visits.

### **Financial Accountability**

Claims for Federal financial participation in the costs of Waiver services are based on State payment for Waiver services that have been rendered to Waiver participants, authorized in the POC, and properly billed by qualified Waiver providers in accordance with the approved Waiver.

The DOM ensures financial audits of ID/DD Waiver providers are conducted. DOM will generate all required financial reports for each Waiver service. Support Coordinators will review reports and compare services billed with the current approved POC. Any discrepancies will be reported to DOM/BMHP on a Discrepancy Report. Audits will also be conducted to verify the maintenance of appropriate financial records and claims which will be reviewed to verify coding and the accuracy of the payments made. When appropriate, immediate action will be taken to address any financial irregularities.

### **Administrative Authority**

DOM maintains ultimate authority and responsibility for the operation of the Waiver by exercising oversight over the performance of the Waiver functions by other State local/regional, non-State agencies, and contracted entities. DOM performs ongoing monitoring of DMH/BIDD on a quarterly basis to assess DMH/BIDD's operating performance and to assess for compliance with the approved 1915 (c) Waiver, DOM policies and specifications in the Interagency Agreement.

Waiver providers must meet and maintain compliance with quality assurance standards in the HCBS ID/DD Waiver document approved by the Centers for Medicare and Medicaid Services (CMS) and in the Mississippi Department of Mental Health Standards. Compliance with quality assurance standards must be maintained for the entire period of time that the provider chooses to provide Waiver services.

A copy of the HCBS ID/DD Waiver document approved by the Centers for Medicare and Medicaid Services (CMS) is available at [Approved 1915\(c\) Waiver \(full content\)](#)

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.09 Pages: 1 Cross Reference:</b>	
<b>Subject: Reimbursement</b>		

Reimbursement for Waiver services can be requested no earlier than the first day of the month following the month in which services are rendered. (Example: services provided in June cannot be billed before July 1). Services may only be provided to participants when authorized by the ID/DD Waiver Support Coordinator as part of the approved Plan of Care. All ID/DD Waiver providers must be enrolled as a Mississippi Medicaid Provider and must maintain an active provider number. All ID/DD Waiver providers except those for therapy services and specialized medical supplies must be certified by DMH.

Detailed billing guidelines for ID/DD Waiver services may be found on the DOM website at <http://www.medicaid.ms.gov/MentalHealthServices.aspx>.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.10 Pages: 4 Cross Reference:</b>	
<b>Subject: Critical Events/Incidents (Abuse/Neglect/Exploitation)</b>		

ID/DD Waiver Support Coordinators and all other DMH providers are required to receive training at least annually regarding Mississippi's Vulnerable Adults Act. The training will include what constitutes possible abuse/neglect/exploitation, who must report, and the procedures for reporting. All providers are also required to receive training about reporting Serious Incidents to the DMH Office of Constituency Services (OCS).

Upon admission and at least annually thereafter, every service provider is required to provide the participant/legal guardian with both the provider's and DMH's procedures for protecting individuals from abuse, neglect, exploitation, and any other form of potential abuse. The procedures must be given orally and in writing. The participant/legal guardian will be asked to sign a form indicating the rights have been given to them in a way that is understandable to them. The participant/legal guardian will be given instructions for reporting suspected violation to the DMH, Office of Constituency Services (OCS) or Disability Rights Mississippi. The DMH toll free Helpline is posted in a prominent place throughout each program site and provided to the participant/legal representative.

All providers must have a written policy for documenting and reporting all critical events/incidents. Documentation regarding critical events/incidents must include (1) a written description of events and actions, (2) all written reports, including outcomes, and (3) a record of telephone calls to DMH/OCS.

Critical events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH/OCS, the agency director, the parent/guardian/legal representative/significant person as identified by the individual receiving services. Documentation regarding the event/incident must be maintained in a central file on site.

Critical events/incidents must be reported to the DMH OCS within twenty-four (24) hours or the next business day. The report can be made by telephone or by submitting a completed Serious Incident Report. If the incident is reported by telephone, the provider must submit a completed Serious Incident Report within five (5) business days.

DMH/BIDD will submit a summary of critical incidents/events to DOM/BMHP with each quarterly report. Upon request, DOM/BMHP will have access to all documentation related to alleged reports of abuse/neglect/exploitation of ID/DD Waiver participants.

Certain critical events/incidents involving Waiver participants must be reported to the OCS and other appropriate authorities within twenty-four (24) hours or the next working day. Examples of critical events/incidents that must be reported by Waiver providers include, but are not limited to, the following:

- Suicide attempts on program property or at a program-sponsored event.
- Suspected abuse/neglect/exploitation (must also be reported to other authorities in accordance with State law).
- Unexplained absence from a residential program of twenty-four (24) hour duration.

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- Absence of any length of time from an adult day center providing services to individuals with Alzheimer's disease and/or other dementia (i.e., wandering away from the premises).
  - Death of a participant on program property, at a program-sponsored event or during an unexplained absence from a residential program site.
  - Emergency hospitalization or emergency room treatment of a participant receiving ID/DD Waiver services.
  - Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.
  - Disasters such as fires, floods, tornadoes, hurricanes, earth quakes, disease outbreaks, etc.
  - Use of seclusion or restraint.

**The above list is not exhaustive. If a Waiver provider has any question whether or not a situation/incident should be reported, the provider is required to contact DMH/OCS. Information regarding the time frames and methods of reporting for each situation is provided in the following table.**

<b>EVENT</b>	<b>Legal Representative</b>	<b>DMH/OCS</b>	<b>MSDH</b>	<b>DHS/DFCS</b>	<b>AGs Office (VAU/MFCU)</b>
Suicide Attempt on program property or program-sponsored event	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Suspected abuse/neglect/exploitation of a participant	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Unexplained absence from a residential program of twenty-four (24) hour duration	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Absence of any length of time from an adult day center providing services to individuals with Alzheimer's disease and/or other dementia (i.e. wandering away from the premises)	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Death of a participant on program property, at a program-sponsored event or during an unexplained absence from a residential program site	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Emergency hospitalization or emergency room treatment of a participant receiving ID/DD Waiver services	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*

EVENT	Legal Representative	DMH/OCS	MSDH	DHS/DFCS	AGs Office (VAU/MFCU)
Use of seclusion or restraint	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Disasters such as fires, floods, tornadoes, hurricanes, earthquakes, disease outbreaks, etc.	ASAP, but within 24 hours	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*		

ASAP=As soon as possible

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

\* Complaints of abuse/neglect/exploitation of participants in **health care facilities** must be reported to the Medicaid Fraud Control Unit (MFCU), Office of the State Attorney General (AG) and to the Mississippi Department of Health. This includes Waiver participants receiving ICF/MR Respite or participants who are hospitalized temporarily **or** if suspected abuse/neglect/exploitation occurred while an ID/DD participant in a hospital or while receiving ICF/MR Respite services. Reporting guidelines are determined by the setting in which the suspected abuse/neglect/exploitation occurred.

\* Suspected abuse/neglect/exploitation that occurs in any Adult Day services facility, which means a community-based group program for adults designed to meet the needs of adults with impairments through individual Plans of Care, which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling participants to live in the community must be reported to the DMH/OCS if the facility is certified by the DMH.

If the alleged perpetrator carries a professional license or certificate, a report should also be made to the entity which governs their license or certificate.

\* Disease outbreaks at a provider site must be reported to Mississippi State Department of Health (MSDH). Reportable diseases include, but are not limited to, tuberculosis, H1N1 influenza, scabies, etc. Any provider who is not sure if a disease is reportable should contact MSDH for guidance.

**All of the above reporting requirements required by state and federal laws are subject to change at any time. All providers are responsible to stay up to date on current laws and regulations related to the protection of vulnerable adults and ensure training is provided to all employees as required.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.11 Pages: 2 Cross Reference:</b>	
<b>Subject: Medication Management and Medical Treatments</b>		

## **Medication Management**

Nurses employed by an agency enrolled as an ID/DD Waiver provider must practice within the current guidelines outlined in the Mississippi Nurse Practice Act and applicable state and federal laws and regulations, regardless of the setting. A Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) **must** be supervised by appropriately qualified staff through a home health agency or other entity allowed by state and federal laws and regulations. Nurses **may not** provide services independently. If a Waiver participant cannot self-administer medications and the legal representative is unavailable, only a licensed nurse, nurse practitioner, physician, or dentist may administer medication at ID/DD Waiver program sites in the community and in the home setting. The following practices must be in place to protect the health and safety of a participant who requires medications or medical procedures/treatments:

- Medications must be stored appropriately in their original containers if a nurse will administer them.
- Nurses may not prepare medications in a medication planner for a non-licensed provider(s) to dispense in his/her absence.
- All medications must be documented in the participant's record by the appropriately licensed medical professional administering them.
- Documentation should reflect if the legal representative administers the participant's medications or if a participant self-administers his/her medications.
- Registered Nurses will assess the participant for medication side effects and report any suspected side effects or untoward effects to the practitioner who prescribed them. Suspected side effects or potential health issues noted by an LPN will be reported promptly to an RN or appropriately qualified staff.

The first-line responsibility for monitoring participant medication regimes lies with the licensed medical professional who prescribes the medication. Licensed medical professional is defined as a physician, physician assistant or certified nurse practitioner, or licensed dentist who meets the state and federal licensing and/or certification requirements. Second-line responsibility is with the nurse providing services to an ID/DD Waiver participant.

Participants have a choice of physicians and pharmacists but are encouraged to be consistent in the use of these professionals in order to ensure continuity of care and prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated by medication prescribed by another physician.

## **Residential Habilitation**

Residential Habilitation providers must make arrangements for a nurse to administer medication(s) if a participant who requires medication cannot self-administer while receiving services. The nurse may **not** accompany the participant to physician visits. However, with the participants permission, the nurse or employing agency, may communicate with the participant's physician. After communicating with the physician, the nurse employed by the Residential Habilitation provider will document the following:

- Physician visits including the reason for the visit.

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- Physician instructions/orders.
  - New prescriptions including any detailed pharmacy information supplied with the prescription.
  - Any pertinent information regarding the participant's medical status.

DOM will make periodic reviews of Residential Habilitation providers to ensure they are following required procedures regarding the medication regimens of individuals who require such. The DOM review team will include a Registered Nurse.

### **Medical Treatments**

All treatment's prescribed by appropriately qualified staff shall be provided or administered by a nurse. Treatments include tube feedings, suctioning, wound care, etc. Documentation must reflect who, including credentials, performs any required medical treatments and an assessment of any wounds, results of suctioning, etc. If the appropriately qualified staff orders the nurse to teach the ID/DD Waiver participant/legal representative to provide or administer treatments, the Registered Nurse (RN) may provide this service in accordance with current nursing laws and regulations.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.12 Pages: Cross Reference:</b>	
<b>Subject: Reserved for Future Use</b>		

**Section 16.12 is RESERVED FOR FUTURE USE.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.13 Pages: 2 Cross Reference:</b>	
<b>Subject: Documentation and Record Maintenance</b>	<b>Maintenance of Records 7.03</b>	

All professional, institutional, and contractual providers participating in the Medicaid program are required to maintain all records that will disclose services rendered and/or billed under the program and, upon request, make such records available to representative of CMS, DOM, the Attorney General Medicaid Fraud Unit, or DHHS in substantiation of any and all claims. Records will also be made available to DMH/BIDD, the operating agency. Records are required to be complete, legible, accurate, accessible, and organized.

### **Services**

An entry or clinical note of each service provided must be in the case record. The entry or clinical note must include **all** of the following documentation:

- Date of service
- Type of service provided
- Time service began and time service ended
- Length of time spent delivering service
- Identification of participant(s) receiving or participating in the service
- Summary of what transpired during delivery of the service
- Evidence that the service is appropriate and approved on the Plan of Care
- Name, title, and signature of individual providing the service

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:

- Documentation requirements in the CMS approved waiver
- DMH Standards
- Evidence that the service is appropriate and approved on the Plan of Care
- Documentation requirements in the DMH/BIDD Record Guide
- Required documentation as specified in other sections of the DOM HCBS ID/DD Waiver manual policies
- DOM requirements for all providers (Refer to Provider Policy Manual Section 7.03 for Maintenance of Records policy)

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If the provider's records do not substantiate services paid under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.14 Pages: 1 Cross Reference: Benefits 2.0 Beneficiary Information 3.0</b>	
<b>Subject: Beneficiary Cost Sharing</b>		

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. **Co-payment may be required of Waiver beneficiaries for those services covered under the State Plan.**

Beneficiaries enrolled in Waiver programs are exempt from co-payment for the **additional** services offered as part of the Waiver. **Additional** services are those specifically listed as covered services under the Waiver.

Refer to Provider Policy Manual Section 2.0 for Benefits policy and Section 3.0 for Beneficiary Information policy.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.15 Pages: 3 Cross Reference:</b>	
<b>Subject: Grievances and Complaints</b>	<b>Critical Events/Incidents 16.10</b>	

Mississippi Code, Section 41-4-7, parts (q) and (y) gives authority for the operation of a grievance/complaint system to the Mississippi State Board of Mental Health. The Department of Mental Health, Office of Constituency Services (DMH/OCS) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. The DMH, Office of Constituency Advisory Council assists the OCS in development of procedures for receiving, investigating, and resolving the grievances/complaints. Personnel issues are not within the purview of DMH/OCS.

A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. The line is answered by OCS staff from 8 a.m. until 5 p.m. during business days. After hours, on weekends and state holidays, trained contract staff answers the line. As a condition of DMH certification, all providers are required to post the toll-free number in a prominent place throughout each program site.

Calls received through the Helpline are categorized and reported as follows:

- Requests for information

Calls requesting information are logged into the Information and Referral Database as information only and the response/action taken is recorded. Callers are advised to call back if unable to reach the number given or if in need of additional information.

- Requests for referrals

Calls requesting referrals for specific services are documented in detail in the Information and Referral Database and one (1) or more referrals are given to the caller. A follow-up is done within two (2) days if the caller has given a call back number.

- Informal grievances

Informal grievances are defined as calls from individuals who do not wish to file a formal complaint **OR** calls from residents of DMH certified facilities. The calls are processed as follows:

- DMH/OCS notifies the program/facility and a verbal response is requested.
- If the complaint is from a resident of a facility, a patient advocate is notified and a verbal response is requested.
- The caller is notified of the response from the program/facility.
- If necessary, the call is upgraded to Level I formal complaint.
- All information/responses are recorded in the Information and Referral Database.

- Level I formal complaints

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Level I formal complaints are defined as complaints related to certification standards, DMH policy, legal issues, Americans with Disabilities Act regulations, etc. Callers who wish to file a formal complaint are supplied with a formal complaint form via fax or mail. At the discretion of the OCS staff, the complaint may be taken verbally if the caller is unable to communicate in writing. Once the verbal/written complaint has been received, OCS has a maximum of thirty (30) days in which to resolve the complaint. The complaint is processed as follows:

- The Level I formal complaint is entered into the Information and Referral Database along with any other documentation and the time line tracking is recorded.
- The facility/program is notified by telephone and a copy of the complaint is faxed to the facility/program within twenty-four (24) hours.
- The facility/program is required to submit a written response to OCS within ten (10) calendar days.
- Failure to respond to the complaint is reported to the appropriate Bureau Director and the DMH Division of Accreditation and Licensure.
- Within twenty-four (24) hours of receiving a response from the facility/program, OCS will notify the caller in writing or by telephone.
- If the response is satisfactory to the caller, the case is closed.
- If the response is not satisfactory to the caller, the caller may appeal. If the complaint involves a program/facility operated and/or certified by DMH, the complainant will be directed to follow the appeal procedure outlined in Chapter II-Board of Mental Health, Section 2. If the complaint involves a program/facility not operated and/or certified by DMH, the complainant will be directed to the appeal procedure established by the specific program/facility. If the complaint involves services being denied, terminated, reduced, denial to increase services when requested, or termination from the waiver, the complainant will be directed to DMH/BIDD for assistance with the appeal process.

- Level II formal complaints

Level II formal complaints are defined as complaints that are of a serious and urgent nature, such as those alleging abuse/neglect. The complaint may be received by telephone or in writing. The complaint is processed as follows:

- The Level II complaint is logged into the Information and Referral Database.
- Within twenty-four (24) hours, DMH OCS will contact the appropriate DMH Bureau Director who may designate program staff to accompany DMH OCS staff on an unannounced on-site investigation.
- Staff involved in the alleged incident will be interviewed.
- DMH OCS will send a detailed written report within three (3) days of the on-site investigation.
- A copy of the report will be sent to the facility director, complainant, DMH Bureau Director, and DMH Division of Accreditation and Licensure.

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- Response to the report is required from the facility (provider) within ten (10) calendar days from the date of the report.
  - The complainant must respond within ten (10) days following receipt of the facility (provider) response if the resolution is not acceptable. In such cases, the complainant will be directed to follow the appeal procedure outlined in Chapter II- Board of Mental Health, Section 2. Appeals to the Board.

- Crisis/suicide

Crisis calls are directed to the designated crisis counselor in the caller's local community mental health center (CMHC). OCS staff will keep the caller on the line until the crisis counselor has intervened or help has arrived. OCS staff will follow up with the caller and/or CMHC staff to obtain information necessary for closing the case. The call and follow-up will be logged into the Information and Referral Database.

If the call involves Stage III (in progress) suicide, OCS staff will immediately notify 911.

- Serious Incidents

Refer to Provider Policy Manual Section 16.10 for Critical Events/Incidents policy.

Anonymous callers may not file a formal complaint. Concerns will be directed to the person in charge of the facility/program. If more than one anonymous caller complains about the same or similar issues, an on-site investigation may be conducted.

The Helpline does not accept employee grievances, unless they involve participants. Employee grievances will be directed to the personnel office of the facility/program.

Request for reports generated through the Information and Referral Database must be made through the appropriate DMH Bureau Director.

DMH/OCS staff participates in annual certifications/site visits. During the visits, staff does the following:

- Gather updated data for the Information and Referral Database.
- Follow up on formal complaints received during the previous year to assure compliance with DMH standards.
- Provide technical assistance on reporting serious incidents and compliance with DMH standards.
- Review the facility's/programs local grievance and complaint procedures for compliance with DMH standards.
- Follow up on crisis calls including the facility's response and compliance with DMH crisis/emergency procedures standards.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver</b>	<b>Section: 16.16 Pages: 2 Cross Reference:</b>	
<b>Subject: Appeals and Hearings</b>	<b>Administrative Hearings for Beneficiaries 7.08</b>	

### **Intermediate Care Facility/Mentally Retarded (ICF/MR) Level of Care (LOC) Denials**

All level of care (LOC) evaluations are conducted by the Diagnostic and Evaluation Teams at the state's five (5) comprehensive regional centers. If it is determined that an applicant does not meet ICF/MR level of care, the applicant/legal representative may appeal. The DMH procedure for appeals includes the following:

- The applicant/legal representative will be notified in writing that eligibility for ICF/MR level of care, thus eligibility for ID/DD Waiver services, has been denied.
- The applicant/legal representative has thirty (30) calendar days from the date of the Notice of Ineligibility to submit an appeal in writing to the Director of BIDD. The applicant/legal representative may submit justification with the appeal. The Notice of Ineligibility must be included with the appeal.
- The Director of BIDD must respond in writing within fifteen (15) calendar days of receipt of the appeal. If sufficient justification was not submitted the appeal, the Director may request additional information and the time line will be extended an additional fifteen (15) days.
- If the Director of BIDD decides that the denial of ICF/MR eligibility should be reversed, the D&E Team will be notified in writing and a copy of the decision will be sent to the applicant/legal representative.
- If the Director of BIDD decides to uphold the denial of ICF/MR eligibility the applicant/legal representative will be notified in writing.
- The applicant/legal representative may then appeal to the DMH Executive Director. The appeal must be in writing and must be submitted within fifteen (15) calendar days of the date on the notification from the Director of DMH/BIDD.
- The DMH Executive Director must respond in writing within fifteen (15) calendar days. If sufficient justification was not submitted with the appeal, the Executive Director may request additional information and the time line will be extended an additional fifteen (15) days.
- The applicant/legal representative will receive written notification of the Executive Director's decision. The decision of the Executive Director is final.

### **Denial, Reduction or Termination of Services**

Decisions made by the DMH/BIDD that result in services being denied, terminated, or reduced may be appealed as follows:

- The applicant/legal representative has thirty (30) days from the date of the Notice of Ineligibility to submit an appeal in writing to the Director of BIDD. The applicant/legal representative may submit justification with the appeal. The Notice of Denial/Reduction/Termination of Services must be included with the appeal.

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- The Director of BIDD must respond in writing within fifteen (15) calendar days of receipt of the appeal. If sufficient justification was not submitted with the appeal, the Director may request additional information and the time line will be extended an additional fifteen (15) days.
  - If the Director of BIDD decides that the denial, reduction, or termination of benefits should be reversed, the applicant/legal representative will be notified in writing and all benefits will remain.
  - If the Director of BIDD decides to uphold the denial of ICF/MR eligibility the applicant/legal representative will be notified in writing.
  - The applicant/legal representative may then appeal to the DMH Executive Director. The appeal must be in writing and must be submitted within fifteen (15) calendar days of the date on the notification from the Director of BIDD.
  - The DMH Executive Director must respond in writing within fifteen (15) calendar days. If sufficient justification was not submitted the appeal, the Executive Director may request additional information and the time line will be extended an additional fifteen (15) days.
  - If the applicant/legal representative disagrees with the decision made by DMH Executive Director a written request to appeal the decision may then be made to the Executive Director of the Division of Medicaid. Refer to section 7.08 of the Provider Policy Manual for policy regarding Administrative Hearings for Beneficiaries.
  - If requested, the ID/DD Waiver Support Coordinator will prepare a copy of applicable documents in the case record and forwards it to DMH/BIDD staff who reviews and forwards it to the Division of Medicaid no later than five (5) days after notification of the appeal.
  - The Division of Medicaid will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place, if applicable. The hearing will be held by telephone unless valid reason is provided by the beneficiary for an in-person hearing. The decision to hold an in-person hearing is at the discretion of the hearing officer. The hearing will be recorded.
  - The hearing officer will make a recommendation, based on review of documentation submitted by DMH and presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. DMH/BIDD will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

Appeal documentation and final determination(s) are filed by DMH/BIDD and DOM/BMHP.

**During the appeals process, contested services that were already in place must remain in place, unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the service providers. The ID/DD Waiver Support Coordinator is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.**

### **Provider Certification Decisions**

Providers who must be certified by the Mississippi Department of Mental Health, Bureau of Intellectual Disabilities and Developmental Disabilities (DMH/BIDD) may appeal certification decisions to DMH. Certification is dependent upon compliance with the Mississippi Department of Mental Health Standards. The standards also address the appeals process. A web copy may be found at <http://www.dmh.state.ms.us>. Click on the link for online documents.