



Administrative Code

Title 23: Medicaid Part 208 Home and Community Based Services Long Term Care

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Title 23: Division of Medicaid

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

Part 208 Chapter 1: HSBS Elderly and Disabled Waiver

Rule 1.1: General

A. Medicaid covers certain home and community based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D).

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

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Eligibility

A. Eligibility requirements for the Elderly & Disabled (E&D) Waiver Program include the following:

1. Beneficiary must be twenty-one (21) years of age or older.
2. Beneficiary must require nursing facility level of care as determined by a standardized comprehensive preadmission screening tool.
3. Beneficiary Nursing Home level of care must be certified by a physician and re-evaluated every twelve (12) months at a minimum.
4. Beneficiary must be in one of the following Categories of Eligibility (COE):
 - a) SSI, or
 - b) 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.

B. Beneficiaries enrolled in the Elderly & Disabled Waiver cannot reside in a licensed personal care home and are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 435.217; 42 CFR 441.301; 42 CFR 440.180; Social Security Act, Section 1915 (c)

Rule 1.3: Provider Enrollment

- A. Providers of long term care/ home and community based waiver services, excluding the intellectual disabilities/ developmental disabilities waiver, must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:
1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
 2. Copy of current licensure card or permit, if applicable,
 3. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9, and
 4. Written confirmation from the IRS confirming your tax identification number and legal name.
- B. To become a HCBS/Elderly & Disabled Waiver Provider, the prospective provider must:
1. Submit a completed proposal package and enter into a provider agreement with the Division of Medicaid.
 2. Conduct a criminal background check on all employees prior to employment and maintain the record in the employee personnel file.
 3. Establish a Mississippi based physical address/office prior to enrollment and maintain the physical address/office until the provider agreement is terminated.
 4. Depending on the provider type, successfully pass a facility inspection by the Division of Medicaid staff/inspector.
- C. Individuals must not apply for a Division of Medicaid provider number for the purpose of providing care to friends/family members.
- D. Provider Qualifications:
1. All providers of E&D waiver services must have an annual physical examination, including a TB skin test.
 2. Providers of Adult Day Care, Homemaker Services, In-Home Respite, and Escorted Transportation must satisfy the applicable qualifications to render services.
 3. Qualification for Adult Day Care Services:

- a) Adult day care services must be provided by an established, qualified facility/agency.
- b) Each adult day care service must meet the following requirements:
 - 1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.
 - 2) The facility must meet the requirements of the American Disabilities Act of 1990.
 - 3) The facility must have a governing body with full legal authority and judiciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements.
 - 4) The facility must have an advisory committee, and the committee must be representative of the community and participant population.
 - 5) The facility must have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.
 - 6) The facility must have a qualified administrator, either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have a master's degree and one (1) year supervisory experience, either full-time or an equivalent, in a social or health service setting; or a bachelor's degree and three (3) years supervisory experience, either full-time or an equivalent, in a social or health service setting; or comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.
 - 7) The facility must have a program director, either center manager, site manager, or center coordinator, responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program in accordance with the participant's needs and any mandatory requirements. The program director must have a bachelor's degree in health, social services, or a related field and one (1) year supervisory experience, either full-time or an equivalent or comparable technical and human services training with demonstrated competence and experience as a manager in a health or human services setting. The program director must be under the direction of the administrator.
 - 8) The facility must have a qualified social service staff person. The staff person must have a master's degree in social work and at least one (1) year of professional work experience, either full-time or an equivalent, in a human services setting; or a bachelor's degree in social work and two (2) years of professional work experience, either full-time or an equivalent in a human

services setting; or a bachelor's degree in a health or social services related field and two (2) years' experience, either full-time or an equivalent, in a human services field. Social Workers must comply with all licensure requirements set by the Mississippi State Board of Examiners for Social Workers and Marriage & Family Therapists. In lieu of a licensed social worker, the functions must be carried out by other health service professionals such as certified rehabilitation counselors, licensed gerontologists, licensed professional counselors, or licensed/certified mental health workers.

- 9) If the facility offers nursing services, there must be a registered nurse (RN). The RN must have a valid state license and a minimum of one (1) year applicable experience, either full-time or an equivalent.
- 10) The facility must have an activities coordinator. The coordinator must have a bachelor's degree and at least one (1) year of experience, either full-time or an equivalent, in developing and conducting activities for the type population to be served or an associate's degree in a related field and at least two (2) years of appropriate experience, either full-time or equivalent.
- 11) The facility must have a program assistant. The assistant must have a high school diploma or the equivalent and at least one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served.
- 12) If the facility prepares food on site, there must be a food service director. The food service director must be a registered dietician (RD), dietetic technician registered (DTR), RD eligible, DTR eligible, or a four (4) year graduate of a baccalaureate program in nutrition/dietetics/food service. In addition, the food service director must have a minimum of one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. If the food is not prepared on site, the facility must contract with a reputable food service provider/caterer.
- 13) The facility must have a secretary/bookkeeper. The secretary/bookkeeper must, at a minimum, have a high school diploma or equivalent and the skills and training to carry out the responsibilities of the position.
- 14) The facility must have a driver. The driver must have a valid state driver license, a safe driving record, and training in first aid and cardiopulmonary resuscitation (CPR). The driver must maintain compliance with all state requirements for licensure/certification. The driver must be aware of basic transfer techniques and safe ambulation.
- 15) If the facility uses volunteers, there must be a record of the volunteer's hours and activities. Volunteers must be individuals or groups who desire to work with adult

day service participants. Volunteers must successfully complete an orientation/training program. The responsibilities of volunteers must be mutually determined by the volunteers and staff. Duties must be performed under the supervision of facility staff members. Duties must either supplement staff in established activities or provide additional services for which the volunteer has special talent/training. The facility must not use volunteers in place of required staff and should use volunteers only on a periodic/temporary basis.

4. Qualifications for Homemaker Services:

- a) Agency must be established and in business for a minimum of one (1) year.
- b) The agency must provide written documentation of the following:
 - 1) The Division of Medicaid provider agreement that includes the agency's agreement to the waiver requirements.
 - 2) Governing structure for assuring responsibility and for requiring accountability for performance.
 - 3) Fiscal management.
 - 4) Personnel Management including personnel policies, job descriptions, and the process for recruitment, selection, retention and termination of homemakers.
 - 5) Roster of qualified homemaker staff.
 - 6) Criteria/procedure for the provision of services including procedures for dealing with emergency service requests.
- c) Agency must have qualified homemaker supervisors which must have:
 - 1) A bachelor's degree in social work, home economics, or a related field and at least one (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals; or
 - 2) Licensure as a registered nurse (RN) or licensed practical nurse (LPN) and one (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals; or
 - 3) A high school diploma and four (4) years' experience, either full-time or an equivalent, working with aged and disabled individuals; and
 - 4) At least two (2) years supervisory experience, either full-time or an equivalent, preferably in a setting with aged and disabled individuals.

- d) The homemaker supervisor may not supervise more than twenty (20) full-time homemakers. Responsibilities include, but are not limited to:
 - 1) Making home visits with the homemaker to observe and evaluate job performance.
 - 2) Submitting supervisor reports and monthly activity sheets.
 - 3) Reviewing/approving service plans.
 - 4) Processing requests for service.
 - 5) Interpreting agency policy and procedure, maintaining appropriate records and reports.
 - 6) Planning and documenting in-service training for homemaker staff.
 - 7) Maintaining accessibility to homemakers for emergencies, case reviews, conferences, and problem solving.
- e) The homemaker supervisor must report directly to the agency director.
- f) Agency must have qualified homemakers. Requirements for homemakers are as follows:
 - 1) Eighteen (18) years of age or older.
 - 2) High school diploma, General Educational Development (GED) Test, or must demonstrate the ability to read the written homemaker assignment and write well enough to complete required forms and reports.
 - 3) Successful completion and passing a forty (40) hour Homemaker Curriculum Training Course or the equivalent, like a Certified Nursing Assistant.
 - 4) Valid Mississippi driver license and access to reliable transportation.
 - 5) Ability to function independently without constant supervision/observation.
 - 6) Physical ability to perform tasks required.
 - 7) Absence of communicable diseases as verified by a physician.
 - 8) Interest in, and empathy for, individuals who are ill, elderly, and/or disabled.
 - 9) Emotional maturity and ability to respond to individuals and situations in a responsible manner.

- 10) Good communication and interpersonal skills; ability to deal effectively, assertively and cooperatively with a variety of people.
- 11) Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population.
- 12) Experience in caring for aged and disabled individuals is preferable but not required.

5. In-Home Respite Qualifications

- a) Must be established and in business for a minimum of one (1) year.
- b) All providers of in-home respite services must submit written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into a provider agreement.
- c) Each in-home respite agency must have qualified in-home respite providers and supervisors.
 - 1) In-home respite provider supervisor must meet the following requirements:
 - i) Bachelor's degree in social work or related profession,
 - ii) At least one (1) year experience, either full-time or an equivalent, working with aged and disabled clients, and
 - iii) Two (2) years supervisory experience, either full-time or an equivalent, or
 - iv) Licensure as a RN or LPN,
 - v) One (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals, and
 - vi) Two (2) years supervisory experience, either full-time or an equivalent, or
 - vii) A high school diploma,
 - viii) Four (4) years' experience, either full-time or an equivalent, working directly with aged and disabled individuals, and
 - ix) Two (2) years supervisory experience, either full-time or an equivalent.
 - 2) In-home respite provider must meet the following requirements:
 - i) Eighteen (18) years of age or older.

- ii) High school diploma/GED, and at least for (4) years, either full-time or an equivalent, experience as a direct care provider to the aged or disabled.
- iii) Certification in CPR and first aid.
- iv) Valid Mississippi driver license and access to reliable transportation.
- v) Ability to function independently without constant supervision/observation.
- vi) Physical ability to perform tasks required.
- vii) Ability to recognize signs of abuse, neglect, and/or exploitation; ability to follow procedures required in the Vulnerable Adult Act.
- viii) Knowledge of how to prevent burns, falls, and fires and knowledge of emergency numbers for contacting emergency personnel if required.
- ix) Absence of communicable diseases as verified by a physician.
- x) Interest in, and empathy for, individuals who are ill, elderly, and/or disabled.
- xi) Emotional maturity and ability to respond to individuals and situations in a responsible manner.
- xii) Good communication and interpersonal skills and an ability to deal effectively, assertively and cooperatively with a variety of people.
- xiii) Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population.

6. Escorted Transportation Qualifications

- a) All escorted transportation (ET) providers must, at a minimum, meet the qualifications and standards set forth for participation in the state Medicaid program as a non-emergency transportation provider. Refer to Part 201, Chapter 2.
- b) All ET providers must be certified by and enter into a provider agreement with the Division of Medicaid.
- c) The ET provider must not have more than two (2) traffic violations and no driving under the influence (DUI) violations.
- d) Providers must obtain and submit to the Division of Medicaid official copies, provided by the Mississippi Department of Public Safety, of driving records for all drivers employed by the agency.

- e) Service Documentation: Written documentation must be kept for all ET services. Each instance of service delivery must include, but is not limited to, the following:
- 1) Date of service,
 - 2) Time of departure from the beneficiary's residence,
 - 3) Actual destination,
 - 4) Time of arrival at destination,
 - 5) Number of miles traveled to destination,
 - 6) Time of departure from this location,
 - 7) Time of return arrival at the beneficiary's residence,
 - 8) Return mileage driven to the beneficiary's residence,
 - 9) Name and signature of the individual providing the ET service,
 - 10) Beneficiary's signature verifying the accuracy of the documentation, and
 - 11) Beneficiary's Medicaid identification number.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; 42 CFR 440.180

Rule 1.4: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
- B. Each individual found eligible for the E & D waiver must be given free choice of all qualified providers.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23); 42 CFR 431.51

Rule 1.5: Quality Management

- A. Waiver providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services
- B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid HCBS staff.

- C. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.302

Rule 1.6: Covered Services

- A. Providers must meet all provider specifications as outlined in the CMS approved waiver to provide the following services through the Elderly and Disabled Waiver:

1. Case Management (CM)

- a) Case management services for the E&D Waiver program are provided through the Mississippi Planning and Development Districts/Area Agencies on Aging (PDD/AAA). Each PDD/AAA providing case management services must be approved by the Division of Medicaid and must enter into a provider agreement.
- b) Case management services are rendered by two (2) member teams which are composed of the following:
 - 1) A Registered Nurse, and
 - 2) A Licensed Social Worker.
- c) Each team must have an assigned case management supervisor. The case management supervisor must not carry an active caseload of clients.
- d) A case management team comprised of a registered nurse and a social worker will maintain an average caseload of one hundred (100) active cases with up to five (5) cases pending approval by the Division of Medicaid. Priority will be given to beneficiaries electing to transition from nursing home to a home/community-based setting. If a case manager leaves a team, the remaining case manager will become a single CM team until the vacant position is filled. The remaining case manager will continue to maintain the caseload. Beneficiaries must not be discharged down to fifty (50) nor should new beneficiaries be added until the team member is replaced. Any exceptions must be approved by the Division of Medicaid. The Case Management Supervisor must document all efforts made to find/hire a new team member.
- e) If a team has a social worker and a nurse, both must make each visit. If one (1) member is out on a prolonged leave/absence, the other team member may conduct the monthly visits, quarterly visits, readmits, and recertification visits alone. Single, or one (1) member, case management teams may also conduct monthly visits, quarterly visits, readmits, and recertification visits alone. The Case Manager supervisor must review and approve all documents of a single case management team prior to submission to the Division of Medicaid.

2. Homemaker Services

- a) Homemaker services are supportive services provided or accomplished primarily in the home and must be rendered by a trained homemaker.
- b) Homemaker services will be provided to assist functionally impaired persons to remain in their home by providing assistance with the following:
 - 1) Activities of daily living,
 - 2) Housekeeping,
 - 3) Laundry,
 - 4) Meal planning,
 - 5) Marketing,
 - 6) Food preparation, and
 - 7) Other types of home management tasks to prevent the risk of institutionalization.
- c) The homemaker and home health aide must not be in the client's home at the same time and must not perform the same services at the same time, maintaining performance of separate duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance must be thoroughly documented.

3. Adult Day Care Services

- a) Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled beneficiaries through an individualized care plan that includes the following:
 - 1) Personal care and supervision,
 - 2) Provision of meals as long as meals do not constitute a full nutritional regimen,
 - 3) Provision of limited health care,
 - 4) Transportation to and from the site, with cost being included in the rate paid to providers, and
 - 5) Social, health, and recreational activities.

- b) Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the beneficiary's assigned case manager.
- c) To receive Medicaid reimbursement the beneficiary must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the beneficiary to and from the facility.

4. Institutional or In-Home Respite Services

- a) Respite Care shall provide non-medical care and supervision/assistance to beneficiaries unable to care for themselves in the absence of the beneficiary's primary full-time, live-in caregiver(s) on a short-term basis.
- b) Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the beneficiary.

c) Institutional Respite Services

- 1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities.
- 2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service.
- 3) Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

d) In-Home Respite Services

- 1) In-Home Respite services shall be provided to beneficiaries unable to care for themselves.
- 2) Criteria for in-home respite services include all of the following:
 - i) Beneficiary must be home-bound due to physical or mental impairments, and
 - ii) Beneficiary must require twenty-four (24) hour assistance by the caregiver, meaning that the beneficiary cannot be left alone/unattended for any period of time.
- 3) In-Home Respite services are limited to no more than sixty (60) hours per month. Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

5. Home Delivered Meals

- a) Requirements for Home Delivered Meals include:
 - 1) Beneficiaries must be unable to leave home without assistance and/or has no responsible caregiver in the home.
 - 2) All eligible beneficiaries must receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the beneficiary will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.
- b) Home Delivered Meals services must not be provided by individual providers.

6. Escorted Transportation

- a) Escorted transportation is offered in addition to medical transportation. Escorted transportation is provided when the State Plan non-emergency transportation is either not available or inadequate to accommodate the needs of the beneficiary.
- b) Family, friends, or community agencies shall be utilized in lieu of escorted transportation. Family members shall not be reimbursed for the provision of escorted transportation under this waiver.
- c) Escorted transportation must be used for trips to doctors' appointments and trips to the pharmacy to pick up medications. The escorted transportation provider must assist the beneficiary into and out of their home, to the vehicle safely, into the doctor's office/pharmacy, remain with the beneficiary throughout the time they are in the doctor's office/pharmacy, and assist them back to the vehicle. The beneficiary must not be left alone or be dropped off unattended.
- d) The escorted transportation provider must not at any time use the beneficiary's personal vehicle to provide services.
- e) Escorted Transportation must be prior approved and arranged by the beneficiary's waiver case manager.
- f) Providers must maintain documentation that includes, at a minimum:
 - 1) The date of services,
 - 2) Time of departure from the beneficiary's residence,
 - 3) Time of arrival at the destination,

- 4) Number of miles traveled to the destination,
 - 5) Time of departure from the location, and
 - 6) Time of arrival back at beneficiary's residence.
 - g) Documentation must be signed and dated by both the provider and the beneficiary.
7. Extended Home Health Services
- a) Beneficiaries may receive twenty-five (25) home health visits each fiscal year through the regular Medicaid program. Through the Elderly and Disabled Waiver, beneficiaries may receive additional home health visits after the initial twenty-five (25) have been exhausted, but only with prior approval of the Division of Medicaid.
 - b) Home Health Agencies must follow all rules and regulations set forth in Part 215. The word "waiver" does not apply to anything other than Home Health visits with prior approval of the Division of Medicaid. Waiver beneficiaries are subject to home health co-payment requirements through the twenty-fifth (25th) visit. Starting with the twenty-sixth (26th) home health visit, within the state fiscal year, the Waiver beneficiary is exempt from home health co-payment requirements.
 - c) Providers must be certified to participate as a home health agency under Title XVIII, Medicare, of the Social Security Act; furnish the Division of Medicaid with a copy of its certification and/or recertification; meet all applicable state and federal laws and regulations; provide the Division of Medicaid with a copy of its certificate of need approval when applicable; and execute a participation agreement with the Division of Medicaid.
 - d) The homemaker and home health aide must not be in the client's home at the same time and must not perform the same duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance must be thoroughly documented.
8. Transition Assistance
- a) Transition Assistance is a one (1) time initial expense required for setting up a household. The expenses must be included in the approved plan of care. Transition Assistance Services are capped at eight hundred dollars (\$800.00) one (1) time initial expense per lifetime.
 - b) To be eligible for Transition Services the beneficiary must meet all of the following criteria:
 - 1) Beneficiary must be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid, and

- 2) Beneficiary must have no other source to fund or attain the necessary items/support, and
 - 3) Beneficiary must be moving from a nursing facility where these items/services were provided, and
 - 4) Beneficiary must be moving to a residence where these items/services are not normally furnished.
- c) Transition Assistance Services include the following:
- 1) Security deposits required to obtain a lease on an apartment or home
 - 2) Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items. Items such as televisions, cable TV access or VCR's are not considered furnishings,
 - 3) Moving expenses,
 - 4) Fees/deposits for utilities or service access such as telephone, electricity, and the like, and
 - 5) Health and safety assurances such as pest eradication, allergen control, or one (1) time cleaning, prior to occupancy,
- d) All transition services are essential to:
- 1) Ensuring that the individual is able to transition from the current nursing facility, and
 - 2) Removing an identified barrier or risk to the success of the transition to a more independent living situation.
- e) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

B. Beneficiaries who choose to reside in a licensed/unlicensed Personal Care Home may not receive Elderly & Disabled Waiver services.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); 42 CFR 431.53; 42 CFR 440.170(a); 42 CFR 440.180

Rule 1.7: Prior Approval/Physician Certification

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain

approval, the waiver provider must complete and submit current Division of Medicaid approved forms as follows:

1. Pre-Admission Screening (PAS),
 2. Web Plan of Care,
 3. Stand Alone Plan of Care,
 4. Admitted and Discharged Form,
 5. Completed Informed Choice form,
 6. Section 10/Certification Page Signed and dated by the Physician, and
 7. Electronic Summary.
- B. An eligible beneficiary must be locked into only one (1) program at a time. Any request to add or increase skilled services listed on the approved plan of care must receive prior approval.

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

Rule 1.8: Documentation/Record Maintenance

- A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the waiver.
- B. In addition, waiver providers must submit copies of all service logs/documentation of visits, along with a copy of their billing for each waiver beneficiary served, to the individual's case manager no later than the fifteenth (15th) of the following month in which the service was rendered. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.9: Beneficiary Cost Sharing

Beneficiaries enrolled in waiver programs are exempt from co-pay for waiver services. Refer to Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 447.50 – 447.59; Social Security Act 1902(a)(14)

Rule 1.10: Reimbursement

- A. Requests for reimbursement for waiver services must be withheld until the first (1st) day of the month following the month in which services were rendered.

B. Extended Home Health services will be paid in accordance with the Home Health reimbursement rules.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15)

Rule 1.11: Due Process Protection

A. The Case Manager must provide written notice to the beneficiary when any of the following occur:

1. Services are reduced,
2. Services are denied, or
3. Services are terminated.

B. The recourse/appeal procedure notice, E&D Waiver or Notice of Action, must contain the following information:

1. The dates, type, and amount of services requested,
2. A statement of the action to be taken,
3. A statement of the reason for the action,
4. A specific regulation citation which supports the action,
5. A complete statement of the beneficiary/authorized representative's right to request a fair hearing,
6. The number of days and date by which the fair hearing must be requested,
7. The beneficiary's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesperson, and
8. The circumstances under which services may be continued if a hearing is requested.

C. Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.307; 42 CFR 431.210; 42 CFR 431 Subpart E

Rule 1.12: Hearings and Appeals

- A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the beneficiary/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.
- B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations or sexual harassment by the service providers. The case manager will maintain responsibility for ensuring that the beneficiary receives all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431 Subpart E; 42 CFR 441.308

Part 208 Chapter 2: HCBS Independent Living Waiver

Rule 2.1: General

- A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.
- B. The IL HCBS Waiver is operated jointly with the Mississippi Department of Rehabilitation Services and services are available statewide.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); Section 1915(c) of the Social Security Act, 42 CFR §440.180(b)(9)

Rule 2.2: Eligibility

- A. Eligibility is limited to individuals age sixteen (16) or older who have severe orthopedic and/or neurological impairments and possess maximum medical improvement potential. Maximum medical improvement potential, as defined by the Division of Medicaid, has been achieved when all of the following criteria are met:
 - 1. Beneficiary is able to communicate effectively with caregivers, personal care attendants (PCAs), counselors, case managers and others.
 - 2. Beneficiary is certified as medically stable by their physician. Medicaid defines medical stability as the absence of all of the following:
 - a) An active, life-threatening condition,
 - b) Intravenous drip to control or support blood pressure,
 - c) Intracranial pressure or arterial monitoring, and

- d) A diagnosis of dementia, Alzheimer's, mental illness, mental retardation or any related condition of such severity that renders the individual unable to direct his/her own care.

B. Individuals must also qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):

1. SSI,
2. Low Income Families and Children Program,
3. Disabled Child Living at home program,
4. Children Under Age nineteen (19) Under 100% of poverty,
5. Disabled Adult Child,
6. Protected Foster Care Adolescents,
7. CWS Foster Children and Adoption Assistance Children,
8. IV-E Foster Children and Adoption Assistance Children, or
9. 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.

Source: Miss. Code Ann. § 43-13-121; §53-13-115; Social Security Act 1915(c)

Rule 2.3: Covered Services

A. The Division of Medicaid covers the following Independent Living Waiver services:

1. Case Management services: These services must be provided by Mississippi Department of Rehabilitation Services (MDRS) IL counselors/registered nurses who meet minimum qualifications listed in Part 208, Chapter 1.
2. Personal Care Attendant (PCA) services
 - a) Services must be provided in accordance with the approved plan of care and may not be purely diversional in nature. Services must include:
 - 1) Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living.

- 2) Assistance with preparation of meals, but not the cost of the meals.
 - 3) Housekeeping chores essential to the health of the beneficiary, when specified in the approved plan of care.
- b) Beneficiaries shall choose a personal care attendant with whom they are comfortable providing their personal care or choose from a list of available, eligible/qualified personal care attendants. Personal care attendant must meet all requirements set forth in Part 208, Chapter 1 or he/she must be trained and determined competent by MDRS. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS IL counselors and registered nurses shall certify and document that the PCA meets the requirements.
 - c) Family members providing personal care services must not be legally responsible for the individual. The Division of Medicaid defines legally responsible for an individual as the parent or step-parent, of a minor child, an individual's spouse, the executor of an individual's estate and/or person with durable/medical power of attorney for the individual. Family members must meet provider standards and must be certified competent by MDRS to perform the required tasks by the beneficiary and the IL counselor/registered nurse. There must be documented justification for the relative to function as the attendant.
 - d) A PCA must be chosen within six (6) months of admission into the waiver, or the participant will be discharged. Discharged information that includes other waiver opportunities and community resources available shall be provided to the participant prior to discharge.
3. Specialized Medical Equipment and Supplies
- a) The need for use of such items must be documented in the assessment/case file and approved on the plan of care.
 - b) Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under Medicaid. Items not of direct medical or remedial benefit to the beneficiary are excluded.
 - c) Equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver document.
 - d) Requests for specialized medical equipment/supplies must be evaluated by the MDRS counselor and/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 plan of care and the request for equipment and/or specialized medical supplies for approval.

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

4. Transition Assistance Services

a) Transition Assistance services include the following:

- 1) Security deposits required to obtain a lease on an apartment or home.
- 2) Essential furnishings defined as a bed, table, chairs, window blinds, eating utensils, and food preparation items. 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 defined as 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) for the one (1) time initial expense per lifetime. These expenses must be included in the approved plan of care.

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

- 1) Be a nursing facility resident whose nursing facility 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;
- 4) Be moving to a residence where these items/services are not normally furnished.

d) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

5. Environmental Accessibility Adaptations

a) Environmental accessibility adaptations must be included in the approved plan of care.

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 adaptation must be evaluated by the MDRS counselor and/or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for environmental accessibility adaptation.
- e) Providers rendering environmental accessibility adaptation services must:
- 1) Meet all state or local requirements for licensure/certification.
 - 2) Provide services in accordance with applicable state housing and local building codes.
 - 3) Ensure the quality of work provided meets standards identified in the waiver.
- f) MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §440.180; 43-13-117(15)

Rule 2.4: Prior Approval/Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility that requires the beneficiary need nursing home level of care.
- B. Clinical eligibility for waiver services will be determined through the utilization of a comprehensive Pre-Admission Screening.
- C. The physician must certify the level of care.

- D. A Plan of Care must be developed by the case manager and, in conjunction with the Pre-Admission Screening shall contain objectives, types of services to be furnished, and frequency of services.
- E. The Pre-Admission Screening (PAS) and the Plan of Care must be completed jointly by the IL counselor and registered nurse.
- F. The Plan of Care must be completed by the IL counselor or the registered nurse at certification.
- G. After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS, the application along with the Plan of Care (POC), must be submitted to the Division of Medicaid for approval.
- H. A beneficiary can only be enrolled in one (1) HCBS waiver program at a time.
- I. Request to add or change services listed on the approved plan of care requires prior approval.
- J. For continued services, IL Waiver participants must be recertified annually.

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

Rule 2.5: Freedom of Choice

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(123)

Rule 2.6: Quality Management

- A. Waiver providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services (CMS).
- B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.
- C. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

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

Part 208 Chapter 3: HCBS Assisted Living Waiver

Rule 3.1: General

- A. Medicaid covers certain HCBS services as an alternative to institutionalization in a nursing facility through the Assisted Living Waiver.
- B. The AL Waiver is administered and operated by the Division of Medicaid.

Source: Miss. Ann. Code §43-13-121; Social Security Act 1915(c); 42 CFR 440.180

Rule 3.2: Eligibility

Eligibility requirements for the Assisted Living Waiver Program include the following:

- A. Beneficiary must be twenty-one (21) years of age or older;
- B. Beneficiary must require nursing facility level of care as determined by a standardized comprehensive preadmission screening; and
- C. Beneficiary must be in the SSI Category of Eligibility (COE) 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.

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

Rule 3.3: Provider Enrollment

- A. To become a HCBS/Assisted Living Waiver Provider, the prospective provider must:
 - 1. Submit a provider proposal packet complete with all necessary information.
 - 2. Submit a copy of the current and active license/certification to function as a Personal Care Home –Assisted Living Facility (PCH-AL).
 - 3. Successfully pass a facility inspection by a Division of Medicaid inspector.
 - 4. Satisfy all criteria and requirements for enrollment as a Medicaid provider in accordance with Part 208, Chapter 1, Rule 1.1, upon completion of items 1-3 in this rule.

Source: Miss. Code Ann. § 43-13-121; §43-11-13; §43-11-5; 42 CFR 455, Subpart E

Rule 3.4: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.

- B. Each individual found eligible for the waiver will be given free choice of all qualified providers.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902(a)(23)

Rule 3.5: Prior Approval/Physician Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. Prior Approval is based on clinical eligibility.
- B. Clinical eligibility for waiver services will be determined through the utilization of a comprehensive Pre-Admission Screening. The physician must provide a signature certifying the level of care meets nursing home level of care. For continued services in the AL Waiver, clinical eligibility must be determined annually using the same preadmission screen.
- C. The Plan of Care form must be completed by the case manager and approved by the Division of Medicaid prior to enrollment into waiver services.
- D. A beneficiary may be locked into only one (1) waiver program at a time.

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

Rule 3.6: Covered Services

- A. The Assisted Living Waiver provides Case Management Services - Case managers must be 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 clients.
- B. Assisted Living Services include the following:
 - 1. Personal care services rendered by personnel of the licensed facility.
 - 2. Homemaker services.
 - 3. Chore services.
 - 4. Attendant care services.
 - 5. Medication oversight/administration personnel must operate within the scope of applicable licenses and/or certifications.
 - 6. Therapeutic, social, and recreational programming services.
 - 7. Intermittent skilled nursing services and interventions must be ordered by the physician.

8. Transportation services:
 - a) Must be specified in the Plan of Care for transporting beneficiaries to medical appointments.
 - b) Transportation services shall be provided by the PCH-AL or through the Division of Medicaid Non-Emergency Transportation (NET) program. Services through NET are available only when the beneficiary has not reached the maximum services limits.
9. The PCH-AL facility must have an electronic emergency attendant call system.
 - a) The attendant call emergency response system is available to the following:
 - 1) Beneficiaries who are at risk of falling;
 - 2) Beneficiaries at risk of becoming disoriented; or
 - 3) Beneficiaries experiencing some disorder that puts them in physical, mental or emotional jeopardy.
 - b) This service 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.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.301, 42 CFR 431.53; 42 CFR 440.170(a); 42 CFR 440.180

Rule 3.7: Quality Management

- A. Waiver providers must meet applicable service specifications, see Part 208, Chapter 1.
- B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to Division of Medicaid.
- C. The quality management strategy for the waiver includes the following:
 1. Level of care need determination consistent with the need for institutionalization.
 2. Plan of care consistent with the beneficiary's needs.
 3. Providers who meet the provider specifications of the CMS approved waiver, including licensure/certification requirements.
 4. Critical event/incident reporting mechanism for beneficiaries and caregivers, to ensure proper reporting concerns/incidents of abuse, neglect, and exploitation.

5. The Division of Medicaid maintains retention of administrative authority over the waiver program.
 6. The Division of Medicaid maintains financial accountability for the waiver program.
- D. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.302

Rule 3.8: Documentation and Record Maintenance Requirements:

- A. Providers participating in the HCBS/Assisted Living Waiver program are required to:
1. Maintain legible, accurate, and complete records.
 2. Disclose and justify the services rendered and billed under the program.
 3. Make these records available, upon request, to representatives of the Division of Medicaid in substantiation of any and all claims. Maintain these records for a minimum of six (6) years.
 4. Maintain statistical and financial data supporting a cost report for at least five (5) years from the date the cost report, or amended cost report or appeal, is submitted to the Division of Medicaid.
 5. Documentation/record maintenance for reimbursement purposes must reflect procedures set forth in the waiver Quality Assurance Standards for each service.
 6. PCH-AL facility providers are required to submit copies of all service logs/documentation of visits, along with a copy of their billing for each waiver beneficiary served, to the individual's case manager no later than the 15th of the following month in which the service was rendered.
- B. Providers must satisfy all requirements for maintenance of records outlined in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 3.9: Beneficiary Cost Sharing

For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver. If services are being paid through regular Mississippi Medicaid, the co-payment is applicable unless exempt by one (1) of the beneficiary groups or services stated in Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 447.50 – 447.59; Social Security Act 1902 (a)(14)

Rule 3.10: Reimbursement

- A. Reimbursement for PCH-AL facility services can be requested no earlier than the first day of the month following the month in which services were rendered.
- B. Reimbursement for PCH-AL facility services is only for those services provided within the facility. Mississippi Medicaid does not reimburse for room and board.
- C. Transportation is an integral part of PHC-AL services and is not reimbursed separately.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15)

Rule 3.11: Hearings and Appeals for Denied/Terminated Services

- A. Decisions made by the Division of Medicaid that result in services being denied, or terminated, may be appealed in accordance with Part 300 of this Code.
- B. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.308; 42 CFR 441.307; 42 CFR 431.210

Part 208 Chapter 4: HCBS Traumatic Brain Injury/Spinal Cord Injury Waiver

Rule 4.1: General

- A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver. Waiver services are available statewide.
- B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and MDRS.

Source: Miss. Code Ann. § 43-13-121; Section 1915(c) of the Social Security Act, 42 CFR §440.180

Rule 4.2: Eligibility

- A. Eligibility is limited to individuals with the following disease(s) or condition(s):
 - 1. 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.

2. 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.
- B. The extent of injury must be certified by the physician.
- C. 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.
- D. Individuals must be certified as medically stable by their physician. The Division of Medicaid defines medically stable as the absence of all of the following:
1. An active, life threatening condition.
 2. Intravenous drip to control or support blood pressure.
 3. Intracranial pressure or arterial monitoring.
- E. Individuals must qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):
1. SSI,
 2. Low Income Families and Children Program,
 3. Disabled Child Living at home program,
 4. Working Disabled,
 5. Children under age nineteen (19) under 100% of poverty,
 6. Disabled Adult Child,
 7. Protected Foster Care Adolescents,
 8. CWS Foster Children and Adoption Assistance Children,
 9. IV-E Foster Children and Adoption Assistance Children, or
 10. An aged, blind, or disabled individual who meets all factors of eligibility if their 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.

Source: Miss. Code Ann. § 43-13-121; §43-13-115; 42 CFR 441.301 (b)(6); 42 CFR 440.180

Rule 4.3: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
- B. Personal care services may be furnished by family members provided they are not legally responsible for the individual.
 - 1. The Division of Medicaid defines a person legally responsible for an individual as the parent, or step-parent, of a minor child or an individual's spouse.
 - 2. Family members must meet provider standards and must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.
 - 3. There must be adequate justification for the family member to function as the attendant.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

Rule 4.4: Quality Assurance Standards

- A. Waiver providers must meet applicable quality assurance standards.
- B. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

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

Rule 4.5: Covered Services

- A. The Division of Medicaid covers the following TBI/SCI Waiver services:
 - 1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver and other services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.
 - a) Case Management services must be provided by Mississippi Department of Rehabilitation Services (MDRS) TBI/SCI counselors/registered nurses who meet minimum qualifications listed in the waiver.
 - 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.

- 2) Provide ongoing monitoring of the services included in the beneficiary's plan of care.
 - 3) Develop, review, and revise the plan of care at intervals specified in the waiver.
 - 4) Conduct monthly contact and quarterly face-to-face visits with the beneficiary.
 - 5) Document all contacts, progress, needs, and activities carried out on behalf of the beneficiary.
2. Attendant Care services are defined as support services provided to assist the beneficiary in meeting daily living needs and to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.
- a) Attendant Care is non-medical, hands-on care of both a supportive and health related nature and does not entail hands-on nursing care.
 - b) Services must be provided in accordance with the approved plan of care and is not purely diversional in nature.
 - c) Services may include, but are not limited to the following:
 - 1) Assistance with activities of daily living defined as assistance with eating, bathing, dressing, and personal hygiene.
 - 2) Assistance with preparation of meals, but not the cost of the meals.
 - 3) Housekeeping chores essential to the health of the beneficiary including changing bed linens, cleaning the beneficiary's medical equipment and doing the beneficiary's laundry.
 - 4) Assistance with community related activities including escorting the beneficiary to appointments, shopping facilities and recreational activities. The cost of activities or transportation is excluded.
 - d) Attendant Care providers must meet minimum requirements as specified in the waiver. MDRS TBI/SCI counselors and registered nurses are responsible for certifying and documenting that the provider meets the training and competency requirements as specified in the current waiver document.
 - e) Attendant Care services may be furnished by family members provided they are not legally responsible for the individual.
 - 1) The Division of Medicaid defines legally responsible for an individual as the

parent (or step-parent) of a minor child or an individual's spouse.

- 2) Family members must meet provider standards and they must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.
 - 3) There must be documented justification for the relative to function as the attendant.
3. Respite services are defined as services to assistance beneficiaries unable to care for themselves. Respite care is furnished on a short-term basis because of the absence of, or the need to provide relief to, the primary caregiver(s).
 - 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 Department of Rehabilitation Services.
 4. Specialized medical equipment and supplies are defined as devices, controls, or appliances that will enhance the beneficiary's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.
 - a) The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.
 - b) Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under Medicaid.
 - c) Items not of direct medical or remedial benefit to the beneficiary are excluded.
 - d) Equipment and supplies must meet the applicable standards of manufacture, design, and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.
 5. Environmental Accessibility Adaptation is defined as those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence, and without which, the beneficiary would require institutionalization.
 - a) The need for these adaptations must be identified in the approved plan of care.
 - b) Environmental accessibility adaptations include the following:

- 1) Installation of ramps and grab bars the widening of doorways.
 - 2) Modification of bathroom facilities.
 - 3) 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) Providers rendering environmental accessibility adaptations must:
- 1) Meet all state or local requirements for licensure of certification.
 - 2) Provide services in accordance with applicable state housing and local building codes.
 - 3) Ensure the quality of work meets standards identified in the waiver.
- e) MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.
6. Transition Assistance services are defined as services provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the TBI/SCI Waiver program.
- a) Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars (\$800.00) for the one (1) time initial expense per lifetime. The expenses must be included in the approved plan of care.
 - b) To be eligible for Transition Services, the beneficiary must meet all of the following criteria:
 - 1) Be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid.
 - 2) Have no other source to fund or attain the necessary items/support.
 - 3) Be moving from a nursing facility where these items/services were provided.
 - 4) Be moving to a residence where these items/services are not normally furnished.

- c) Transition Assistance Services include the following:
 - 1) Security deposits required to obtain a lease on an apartment or home.
 - 2) Essential furnishings defined as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Televisions and 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 defined as pest eradication, allergen control, or one-time cleaning prior to occupancy.
- d) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15); 42 CFR 440.180

Rule 4.6: Prior Approval/Certification

- A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility.
- B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.
- C. The physician must certify the level of care.
- D. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. A 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.
- E. The Plan of Care must be developed by the case manager and, in conjunction with the Pre-Admission Screening, should contain objectives, types of services to be furnished, and frequency of services.
- F. After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, the application along with the Plan of Care (POC) must be submitted to the Division of Medicaid for approval.
- G. At the time of the initial certification, the Pre-Admission Screening and the Plan of Care must be completed jointly by the TBI/SCI counselor and registered nurse.

- H. At the time of recertification, the Plan of Care must be completed by the IL counselor or the registered nurse.
- I. A beneficiary can only be enrolled in one HCBS waiver program at a time.
- J. Request to add or change services listed on the approved plan of care requires prior approval.

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

Rule 4.7: Documentation and Record Keeping

- 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, Ch.1, Rule 1.3.
- B. Waiver providers must submit copies of all service logs/documentation of visits.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 4.8: Beneficiary Cost Sharing

- A. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver.
- B. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(14)

Rule 4.9: Reimbursement

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Due Process Protection

Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

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

Rule 4.11: Hearings and Appeals

- A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed.
 - 1. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.
 - 2. All appeals must be in writing.
- B. The beneficiary/legal representative is entitled to initially appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor.
- C. If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid no later than five (5) days after notification of the state level appeal.
- D. The Division of Medicaid must assign a hearing officer.
- E. The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case and the beneficiary/legal representative will receive written notification of the decision.
- F. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations, or sexual harassment by the service providers. The TBI/SCI counselor/registered nurse is responsible for ensuring that the beneficiary, receive all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.210; 42 CFR 441.307; 42 CFR 441.308

Part 208 Chapter 5: HCBS Intellectual Disabilities/Developmental Disabilities Waiver

Rule 5.1: Eligibility

- A. The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) through its Intellectual Disability/Developmental Disability (ID/DD) Waiver.
 - 1. The ID/DD HCBS Waiver offers broad discretion, not generally afforded, so that the needs of individuals under the State Medicaid Plan may be addressed.

2. The ID/DD HCBS Waiver is operated jointly with the Mississippi Department of Mental Health.
3. ID/DD HCBS Waiver services are available statewide.
4. ID/DD Waiver carries no age restrictions.
5. A beneficiary may be enrolled in only one (1) HCBS Waiver program at a time.

B. All the following eligibility requirements must be met to receive ID/DD Waiver services:

1. An individual must have one (1) of the following:
 - a) An intellectual disability is defined by the Division of Medicaid as an individual with all the following:
 - 1) An IQ score of approximately seventy (70) or below;
 - 2) A determination of deficits in adaptive behavior; and
 - 3) Manifestation of disability prior to the age of eighteen (18).
 - b) A developmental disability is defined by the Division of Medicaid as a severe, chronic disability which is a condition attributable to cerebral palsy, 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.
 - 1) The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely.
 - 2) The condition results in substantial functional limitations in three (3) or more of the following major life activities:
 - i) Self-care,
 - ii) Understanding and use of language,
 - iii) Learning,
 - iv) Mobility,
 - v) Self-direction, or
 - vi) Capacity for independent living and economic self-sufficiency.

- 3) The individual also 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 an extended duration.
 - 4) An exception to this definition is 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 above criteria if, without services and supports, there is a high probability of meeting those criteria later in life.
- c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. Applicant must require a level of care found in an ICF/MR.
 3. Applicant must qualify for full Medicaid benefits in one of the following categories:
 - a) SSI,
 - b) Low Income Families and Children Program,
 - c) Disabled Child Living at Home Program,
 - d) Working Disabled,
 - e) Children Under Age Nineteen (19) Under 100% of Poverty,
 - f) Protected Foster Care Adolescents,
 - g) CWS Foster Children and Adoption Assistance Children,
 - h) IV-E Foster Children and Adoption Assistance Children,
 - i) Child under Age six (6) at 133% Federal Poverty Level, or
 - j) An aged, blind, or disabled individual whose income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.180; Social Security Act 1915 9(b)(c)

Rule 5.2: Provider Enrollment

- A. Division of Medicaid ID/DD Waiver providers must be certified by the Mississippi Department of Mental Health (DMH), Bureau of Intellectual Disabilities and Developmental Disabilities (DMH/BIDD) except for the providers listed below. DMH/BIDD Certification is dependent upon compliance with the Mississippi Department of Mental Health Standards.
- B. The provider must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the ID/DD Waiver services and have a current Mississippi Medicaid provider number. The following providers are not required to have DMH certification:
 - 1. Occupational therapist (OT),
 - 2. Speech-language therapist (ST),
 - 3. Physical therapist (PT), or
 - 4. Durable Medical Equipment (DME).
- C. All providers must comply with the CMS approved ID/DD Waiver.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 5.3: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
- B. When it is determined that a beneficiary is likely to require a level of care provided in the Waiver, the beneficiary/legal representative must 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.
- C. The choice made by the beneficiary/legal representative must be documented and signed by the beneficiary/legal representative and must be maintained in the ID/DD Waiver case record.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.302 (d); Social Security Act 1902 (a)(23)

Rule 5.4: Level of Care Evaluation/ Reevaluation and Participant Certification/Recertification

- A. All level of care (LOC) evaluations and reevaluations must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the Department of Mental Health's five (5) comprehensive regional centers. All members of the teams must be state employees and meet the Mississippi State Personnel Board's minimum requirements for hire.

B. Initial LOC evaluations:

1. Must be conducted in an interdisciplinary team format which must include a psychologist, psychometrist, speech pathologist, and social worker.
 - a) Other disciplines may participate, as needed, based on the applicant's needs.
 - b) The educational/professional qualifications for evaluators conducting the initial level of care evaluation are the same for ID/DD Waiver and ICF/MR services.
 - c) All team members must be appropriately licensed/certified under State law for their respective disciplines.
2. For both ID/DD Waiver and institutionalized individuals the Pre-Admission Screening (PAS) system must be completed.
 - a) The specific battery of standardized diagnostic and assessment instruments chosen for initial evaluations are based on each individual, depending on factors as communication and motor skills.
 - b) Evaluators must choose instruments which, in their professional opinion, will most accurately assess the individual's level of function in all areas of development.
 - c) There is not a single instrument/tool used to determine if an individual meets the requirements for ICF/MR level of care.
3. The D&E team must complete the Inventory for Client and Agency Planning (ICAP) to establish a general baseline for reevaluations.

C. Reevaluations of level of care must be conducted at least annually by the ID/DD Waiver Support Coordinators.

1. All reevaluations must be reviewed by ID/DD Waiver Support Coordination Directors prior to submission to DMH/BIDD for review and approval or denial.
2. The reevaluation LOC differs from the initial LOC evaluation in that a battery of standardized assessments is not administered.
3. The continuing need for ID/DD Waiver services is verified by:
 - a) Conducting a new ICAP and comparing the scores from year to year.
 - b) An ongoing evaluation of the individual's needs and use of ID/DD Waiver services.
4. If there is a significant change in the ICAP scores, the D&E team must conduct a review to determine if the individual's level of care needs have changed.

- D. All participants must be initially certified by DMH as needing ICF/MR level of care before services provided through the ID/DD Waiver can begin. Participants must be recertified by DMH at least every twelve (12) months thereafter to continue receiving ID/DD Waiver services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.180; Social Security Act 1915 (b)(c)

Rule 5.5: Covered Services

- A. ID/DD Waiver services must 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).
- B. The ID/DD Waiver offers the following services:
1. Support Coordination as defined by the Division of Medicaid to include 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.
 2. Respite Care is defined by the Division of Medicaid 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.
 - a) The respite worker provides the care in which the caregiver would normally provide during that time and may accompany the participant on short outings such as those for exercise, recreation or shopping.
 - b) 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.
 - c) 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, Physical Therapy, Speech Therapy, Speech Therapy (PT/OT/ST) and/or Behavior Support Intervention.
 - d) Residential habilitation participants who live in group homes or staffed, residences and participants who live alone cannot receive in-home or community respite.
 - e) In-home and community respite services include medication administration and other medical treatments to the extent permitted by State law.
 - f) Training is not provided as a component part of in-home and community respite.

- g) 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.
 - h) Respite services must 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 services must be provided in the participant's home by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), or a Certified Nursing Assistant (CNA).
 - i) 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.
 - ii) A Certified Nurse's Aide may provide in-home respite services if those services do not require a licensed nurse to provide them. CNA's must be employed by an agency certified by MDH and enrolled as an ID/DD Waiver provider. CNA's must be supervised by an RN.
 - iii) If in-home services are provided to more than one (1) participant in the same residence, both participants must be immediately related as defined by the Division of Medicaid as siblings or parent/sibling. The provider must bill separately for each participant.
 - iv) The provider must not run personal errands while caring for the participant. Services must not be provided in the home of the respite worker, only in the home of the individual receiving the services.
 - j) Community Respite services must be provided in a community setting.
 - i) Community Respite cannot be provided overnight and cannot be provided in a private residence.
 - ii) Community Respite cannot be used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adults, or Prevocational Services.
 - k) ICF/MR Respite services must be provided in a state-licensed ICF/MR facility. ICF/MR respite cannot exceed-thirty (30) days per certification period.
3. Residential Habilitation is defined, by the Division of Medicaid, 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.

- a) Staff must be available on site twenty-four (24) hours per day seven (7) days per week and must be able to respond to requests for assistance within five (5) minutes.
 - b) The provider must provide 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.
 - c) The provider must oversee the participant's health care needs by assisting with:
 - 1) Making medical appointments;
 - 2) Transporting and accompanying the participant to appointments; and
 - 3) Talking with medical professionals, if the participant gives permission to do so.
 - d) 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.
 - e) Transportation service is a component part of Residential Habilitation and is included in the reimbursement rate. Providers cannot bill separately for transportation services and must not charge participants for these services. Services include transportation:
 - 1) To and from job sites;
 - 2) For shopping or other community activities;
 - 3) To leisure events; and/or
 - 4) To appointments.
 - f) 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.
4. Day Services-Adults is defined, by the Division of Medicaid, 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 acquisition of skills, greater independence and personal choice.

- a) Services must take place in a non-residential setting, separate from the home or facility in which the participant resides.
 - b) Services must be 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.
 - c) Services cannot exceed one hundred thirty (130) hours per month.
 - d) Meals provided as part of this service do not constitute a "full nutritional regimen," but the program must provide a mid-morning snack, a nutritious noon meal, an afternoon snack, and offer choices of food and drink.
 - e) Participants with degenerative conditions and/or those who have chosen to retire can receive services that include supports designed to maintain skills and prevent or slow regression.
 - f) Participants receiving services can 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 can be received during the same time period, but participants may receive multiple services on the same day.
 - g) Services must be provided in DMH certified sites and/or in community settings.
 - h) Transportation between the participant's place of residence and the service site for community outings must be provided as a component part of Day Services-Adults.
 - 1) The cost of transportation is included in the rate paid to providers.
 - 2) 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-Adults.
5. Prevocational Services are defined, by the Division of Medicaid, as services to prepare a participant for paid employment. Services address underlying habilitative goals 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.
- a) Services must be reflected in the participant's Prevocational Service Plan and are directed to habilitative rather than explicit employment objectives.
 - b) Services must not exceed one hundred thirty (130) hours per month.
 - c) 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).

- d) 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.
 - e) Personal care/assistance may be a component of Prevocational Services, but it must not comprise the entirety of the service.
 - f) Participants who receive Prevocational Services must be compensated in accordance with applicable federal laws and regulations.
 - g) 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.
 - h) Participants receiving Prevocational Services may also receive educational, Supported Employment and/or Day Services-Adults.
 - i) 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 cannot bill separately for transportation services and must not charge participants for these services.
6. Supported Employment services are defined, by the Division of Medicaid, as 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.
- a) Supported Employment may include assisting the participant to locate a job or develop a job on the participant's behalf.
 - b) Supported Employment also includes services and supports to assist the participant in achieving self-employment to include the following:
 - 1) Aiding the participant in identifying potential business opportunities.
 - 2) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business.
 - 3) Identifying supports necessary for the participant to successfully operate the business.
 - 4) On-going assistance, counseling and guidance once the business has launched.

- c) Supported Employment services must be provided at work sites where persons without disabilities are employed and 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.
 - d) 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.).
 - e) Personal care/assistance may be a component of Supported Employment, but it must not comprise the entirety of the service.
 - f) Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities.
 - g) Medicaid funds will not be used to defray the expenses associated with starting or operating a business.
 - h) 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 can be received during the same time period, but a participant can receive multiple services on the same day, except Behavior Support/Intervention services which be provided simultaneously with Supported Employment.
 - i) Transportation between the participant's residence and/or other habilitation sites and the employment site is a component part of Supported Employment.
 - 1) The cost of transportation is included in the rate paid to the provider.
 - 2) Providers cannot bill separately for transportation services and should not charge participants for these services.
7. Home and Community Supports (HCS) are defined, by the Division of Medicaid, as 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 must also provide safe access to the community. HCS must be provided in a participant's private residence and/or community settings.
- a) Services include the following:
 - 1) Hands-on assistance or cuing/prompting the participant to perform a task.

- 2) Accompanying and assisting the participant in accessing community resources and participating in community activities.
 - 3) Medication administration and other medical treatments to the extent permitted by current State law.
 - 4) Supervision and monitoring in the participant's home, during transportation, and in the community setting.
 - 5) Provision for 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 cannot comprise the entirety of the service.
 - 6) Assistance with money management, but not receiving or disbursing funds on behalf of the participant.
 - 7) Grocery shopping, meal preparation and assistance with feeding, not to include the cost of meals themselves.
- b) HCS cannot be provided in school or be used as a substitute for educational services.
 - c) HCS must be provided on an episodic or regularly scheduled basis.
 - d) HCS cannot be provided to a participant who lives in a residential setting or who is an inpatient of a hospital, nursing facility, or ICF/MR, if the facility is billing Medicaid, Medicare, and/or private insurance.
 - e) 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 must 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 the Division of Medicaid Bureau of Program Integrity.
 - f) 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.
8. Behavior Support/Interventions is defined, by the Division of Medicaid, as a service 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 must work directly with the beneficiary and train staff and family members to assist in the implementation of specific behavior support/intervention programs.

- a) Services must not exceed ten (10) hours per year for evaluation and eight hundred (800) hours per year for direct services.
 - b) Services must 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.
 - c) 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.
 - d) Behavior Support/Intervention services include the following:
 - 1) 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.
 - 2) 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.
 - 3) 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.
 - 4) 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.
9. Physical therapy, occupational therapy, and speech-language pathology is covered until the participant reaches maximum health care goals or no longer meets medical necessity criteria for prior authorization/pre-certification.
- a) Therapy services provided through the waiver begin at the termination of State Plan services.
 - b) 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.
 - c) Therapy services are considered to be both cost-effective and necessary to prevent

institutionalization. Services are limited as follows:

- 1) Maximum of three (3) hours per week for speech-language pathology,
 - 2) Maximum of three (3) hours per week for physical therapy, and
 - 3) Maximum of two (2) hours per week for occupational therapy.
- d) Therapy providers must meet state and federal licensing/certification requirements.
10. Specialized Medical Supplies are defined, by the Division of Medicaid, as those supplies available under the waiver to beneficiaries who are not covered for such supplies under regular benefits.
- a) When specialized medical supplies are not available or have been exhausted under the regular services, they are covered through the ID/DD Waiver, if they are on the participant's current approved POC.
 - b) DME providers must meet state and federal licensing/certification requirements.

Source: Miss. Code Ann. § 43-13-121; 20 USC 1401; Social Security Act 1915 (b)(c); 42 CFR 431.53; 42 CFR 440.170(a); 43-13-117(15); 42 CFR 440.180

Rule 5.6: Quality Management Strategy (QMS)

- A. The State is required to make assurances concerning the protection of participant health and welfare, financial accountability, and other elements of Waiver operation.
- B. Discovery, remediation and improvement strategies for the ID/DD Waiver center, primarily on the implementation of the Mississippi Department of Mental Health (DMH) Standards.
 1. 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.
 2. All providers, except PT/OT/ST and DME, 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.
 3. These standards must be implemented and monitored by DMH/BIDD.
- C. Quality Assurance Performance Measurement include all the following:
 1. Level of Care Assurances

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

2. Individualized Plans of Care Assurances

- a) The participant's assessed Waiver and non-Waiver needs including health, safety, and risk factors and personal goals, are addressed in the POC.
- b) The POC is updated/revised at least annually and/or when warranted by changes in the participants needs.
- c) Participants are afforded the choice between Waiver services and institutional care.
- d) Participants are afforded a choice between/among services and providers.
- e) Services are delivered in accordance with the POC, including the type, scope, amount, duration and frequency specified in the POC.

3. Qualified Providers Assurances

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

4. Health and Welfare Assurances

- a) There is continuous, ongoing monitoring of the health and welfare of individuals served through the Waiver and remediation action is initiated when appropriate. When instances of suspected abuse, neglect and exploitation are discovered,

appropriate reports are submitted.

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

5. Financial Accountability Assurances

- a) 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.
- b) The Division of Medicaid ensures financial audits of ID/DD Waiver providers are conducted. When appropriate, immediate action will be taken to address any financial irregularities.

6. Administrative Authority Assurances

- a) The Division of Medicaid 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. The Division of Medicaid 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 Waiver, Division of Medicaid's rules and specifications in the Interagency Agreement.
- b) 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.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1915(b)(c); 42 CFR 441.302

Rule 5.7: Reimbursement

- A. Reimbursement for Waiver services can be requested no earlier than the first (1) day of the month following the month in which services are rendered.
- B. Services can only be provided to participants when authorized by the ID/DD Waiver Support Coordinator as part of the approved Plan of Care.
- C. All ID/DD Waiver providers must be enrolled as a Mississippi Medicaid Provider and must maintain an active provider number.

D. All ID/DD Waiver providers, except those for therapy services and specialized medical supplies, must be certified by DMH.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.180; 43-13-117(15)

Rule 5.8: Critical Events/Incidents and Abuse/Neglect/Exploitation

- A. ID/DD Waiver Support Coordinators and all other DMH providers must receive training at least annually regarding Mississippi's Vulnerable Adults Act. The training must 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 Consumer Supports (OCS).
- B. Every service provider must 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.
1. The procedures must be provided upon admission and at least annually thereafter.
 2. The procedures must be given orally and in writing.
 3. The participant/legal guardian must sign indicating the rights have been given to them in a way that is understandable to them.
 4. The participant/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Supports (OCS) or Disability Rights Mississippi.
 5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the participant/legal representative.
- C. 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.
- D. 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.
- E. Critical events/incidents must be reported to the DMH OCS within twenty-four (24) hours, or

the next business day, by telephone or written report. If the incident is reported by telephone, the provider must submit a completed report within five (5) business days.

- F. DMH/BIDD must submit a summary of critical incidents/events to the Division of Medicaid with each quarterly report.
- G. Certain critical events/incidents involving Waiver participants that must be reported to the OCS and other appropriate authorities within twenty-four (24) hours or the next working day, include, but are not limited to, the following:
 - 1. Suicide attempts on program property or at a program-sponsored event.
 - 2. Suspected abuse/neglect/exploitation, which must also be reported to other authorities in accordance with State law.
 - 3. Unexplained absence from a residential program of twenty-four (24) hour duration.
 - 4. Absence of any length of time from an adult day center providing services to individuals with Alzheimer's disease and/or other dementia.
 - 5. Death of a participant on program property, at a program-sponsored event or during an unexplained absence from a residential program site.
 - 6. Emergency hospitalization or emergency room treatment of a participant receiving ID/DD Waiver services.
 - 7. Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.
 - 8. Disasters including fires, floods, tornadoes, hurricanes, earth quakes and disease outbreaks.
 - 9. Use of seclusion or restraint.
- H. If a Waiver provider has any question whether or not a situation/incident should be reported, the provider must contact DMH/OCS.
- I. 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).
- J. 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.

- K. Suspected abuse/neglect/exploitation that occurs in any Adult Day services facility, which Division of Medicaid defines as 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.
- L. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.
- M. Disease outbreaks at a provider site must be reported to Mississippi State Department of Health (MSDH).

Source: Miss. Code Ann. § 43-13-121; 41-4-7; Social Security Act 1915 (b)(c);

Rule 5.9: Medication Management and Medical Treatments

- A. 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.
 - 1. 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.
 - 2. Nurses cannot provide services independently.
 - 3. 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.
- B. The following practices must be in place to protect the health and safety of a participant who requires medications or medical procedures/treatments:
 - 1. Medications must be stored appropriately in their original containers if a nurse will administer them.
 - 2. Nurses may not prepare medications in a medication planner for a non-licensed provider(s) to dispense in his/her absence.
 - 3. All medications must be documented in the participant's record by the appropriately licensed medical professional administering them.

4. Documentation must reflect if the legal representative administers the participant's medications or if a participant self-administers his/her medications.
 5. Registered nurses must 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 must be reported promptly to an RN or appropriately qualified staff.
 6. The first-line responsibility for monitoring participant medication regimes lies with the licensed medical professional who prescribes the medication. Licensed medical professional is defined by the Division of Medicaid as a physician, physician assistant or certified nurse practitioner, or licensed dentist who meets the state and federal licensing and/or certification requirements.
 7. Second-line responsibility is with the nurse providing services to an ID/DD Waiver participant.
- C. 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, must document the following:
1. Physician visits including the reason for the visit.
 2. Physician instructions/orders.
 3. New prescriptions including any detailed pharmacy information supplied with the prescription.
 4. Any pertinent information regarding the participant's medical status.
- D. All treatment's prescribed by appropriately qualified staff must be provided or administered by a nurse.
1. Documentation must reflect who, including credentials, performs any required medical treatments and an assessment of the treatment.
 2. 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.

Source: Miss. Code Ann. § 43-13-121; 73-15-1 thru 73-15-35

Rule 5.10: Documentation and Record Maintenance

- A. Documentation of each service provided must be in the case record. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.
- B. The entry or clinical note must include all of the following documentation:
 - 1. Date of service,
 - 2. Type of service provide,
 - 3. Time service began and time service ended,
 - 4. Length of time spent delivering service,
 - 5. Identification of participant(s) receiving or participating in the service,
 - 6. Summary of what transpired during delivery of the service,
 - 7. Evidence that the service is appropriate and approved on the Plan of Care, and
 - 8. Name, title, and signature of individual providing the service.
- C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:
 - 1. Documentation requirements in the CMS approved ID/DD Waiver,
 - 2. DMH Standards,
 - 3. Evidence that the service is appropriate and approved on the Plan of Care, and
 - 4. Documentation requirements in the DMH/BIDD Record Guide.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 5.11: Beneficiary Cost Sharing

- A. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver.
- B. If services are being paid through regular Mississippi Medicaid benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; Section 1902(a) (14) of the Social Security Act; 42 CFR 447.50 - 447.

Rule 5.12: Grievances and Complaints

- A. The Department of Mental Health, Office of Consumer Supports (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.
- B. Personnel issues are not within the purview of DMH/OCS.
- C. A toll-free Helpline must be available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.
- D. Calls received through the Helpline are categorized and reported as follows:
 - 1. 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.
 - 2. Calls requesting for 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 must be conducted within two (2) days if the caller has given a call back number.
 - 3. Informal grievances calls are defined, by the Division of Medicaid, 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:
 - a) DMH/OCS notifies the program/facility and a verbal response is requested.
 - b) If the complaint is from a resident of a facility, a patient advocate is notified and a verbal response is requested.
 - c) The caller is notified of the response from the program/facility.
 - d) If necessary, the call is upgraded to Level I formal complaint.
 - e) All information/responses are recorded in the Information and Referral Database.
 - 4. Level I formal complaints are defined, by the Division of Medicaid, as complaints related to certification standards, DMH policy, legal issues and/or Americans with Disabilities Act regulations.

- a) Once the verbal/written complaint has been received, OCS has a maximum of thirty (30) days in which to resolve the complaint.
 - b) The facility/program must be notified by telephone and a copy of the complaint faxed to the facility/program within twenty-four (24) hours.
 - c) The facility/program must submit a written response to OCS within ten (10) calendar days.
 - d) Failure to respond to the complaint is reported to the appropriate Bureau Director and the DMH Division of Accreditation and Licensure.
 - e) Within twenty-four (24) hours of receiving a response from the facility/program, OCS will notify the caller in writing or by telephone.
 - f) If the response is satisfactory to the caller, the case is closed.
 - g) 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.
5. Level II formal complaints are defined by the Division of Medicaid as complaints that are of a serious and urgent nature. The complaint may be received by telephone or in writing. The complaint is processed as follows:
- a) The Level II complaint is logged into the Information and Referral Database.
 - b) 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.
 - c) Staff involved in the alleged incident will be interviewed.
 - d) DMH OCS must send a detailed written report within three (3) days of the on-site investigation.
 - e) A copy of the report will be sent to the facility director, complainant, DMH Bureau Director, and DMH Division of Accreditation and Licensure.

- f) Response to the report is required from the facility (provider) within ten (10) calendar days from the date of the report.
 - g) 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 DMH appeal procedure.
6. Crisis/suicide calls are directed to the designated crisis counselor in the caller's local community mental health center (CMHC). OCS staff must keep the caller on the line until the crisis counselor has intervened or help has arrived. OCS staff must 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, an in progress suicide, OCS staff must immediately notify 911.
7. Serious Incidents - Refer to Part 208, Chapter 5, Rule 5.8.
- E. Anonymous callers cannot file a formal complaint. Concerns will be directed to the person in charge of the facility/program. If more than one (1) anonymous caller complains about the same or similar issues, an on-site investigation may be conducted.
 - F. The Helpline does not accept employee grievances, unless they involve participants. Employee grievances will be directed to the personnel office of the facility/program.
 - G. Request for reports generated through the Information and Referral Database must be made through the appropriate DMH Bureau Director.

Source: Miss. Code Ann. § 43-13-121; Section 41-4-7, parts (q) and (y).

Rule 5.13: Appeals and Hearings

- A. If it is determined that an applicant does not meet ICF/MR level of care at the completion of an initial evaluation by the D&E team, the applicant/legal representative may appeal.
 - 1. 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.
 - 2. 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.
 - 3. 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.

4. 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.
 5. If the Director of BIDD upholds the denial of ICF/MR eligibility the applicant/legal representative will be notified in writing.
 6. 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.
 7. 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.
 8. The applicant/legal representative will receive written notification of the DMH Executive Director's decision. The decision of the DMH Executive Director is final.
- B. Decisions made by the DMH/BIDD that result in services being denied, terminated, or reduced may be appealed.
1. 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.
 2. 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.
 3. 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.
 4. If the Director of BIDD decides to uphold the denial of ICF/MR eligibility the applicant/legal representative will be notified in writing.
 5. 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.
 6. 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.

7. 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.
 8. If requested, the ID/DD Waiver Support Coordinator will prepare a copy of applicable documents in the case record and forward 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.
 9. The Division of Medicaid will assign a hearing officer. The beneficiary/legal representative must 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 must be recorded.
 10. 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, must 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.
- C. Appeal documentation and final determination(s) are filed by DMH/BIDD and the Division of Medicaid/BMHP.
- D. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations or sexual harassment by the service providers. The ID/DD Waiver Support Coordinator is responsible for ensuring that the beneficiary, continues to receive all services that were in place prior to the notice of change.
- E. 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.

Source: Miss. Code Ann. § 43-13-121; Miss Code Ann § 41-4-7; 42 CFR 441.308