

Division of Medicaid	New: X	Date: 03/01/06
State of Mississippi	Revised:	Date:
Provider Policy Manual	Current:	
Section: HCBS-Elderly & Disabled Waiver	Section: 65.01	
Subject: Introduction	Pages: 1	
	Cross Reference:	

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

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

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

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

The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS-Elderly & Disabled Waiver	Section: 65.02 Pages: 1 Cross Reference:	
Subject: Eligibility		

The Elderly and Disabled Waiver provides services to individuals who, but for the provision of such services, would require placement in a nursing facility. It is a statewide program that allows qualified beneficiaries to remain in a home or community-based setting.

Eligibility requirements for the Elderly and Disabled Waiver Program include following:

- Beneficiary must be 21 years of age or older, **AND**
- Beneficiary must have a deficit in at least three (3) activities of daily living, **AND**
- Beneficiary must require nursing facility level of care, if assistance is not otherwise provided, **AND**
- Beneficiary must be aged, blind or disabled and currently qualify for Medicaid due to receipt of SSI cash assistance or qualify for Medicaid based on income that is under 300% of the SSI limit for an individual. Resources must be less than \$4,000.00.

Nursing Home level of care must be certified by a physician. The level of care must be re-evaluated every twelve (12) months at a minimum.

Beneficiaries enrolled in the Elderly & Disabled Waiver are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS-Elderly & Disabled Waiver	Section: 65.03 Pages: 1 Cross Reference:	
Subject: Provider Enrollment		

Providers interested in becoming providers of Elderly and Disabled Waiver services must complete a proposal package and enter into a provider agreement with the Division of Medicaid. Providers interested in becoming a provider of Adult Day Care Services must also undergo a facility inspection.

Proposal Packet

A proposal packet may be obtained through the Division of Medicaid, HCBS section of the Bureau of Long Term Care. Upon completion, the proposal packet must be **mailed** back to the Division of Medicaid, HCBS section of the Bureau of Long Term Care. DOM HCBS staff will review the proposal.

Adult Day Care Services Facility Inspection

Upon completion of the proposal packet for Adult Day Care Services, DOM HCBS staff will inspect the facility to ensure that the facility meets the waiver quality assurance standards.

Mississippi Medicaid Provider Application

When all requirements noted above have been satisfied, DOM HCBS staff will mail a Mississippi Medicaid Provider Application. The completed application must be **mailed** back to the Division of Medicaid, HCBS section of the Bureau of Long Term Care. DOM HCBS staff will review the application. If approved, the application will be forwarded to the Bureau of Provider/Beneficiary Relations for approval. When all approvals have been obtained, the application will be sent to the fiscal agent.

Upon notification that a provider number has been issued, DOM HCBS staff will send a welcome letter to the new provider. The appropriate case manager will be notified to add the provider to the referral list.

Providers may not submit the proposal or the enrollment application for waiver services electronically.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS-Elderly & Disabled Waiver	Section: 65.04 Pages: 1 Cross Reference:	
Subject: Freedom of Choice		

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

Elderly and Disabled Waiver program will not restrict a beneficiary's freedom to choose providers. During the initial enrollment period and upon annual recertification, the beneficiary will be provided with a list of participating waiver providers, and the beneficiary may select the providers they want to deliver services. The beneficiary has the right to modify or cancel services at anytime with the prior approval of the case manager.

When Medicaid waiver beneficiary selects a company that is owned and/or operated by a family member, the services may be delivered by an employee who is a family member provided the following conditions are met:

- The employee (family member) has completed the normal and expected course of training, **and**
- The agency maintains employment records for the employee (family member).

Exception: a family member providing waiver services must be someone not normally considered a caregiver. For example, an adult child may not provide waiver services to a parent.

When the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services as specified in Section 65.12, Due Process Protection.

Division of Medicaid	New: X	Date: 03/01/06
State of Mississippi	Revised:	Date:
Provider Policy Manual	Current:	
Section: HCBS/Elderly & Disabled Waiver	Section: 65.05	
Subject: Referral Process	Pages: 1	
	Cross Reference:	

The number of beneficiaries enrolled in the E&D Waiver program is limited. Availability is based on program attrition/growth. Two waiting lists are maintained for the E&D Waiver program.

PDD E&D Referral List

The Mississippi Planning and Development Districts/Area Agencies on Aging maintain the PDD E&D Referral List for individuals who are not residing in a nursing facility and who wish to apply for the E&D Waiver Program. An individual may apply for waiver services when his/her name rises to the top of the list.

Billy A. Referral List

The Bureau of Long Term Care, Division of Medicaid, maintains the "Billy A. Referral List." An individual on this list must currently reside in a nursing facility, must wish to apply for the E&D Waiver program, and must have answered "yes" to Q1A in the CMS Case Mix Survey for second quarter 2004. An individual may apply for waiver services when his/her name rises to the top of the list. A specific number of the total E&D Waiver slots must be maintained annually for this referral group.

If a qualified Billy A. referral is unable to transition out of the nursing facility to the E&D Waiver within six (6) months and one (1) week of slot availability, the reason will be documented and the referral file may be closed.

Billy A. Referral case files may be closed for any of the following reasons:

- The applicant is unable to transition from the nursing facility to the community at the end of six (6) months and (1) one week following his or her application date.
- It is determined that the applicant is not eligible for Medicaid and/or the E & D Waiver Program.
- The applicant informs DOM HCBS staff that he/she is no longer interested in moving to the community.
- The applicant dies.
- The applicant leaves the nursing facility without assistance from the Mississippi Department of Rehabilitation Services (MDRS)/Office of Special Disability Programs (OSDP).

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS/Elderly & Disabled Waiver	Section: 65.06 Pages: 1 Cross Reference:	
Subject: Prior Approval/Physician Certification		

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 initial approval, the following forms must be submitted:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care

DOM 260 HCBS Physician Certification

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the client meets the medical criteria for nursing facility care. The physician's signature must be dated within thirty (30) days of the submission of the form.

HCBS 305 Assessment

The HCBS 305 Assessment form is completed by the case manager. The tool is used to determine eligibility for case management and services needed to maintain the beneficiary in the home.

DOM 301 HCBS Plan of Care

The DOM 301 HCBS Plan of Care form is completed by the case manager. This form, in conjunction with the HCBS 305 Assessment, contains objectives, types of services to be furnished, and frequency of services.

All three (3) forms must be submitted to the HCBS section of the Bureau of Long Term Care. DOM HCBS staff will review/process the documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. The original DOM 260 HCBS Physician Certification and the DOM 301 HCBS Plan of Care will be returned to the case management provider to retain as part of the case record.

A beneficiary may be locked into only one program at a time. Any request to add or decrease services listed on the approved plan of care requires prior approval.

Division of Medicaid	New: X	Date: 03/01/06
State of Mississippi	Revised:	Date:
Provider Policy Manual	Current:	
Section: HCBS/Elderly & Disabled Waiver	Section: 65.07	
Subject: Covered Services	Pages: 5	
	Cross Reference:	
	Home Health 40.0	

The following services are provided through the Elderly and Disabled Waiver:

- Case Management
- Homemaker
- Adult Day Care
- Institutional or In-Home Respite
- Home Delivered Meals
- Escorted Transportation
- Expanded Home Health Visits
- Transition Assistance

Case Management

Case management services assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services. 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.

Case management services are rendered by teams. Each team is composed of two (2) case managers. One case manager is a Registered Nurse and the other is a Licensed Social Worker. Each team must have an assigned case management supervisor. The case management supervisor should not carry an active caseload of clients.

A case management team should maintain a caseload of no more than 50 beneficiaries. The team of a registered nurse and social worker should maintain a caseload of no more than 100 beneficiaries. If a case manager leaves a team, the remaining case manager should continue to maintain the caseload. Beneficiaries should not be discharged "down to 50" nor should new beneficiaries be added until the team member is replaced. The Case Management Supervisor should document all efforts made to find/hire a new team member.

If a team has a social worker and a nurse, **both** are expected to make each visit. If one 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 (one member) case management teams may also conduct monthly visits, quarterly visits, readmits, and recertification visits alone.

Initial assessments and/or recertification performed by a single member of the team must be reviewed, approved, signed and dated by the case management supervisor on the bottom of the

last page of the assessment. The case management supervisor should write “reviewed and approved” before signing and dating the form. If the documentation by the case manager is inaccurate, incomplete, or otherwise does not meet the supervisor’s approval, the case management supervisor must immediately take appropriate corrective action to obtain the quality of documentation necessary to sustain approval. A copy of the unapproved documentation should be kept in a separate record.

Homemaker Services

Homemaker services are supportive services provided or accomplished primarily in the home by a trained homemaker. Services include education and/or provision of home management tasks to assist in strengthening family life, promoting self-sufficiency, and enhancing quality of life.

The purpose of Homemaker services is to assist functionally impaired persons to remain in their home by providing assistance in the activities of daily living, housekeeping, laundry, meal planning, marketing, food preparation, and other types of home management tasks to prevent the risk of institutionalization.

Homemaker and home health aides must not perform the same services at the same time. (Example: both the homemaker and home health aide cannot give the beneficiary a bath or make the beneficiary’s bed and then bill for the service. **It is recommended that the homemaker and home health aide not be in the client’s home at the same time, and that they perform separate duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance should be thoroughly documented.**

Adult Day Care Services

Adult Day Care is a structured, comprehensive program which provides a variety of health, social and related supportive services in a protected setting during daytime and early evening hours. This community-based service is designed to meet the needs of aged and disabled beneficiaries through an individualized care plan that includes the following:

- Personal care and supervision
- Provision of meals as long as meals do not constitute a full nutritional regimen
- Provision of limited health care
- Transportation to and from the site
- Social, health, and recreational activities

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. Activities that are diversionary in nature are not allowed.

The beneficiary must be at the facility at least four (4) hours per day (but may stay longer if desired), but less than (24) hours per day for Medicaid reimbursement.

Institutional or In-Home Respite Services

Respite Care provides assistance to beneficiaries unable to care for themselves. Care is furnished on a short-term basis because of the absence of, or the need to provide relief to, the primary caregiver(s).

1. Institutional Respite Services

Institutional respite may only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities. 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.

Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

2. In-Home Respite Services

In-Home Respite services are provided to beneficiaries unable to care for themselves. Criteria for in-home respite services include **all** of the following:

- Beneficiary must be home-bound due to physical or mental impairments, **and**
- Beneficiary must require twenty-four (24) hour assistance by the caregiver, i.e., cannot be left alone/unattended for any period of time, **and**
- Caregiver must live in the home and document that the beneficiary has no other family member who is able to assist.

In-Home Respite services are limited to no more than forty (40) hours per month.

Home Delivered Meals

Home Delivered Meals are nutritionally balanced meals delivered to the home of a beneficiary who is unable to leave home without assistance and/or is unable to prepare meals. All eligible beneficiaries may 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 may qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

Home Delivered Meals services are not provided by individual providers. The Area Agencies on Aging provide the services through a contractual agreement with the Division of Medicaid.

Escorted Transportation

Escorted Transportation is provided when the State Plan Non-Emergency Transportation is either not available or inadequate to accommodate the needs of the E&D Waiver beneficiary. Whenever possible, family, neighbors, friends, or community agencies will be utilized in lieu of Escorted Transportation.

Escorted Transportation must be prior approved and arranged by the beneficiary's waiver case manager.

Providers must maintain documentation that includes, at a minimum, the date of services, time of departure from the beneficiary's residence, time of arrival at the destination, number of miles traveled to the destination, time of departure from the location, and time of arrival back at beneficiary's residence. Documentation must be signed and dated by both the provider and the beneficiary.

Expanded Home Health Services

Beneficiaries may receive twenty-five (25) home health visits each fiscal year through the regular Medicaid program. Services must be pre-certified. 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 DOM HCBS Program Nurse.**

Home Health Agencies must follow all rules and regulations set forth in Section 40 of this manual.

The word "waiver" does not apply to anything other than Home Health visits with prior approval of the **DOM HCBS Program Nurse.** The Elderly and Disabled Waiver allows for extended state plan home health services **only after** the 25 visits allowed under the state plan have been exhausted. Waiver beneficiaries are subject to home health co-payment requirements through the 25th visit. Starting with the 26th home health visit, within the state fiscal year, the Waiver beneficiary is exempt from home health co-payment requirements.

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 (DOM) with a copy of its certification and/or recertification, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need approval when applicable, and execute a participation agreement with DOM.

Homemaker and home health aides must not perform the same services at the same time. (Example: both the homemaker and home health aide cannot give the beneficiary's bath or make the beneficiary's bed and then bill for the service. **It is recommended that the homemaker and home health aide not be in the client's home at the same time, and that they perform separate duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance should be thoroughly documented.**

Transition Assistance

Transition Assistance services are services provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the Elderly and Disabled Waiver program. Transition Assistance is a one-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 \$800.00 one-time initial expense per lifetime.**

1. Eligibility

To be eligible for Transition Services the beneficiary must meet **all** of the following criteria:

- Beneficiary must be a nursing facility resident whose nursing facility services are paid for by DOM, **and**
- Beneficiary must have no other source to fund or attain the necessary items/support, **and**
- Beneficiary must be moving from a nursing facility where these items/services were provided, **and**
- Beneficiary must be moving to a residence where these items/services are not normally furnished.

2. Services

Transition Assistance Services include the following:

- Security deposits required to obtain a lease on an apartment or home
- 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)
- Moving expenses
- Fees/deposits for utilities or service access such as telephone, electricity, etc.
- Health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy

3. Exclusions

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

Division of Medicaid	New: X	Date: 03/01/06
State of Mississippi	Revised:	Date:
Provider Policy Manual	Current:	
Section: HCBS/Elderly & Disabled Waiver	Section: 65.08	
Subject: Quality Assurance Standards	Pages: 1	
	Cross Reference:	

Waiver providers must meet applicable quality assurance standards. The standards are part of the waiver document approved by the Centers for Medicare and Medicaid Services.

DOM HCBS staff will send a copy of the Quality Assurance Standards to the prospective waiver provider upon receipt of the proposal packet /enrollment application. In addition, DOM HCBS staff will notify waiver providers when revisions are made to the standards.

Waiver providers are required to report changes in contact information, staffing, and licensure within ten (10) days to DOM HCBS staff. DOM HCBS staff will contact waiver providers annually to verify/update information and to ensure that all services are being provided.

Division of Medicaid	New: X	Date: 03/01/06
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Section: HCBS-Elderly & Disabled Waiver	Section: 65.09	
	Pages: 1	
Subject: Documentation/Record Maintenance	Cross Reference:	

All providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. Statistical and financial data supporting a cost report must be maintained for at least five (5) years from the date the cost report (or amended cost report, or appeal) is submitted to DOM.

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth for applicable waiver Quality Assurance Standards. In addition, waiver 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. The case manager may make an initial verbal request for missing documentation and billing verification from the waiver provider, allowing ten (10) working days for the information to be received. If the information is not provided within the allotted time, the case manager or case management supervisor may make a second verbal request allowing an additional ten (10) working days for the information to be received. If the information is still not received, the third request **must** be made by the case management supervisor in writing and copied to the HCBS Division Director. The written request should reference the dates that the first and second requests were made and the name of the person to whom the request was made. An additional ten (10) days must be allowed for the provider to submit the required missing documentation. The letter should indicate that no further referrals will be made to the provider until all required documentation is received. If the information is still not received, the HCBS Division Director will determine appropriate action.

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

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

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS-Elderly & Disabled Waiver	Section: 65.10 Pages: 1 Cross Reference:	
Subject: Beneficiary Cost Sharing		

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. Beneficiaries enrolled in waiver programs are exempt from co-pay for waiver services. Co-pay is required for services other than waiver services. Refer to Beneficiary Information, Section 3.08, in this manual.

Division of Medicaid	New: X	Date: 03/01/06
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Provider Policy Manual	Current:	
Section: HCBS/Elderly & Disabled Waiver	Section: 65.11	
Subject: Reimbursement	Pages: 1	
	Cross Reference:	
	Home Health 40.12	

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered. (Example: services provided in June, cannot be billed before July 1.)

Covered services under the Elderly & Disabled Waiver are reimbursed according to reimbursement methodology listed below.

Service	Code	Modifier	Billing Unit
Case Management	T2022	U1	Monthly
In-Home Respite	S5150	U1	15 min. unit
Institutional Respite	S5151	U1	Daily
Adult Day Care	S5102	U1	Daily
Homemaker Services	S5130	U1	15 min. unit
Home Delivered Meals	S5170	U1	Per meal
Escorted Transportation	T2001	U1	Hourly
Transition Assistance	T2038	U1	One-time initial expense per lifetime up to \$800.00

Extended Home Health services will be paid in accordance with the Home Health reimbursement policy. Refer to Section 40.12 of this manual.

Division of Medicaid	New: X	Date: 03/01/06
State of Mississippi	Revised:	Date:
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Section: HCBS/Elderly & Disabled Waiver	Section: 65.12	
Subject: Due Process Protection	Pages: 1	
	Cross Reference:	

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

- Services are reduced
- Services are denied
- Services are terminated

The recourse/appeal procedure notice (E&D Waiver Notice of Action) must contain the following information:

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

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.

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Section: HCBS/Elderly & Disabled Waiver	Section: 65.13	
Subject: Hearings and Appeals	Pages: 1	
	Cross Reference:	

Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision. All appeals must be in writing.

The beneficiary/legal representative is entitled to initial appeal at the local level with the case manager/case manager supervisor. The Notice of Action decision will be explained at that time. The local hearing will be documented and become a permanent part of the beneficiary file.

If the beneficiary/legal representative disagrees with the decision of the local case management agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the case management provider will prepare a copy of the case record and forward it to the Division of Medicaid, Bureau of Long Term Care no later than five (5) days after notification of the state level appeal.

The Division of Medicaid, Bureau of Long Term Care will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

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. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. The case manager will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

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