Title 32: REHABILITATION SERVICES
Part 1: OFFICE OF SPECIAL DISABILITY PROGRAMS (OSDP)
Subpart 1: POLICY MANUAL

OFFICE OF SPECIAL DISABILITY PROGRAMS
POLICY MANUAL

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Mission Statement

It is the mission of the Mississippi Department of Rehabilitation Services to provide appropriate and comprehensive services to Mississippians with disabilities in a timely and effective manner. Programs and services assist individuals with disabilities to live independently in their home and community.

Service Limitations Waiver

The OSDP Policy and Procedure Manual establishes guidelines in terms of case service procedures and expenditures. In instances where limitations have been written into policies, OSDP leadership reserves the right to waive any such limitations in order to meet the specific needs of the individual. Any policies other than those set forth by federal and/or state law or regulations are not absolute and may be considered for exceptions or waiver.

SECTION 1: GENERAL POLICIES

1.0 Non-Discrimination

No individual or group of individuals is excluded from or found ineligible of services on the basis of age, color, religion, gender, gender identity, national origin, type of disability, marital status, sexual orientation or military status.

Individuals eligible for services in the State will not be discriminated against based on their geographic residence in Mississippi.

1.1 Confidential Nature of Medical Information (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (PL 104- 191), also known as HIPAA is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is information that identifies or could be used to identify an individual that relates to the:

- Past, present, or future physical mental health or condition of the individual;
- Provision of health care to the individual; or
- Past, present, or future payment for the provision of health care to the individual.

HIPAA also includes provisions for the privacy and security of health information, specifies electronic standards for the transmission of health information and requires unique identifiers for providers.

1.2 Member Authorized or Legal Representative

Members have the right to appoint a designated authorized representative. The authorized

representative is the only person that can permit the use or disclosure or obtain information on behalf of the member.

1.3 Client Assistance Information

MDRS will advise and inform applicants and individuals eligible for services and benefits available under the *Rehabilitation Act of 1973* (*Rehabilitation Act*), as amended by the *Workforce Innovation and Opportunity Act* (*WIOA*), and title I of the *Americans with Disabilities Act of 1990* (*ADA*), including students with disabilities under section 113 and individuals with disabilities employed at subminimum wage under section 511 of the *Rehabilitation Act*. In addition, applicants and eligible individuals may be provided advocacy and representation to ensure their rights in their relationship with projects, programs, and services to protect their rights provided under the *Rehabilitation Act*.

1.4 Abuse, Neglect, Exploitation of a Vulnerable Adult

It is the policy of MDRS that the persons we serve be treated with dignity and respect at all times. This includes the right to be free from psychological and/or physical abuse, neglect, and/or exploitation. Incidents of abuse, neglect, exploitation will be reported to the appropriate entities.

1.5 Accessibility of Individual Identifiable Health Information to the Member

Except as provided elsewhere in this section, if requested in writing by an applicant or eligible individual or representative, MDRS makes all requested information in an individual's record of services accessible to the individual and will release the information to the individual or the individual's representative in a timely manner.

MDRS has established reasonable fees to cover costs of duplicating records or making extensive searches and has established policies and procedures governing access to records.

If duplication of records is requested, by a member or a member's representative, for that member's own use, no fees for reproducing those records shall be charged, unless the volume of such requested information is so extensive as to exceed 20 pages. Should a request for information exceed 20 pages, the Agency employee processing the request shall institute common procedure for such requests by persons authorized to have access to this information by contacting the Office of Finance for the Agency and requesting a "fund number" for receipt of money collected to defray the cost of duplicating the requested records. The employee may then charge the requesting party a fee of $.25 (twenty-five cents) for each page in excess of 20 pages for the information. Payment should be requested in the form of check or money order, payable to the "Mississippi Department of Rehabilitation Services." When funds are collected, a receipt will be issued to the purchaser. A duplicate receipt will be forwarded to the State along with the check or money order. There will be no charge to State or Federal agencies associated in providing services directed toward the member's rehabilitation program, or any other agencies that have an exchange of information agreement with this Agency.

1.6 Releasing Individual Identifiable Health Information That May Be Harmful to the Member

Medical, psychological, or other information that MDRS determines may be harmful to the individual may not be released directly to the individual, but must be provided to an individual, which may include, among others, an advocate, a family member, or a qualified medical or mental health professional, unless a representative has been appointed by a court to represent the individual, in which case the information must be released to the court-appointed representative.

1.7 Releasing Individual Identifiable Health Information Obtained From Other Sources

If personal information has been obtained from another agency or organization, it may be released only by, or under the conditions established by, the other agency or organization.

1.8 Inaccurate or Misleading Individual Identifiable Health Information

An applicant or eligible individual who believes that information in the individual's record of services is inaccurate or misleading may request that the designated Agency amend the information. If the information is not amended, the request for an amendment will be documented in the record of services.

1.9 Release of Information for Audit, Evaluation, and Research

Personal information may be released to an organization, agency, or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the rehabilitation program or for the purposes that would significantly improve the quality of life for applicants and eligible individuals and only if the organization, agency, or individual assures that:

- The information will be used only for the purpose for which it is being provided.
- The information will be released only to persons officially connected with the audit, evaluation, or research.
- The information will not be released to the involved individual.
- The information will be managed in a manner to safeguard confidentiality; and
- The final product will not reveal any personal identifying information without the informed written consent of the involved individual or the individual's representative.

1.10 Releasing Individual Identifiable Health Information for Legal Investigations

MDRS must release personal information in response to investigations in connection with the law enforcement, fraud, or abuse, unless expressly prohibited by Federal or State laws or regulations, and in response to an order issued by a judge, magistrate, or other authorized judicial officer.

MDRS also may release personal information in order to protect the individual or others if the individual poses a threat to his or her safety or to the safety of others.

Notice

When the Agency makes a disclosure to any person or entity other than the client, the following or similar statement shall accompany the disclosure:

NOTICE

THIS IS CONFIDENTIAL INFORMATION FROM THE RECORDS OF THE MISSISSIPPI DEPARTMENT OF REHABILITATION SERVICES. STATE AND FEDERAL LAWS AND REGULATIONS PROHIBIT YOU FROM MAKING ANY FUTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE INFORMED WRITTEN CONSENT OF THE CLIENT FOR WHOM THIS INFORMATION PERTAINS. ANY SUCH FURTHER DISCLOSURE COULD RESULT IN CIVIL OR CRIMINAL LIABILITY.

1.11 Release of Information Regarding Deceased Member

If information is requested concerning a deceased member, the Agency shall release such information only to the executor of a probate will or the administrator of the estate upon written proof of such status by the court. No other heirs or family members shall be given any information without a court order.

1.12 Disposal of Case Records

When disposing of records, care must be taken to prevent inappropriate disclosure of confidential information contained in Agency files. Such files must be shredded, burned, or otherwise destroyed to prevent the unwarranted use of this information.

Case records can be shredded six (6) years after the date of case closure.

1.13 Notice of Action (Home and Community Based Waiver Services)

The applicant/member will be informed in writing of a decision that will result in the following:

- Being determined ineligible for services;
- The amount (quantity) of the service the member will receive;
- The request for particular services being denied;
- Being determined ineligible for continued services.

The Notice of Action shall contain the following information:

- A description of the action the provider has taken or intends to take;
- An explanation for the action;

- Notification that the member/representative has the right to file an appeal;
- Procedures for filing an appeal;
- Notification of member/representative's right to request a Fair Hearing;
- Notice that the member/representative has the right to have benefits continued pending the resolution of an appeal; and
- The specific regulations or the change in Federal or State Law that supports or requires the action. (Authority: Title 42, CFR 431, Subpart E)

1.14 Advance Notice (Home and Community Based Waiver Services)

Notice of decisions must be given in advance to ensure members have the right to appeal. Timelines are set for the use of appropriate interventions and opportunities for conflict resolution through mediation or other techniques before initiating actions to suspend, deny or terminate services. These timelines are as follows:

Advance Notice – The member must receive a notice at least 10 (ten) calendar days before the effective date of an action.

Advance Notice Less Than 10 (ten) days – The member may be given a notice less than 10 (ten) days before the action will occur if the following occurs:

- There is factual information confirming the death of the member;
- The member has been admitted to a nursing home;
- The member has been admitted to a hospital/institution for more than 30 days;
- Member gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information (i.e. states he/she no longer wants services);
- Whereabouts of the member are unknown and the post office returns agency mail directed to him indicating no forwarding address;
- Member has been accepted for Medicaid services in another state;
- Loss of Medicaid eligibility. The effective date of the action must match the effective date of the termination of Medicaid eligibility.

Advance Notice In Cases of Probable Fraud – A notice may be given to the member five (5) days before an action if there are facts that have been verified, if possible, through reliable sources, that there is probable fraud by the member.

1.15 Hearings and Appeals (Home and Community Based Services)

Decisions that result in services being denied, terminated, or reduced may be appealed. The member/legal representative has thirty (30) days from the date on the notice to appeal the decision. **All appeals must be in writing.**

The member/legal representative is entitled to an initial appeal at the local level with the MDRS/OSDP Counselor and the immediate supervisor. The action will be explained at that time. The local hearing will be documented and become a permanent part of the member file.

If the member/legal representative does not agree with the decision made following the local hearing, he/she may appeal that decision by requesting a State-level hearing within 15 days of the notice of the local hearing decision. The member/legal representative must submit this request in writing to the Division of Medicaid. Upon receiving the notification from the Division of Medicaid that the member has requested a State level hearing, the OSDP Case Manager/District Manger assigned will prepare a copy of the pertinent case file documentation used to reach the decision and send the copy to OSDP in the State Office. The copy of the documentation must be forwarded to the Division of Medicaid no later than five (5) days after MDRS has been notified that the member has requested a State level hearing.

The Division of Medicaid will assign a hearing officer. The member/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 of the Division of Medicaid. The Executive Director will make the final determination of the case, and the member/legal representative will receive written notification of the decision. The final administrative action, including state or local, will be made within ninety (90) days of the date of the initial request for a hearing. OSDP 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 or sexual harassment of the service providers. The OSDP Case Manager/registered nurse is responsible for ensuring that the member receives all services that were in place prior to their receipt of the notice that informed them that an action will occur regarding services.

1.16 The False Claims Act (Deficit Reduction Act of 2005)

The Department of Rehabilitation Services has a strong and continuing commitment to ensure that its services are conducted in accordance with applicable laws relating to all professional practices, third party reimbursement, and contractual and legal obligations. Knowledge of applicable laws that could affect the Department is essential for employees. One such law is the False Claims Act.

The False Claims Act is aimed at the following conduct:

(1) knowingly presenting or causing to be presented a false or fraudulent claim for payment to the government

(2) knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government; or

(3) engaging in a conspiracy to defraud the government by getting a false or

fraudulent claim allowed or paid.

For purposes of the False Claims Act, the terms “knowing” and “knowingly” mean that a person, with respect to information:

(1) has actual knowledge of the information

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of $5,000 to $10,000 per false claim.
Examples of fraud include, but are not limited to:

- billing for services not rendered;
- requesting, offering, or receiving a kickback, bribe, or rebate;
- using an incorrect or inappropriate provider number in order to be paid;
- selling or sharing patients’ Medicare/Medicaid numbers so false claims can be filed;
- falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government;
- submitting time and task (services) which were not provided;
- filing a false time entry/authorization/claim;
- submitting false invoice;
- billing for equipment/supplies never ordered;
- billing Medicaid/Medicare for new equipment but providing the member used equipment;
- billing Medicaid/Medicare for expensive equipment but providing the member cheap equipment; and
- charging more than once for the same service.

For more detailed language of the Statute see Appendix 1.

Furthermore, to encourage citizens to report violations, certain protections are in place to shield an individual from retaliation for bringing suit against his or her employer. Any such individual is protected under the “whistleblower” section of the False Claims Act.

1.17 **Appeal Process for Non-Waiver Client**s

MDRS provides an opportunity to request a Fair Hearing to individuals:

1. Who are not given the choice of home and community-based services as an alternative to the institutional care,
2. Who are denied the service(s) of their choice or the provider(s) of their choice, or
3. Whose services are denied, suspended, reduced, or terminated.

MDRS must provide the individual with a Notice of Action (NOA) via certified mail as required in 42 CFR §431.210. The NOA must include:

- A description of the action the provider has taken or intends to take,
- An explanation for the action,
- Notification that the participant has the right to file an appeal,
- Procedures for filing an appeal,
- Notification of participant's right to request a Fair Hearing,
- Notice the participant has the right to have benefits continued pending the resolution of the appeal, and
- The specific regulations or the change in Federal or State law that supports or requires the action.

The participant or his/her representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. The request for a local or state hearing must be made in writing by the participant or his/her legal representative.

The participant may be represented by anyone he/she designates. If the participant elects to be represented by someone other than a legal representative, he/she must designate the person in writing.

The participant has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period is extended if the participant can show good cause for not filing within (30) days.

A hearing cannot be scheduled until a written request is received by MDRS or the State (MDRS) office. If the written request is not received within the thirty (30) days of the NOA, services will be discontinued.

At the local hearing level, MDRS issues a determination within thirty (30) days of the date of the initial request for a hearing.

If a local appeal is received within the 30 days of receipt of the Notice of Action, the District Manager has five (5) days to meet with the participant to address their appeal. If the District Manager concurs with the initial discharge NOA, he/she will send a written notice to the client within five (5) business days. The letter will include information on

how to request a State (MDRS) hearing. A State (MDRS) hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.

At the State office hearing level, MDRS issues a determination within ninety (90) days of the date of the initial request for a hearing. The participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record.
2. The right to have legal representation at the hearing and to bring witnesses.
3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process, except when there is a threat of harm of the participant or the service provider.

1.18 Whistleblower

A whistleblower is an individual who makes an initial report to the appropriate government entity or law enforcement that a false claim has occurred or may have occurred.

Additionally, a whistleblower is one who participates in investigations, testimony, or assistance in an action filed or to be filed under the False Claims Act.

Whistleblower Protection

The False Claims Act provides protection to individuals whose employer retaliates against him/her because of the employee's participation in an action taken under the False Claims Act. The protection is available to any employee who is terminated, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee investigates, files or participates in an action under the False Claims Act.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is terminated, and any other damages sustained if the employee is otherwise discriminated against.

What Protections Are Afforded to Whistleblowers?

1. An employer may not make, adopt, or enforce any rule, regulation, or policy preventing an employee from being a whistleblower.
2. An employer may not retaliate against an employee who is a whistleblower.
3. An employer may not retaliate against an employee for refusing to participate in an

activity that would result in a violation of a state or federal statue, or a violation or non-compliance with a state or federal rule or regulation.

4. An employer may not retaliate against an employee for having exercised his or her rights as a whistleblower in any former employment.

1.19 **Fraud/Abuse**

MDRS/OSDP endorses the concept that people who provide services are essentially honest and are entitled to the same protection under the law as all other individuals. However, when there is an indication of potential fraud, the allegations must be investigated.

MDRS/OSDP is responsible for identifying, investigating, and referring cases of suspected fraud or abuse of Medicare or Medicaid.

To help carry out this responsibility, OSDP must be prepared to exclude paying for services when any provider defrauds or abuses the Medicare or Medicaid program.

To determine the existence of fraud and/or abuse, the following must be established:

- intentional misstatement or concealment by direct care worker or vendor created a false impression;
- MDRS/OSDP paid the direct care worker or vendor based on the false impression, when the payment would not have been made if the truth had been known; or
- practices are inconsistent with sound fiscal, business practices, and these inconsistent practices result in unnecessary cost to the program and payment for services that were not provided.

Examples of fraud include, but are not limited to:

- billing for services not rendered;
- requesting, offering, or receiving a kickback, bribe, or rebate;
- using an incorrect or inappropriate provider number in order to be paid;
- selling or sharing patients' Medicare/Medicaid numbers so false claims can be filed;
- falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government;
- submitting time and task (services) which were not provided;
- filing a false time log/authorization/claim;
- submitting a false invoice;
- billing for equipment/supplies never ordered;
- billing Medicaid/Medicare for new equipment but providing the member used equipment;
- billing Medicaid/Medicare for expensive equipment but providing the member cheap equipment; and
- charging more than once for the same service.

Pursuant to United States Code § 3729. False claims (a) LIABILITY FOR CERTAIN ACTS.— (1) IN GENERAL, any person who— (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of sub1paragraph (A), (B), (D), (E), (F), or (G); is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1), plus 3 times the amount of damages which the Government sustains because of the act of that person.

The current FCA penalty, as of February 12, 2024, is "Min $13,946, Max $27,894" plus treble damages (three times the amount that the government is defrauded).

31 U.S.C. 3729(a)	False Claims Act; FN3 Violations	28 CFR 85.3(a)(9)	Min 11,803, Max 23,607	Min 12,537, Max 25,076	Min 13,508, Max 27,018	Min 13,946, Max 27,894

In addition, if MDRS receives an overpayment from Medicaid, MDRS shall:

- report and return the overpayment to the Mississippi Division of Medicaid;
- notify the Mississippi Division of Medicaid in writing of the reason for the overpayment;
- must be reported and returned by the later of;
  a) the date which is 60 days after the date on which the overpayment was identified; or
  b) the date any corresponding cost report is due, if applicable.

How To Report Fraud or Abuse

You can report fraud or abuse multiple ways as listed below, including by phone, postal mail, fax and online forms. It is advised that you do not email forms or submit online forms with protected health information or personally identifiable information, to protect confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996.

MS Department of Rehabilitation Services:

- Phone: 601-853-5233
- FAX: 601-853-5218
- Mailing Address:
  ATTN: Office of Program Integrity
  1281 Hwy. 51 North
  Madison, MS 39110

MS Division of Medicaid Contact Information:

- Toll-free: 800-880-5920
- Phone: 601-576-4162
- FAX: 601-576-4161
- Mailing Address:
  ATTN: Office of Program Integrity
  550 High Street, Suite 1000
  Jackson, MS 39201

Office of Inspector General (OIG) Hotline Contact Information:

- Online form
- Toll-free: 800-447-8477
- FAX: 800-223-8164
- Mailing Address:
  U.S. Department of Health & Human Services
  Office of Inspector General
  ATTN: OIG Hotline Operations
  P.O. Box 23489
  Washington, D.C. 20026

1.20 Fingerprint and Criminal Background Checks

As of July, 1, 2010, in accordance with Section 37-33-157 of the Mississippi Code Annotated of 1972, the Mississippi Department of Rehabilitation Services (also referred to herein as "MDRS" and "department") is authorized to fingerprint and perform state and federal background checks on persons performing services for or on behalf of the department. This includes a current state and federal criminal history record check, child abuse registry check, sex offender registry check, and vulnerable person abuse or neglect check.

MDRS is authorized to use the results of the fingerprinting and background checks for the purposes of employment decisions and/or actions and service provision to consumers of the department's services.

Specifically, any person who has been convicted of a felony in this state or any other jurisdiction is not eligible to be employed as a direct care worker (DCW) with MDRS.

Any person subject to registration as a sex offender in this state or any other jurisdiction is not eligible to be employed as a DCW by MDRS. Likewise, any person subject to registration in a child abuse registry, or convicted of a criminal offense related to the abuse or neglect of a vulnerable person or a child in this state or any other jurisdiction, is not eligible to be employed as a direct care worker (DCW) with MDRS.

Any person who has been charged with or convicted of certain misdemeanor crimes that could adversely affect the health, safety or welfare of the participants of MDRS is precluded from employment as a DCW. Such misdemeanors include, but are not limited to:

(a) Neglect or abuse of a vulnerable adult,
(b) Theft,
(c) Indecent exposure,
(d) Shoplifting,
(e) Forgery,
(f) Assault,
(g) Misconduct involving weapons, firearms, or explosives
(h) Unlawful drug possession, use, or sale,
(i) Domestic violence,
(j) Arson,
(k) Endangerment,
(l) Identity theft,
(m) Fraudulent use of a credit card

MDRS reserves the right to review and consider other misdemeanor charges and convictions on a case-by-case basis.

The aforementioned background and registry checks will be performed prior to a DCW's employment with the department, every two (2) years thereafter, and as deemed necessary by MDRS. If performed prior to the two years, the HR department must be consulted first. In the event that an adverse finding or findings are identified within the criminal background and registry checks, the person will be disqualified from being employed as a DCW if such findings are discovered prior to employment with MDRS, and the person will be terminated immediately if discovered subsequent to the person's employment with MDRS. However, the person can be found eligible for employment or re-employment in the event that he or she can prove that they were not found guilty of the offense for which they were denied employment or for which they were terminated. Acceptable proof of a not guilty verdict for a criminal offense shall be in the form of a certified court copy of a not guilty verdict judgment, or a certified copy of a court abstract evincing a not guilty verdict. In the case of a disqualifying misdemeanor criminal charge, a certified court copy of a release, dismissal or nolle prosequi of such charge or charges shall be considered as proof of such a disposition by the court in which the charges were brought. If the DCW refuses to have an updated background check, they will be terminated.

MDRS and its agents, officers, employees, attorneys and representatives shall be exempt from liability for any findings, recommendations or actions taken through the use of the results of the fingerprinting and background checks; and for related purposes.

1.21 Direct Care Worker (DCW) Social Media Policy

It is considered to be protected expression for Direct Care Workers (DCWs) to engage in social media activity concerning issues of public concern, while on personal time and in a personal capacity. DCWs maintain their First Amendment rights, but any speech or expression, even in a personal capacity, causing disruption or that undermines the effectiveness and/or operation of AbilityWorks, Inc., and MS Department of Rehabilitation Services (MDRS) is prohibited.

Any of the following social media activity, comments, expression or posts by a DCW in his or her professional or personal capacity are also prohibited:

a) Content that is discriminatory, harassing, or physically threatening;
b) Disclosure of personal information that is confidential or proprietary;
c) Content that demonstrates unlawful conduct.

DCWs who violate this policy are subject to termination.

1.22 DCW Electronic Visit Verification (EVV) and Smart Device Requirements Policy

In December 2016, Congress enacted the 21st Century Cures Act, which requires all states to implement Electronic Visit Verification (EVV) for all Medicaid financed Personal Care Attendants (PCAs). EVV is a process that uses technology to verify provider visits for personal care services in the home. It gives PCAs, Case Managers and the Division of Medicaid access to service delivery information in real time. The HHAeXchange smart device application will be the tool used to provide this information.

Effective August 1, 2023, all PCAs are required to have access to a smart device (i.e. smart phone, iPad, tablet, etc.). The smart device needs to be compatible with downloading the HHAeXchange EVV application where services are rendered. WiFi and internet connections must be accessed routinely for the functionality of this application.

The HHAeXchange application will electronically document time in and time out features and tasks that are performed in the home of the participant on a shift by shift basis. The mobile application is GPS-enabled, so it will log the address where the PCA is clocking in and out to ensure they are at the proper location during their shift.

PCAs will be paid based on the data received through this smart device application. The PCA may only work hours approved on the participants' Plan of Services and Support (PSS). PCAs who knowingly work over the approved hours, without prior approval, will be subject to termination. In addition, any PCA who allows the participant, another PCA or any other individual to falsely clock in on their behalf will be terminated immediately.

1.23 Conflict of Interest and Improper Use of Office

Miss. Code Ann. § 25-4-101. Legislative Declaration of Public Policy

The legislature declares that elective and public office and employment is a public trust and any effort to realize personal gain through official conduct, other than as provided by law, or as a natural consequence of the employment or position, is a violation of that trust. Therefore, public servants shall endeavor to pursue a course of conduct which will not raise suspicion among the public that they are likely to be engaged in acts that are in violation of this trust and which will not reflect unfavorably upon the state and local governments.

Miss. Code. Ann. § 25-4-105. Contract Restrictions and Other Prohibited Conduct; Penalties

(1) No public servant shall use his official position to obtain, or attempt to obtain, pecuniary benefit for himself, other than that compensation provided for by law, or to obtain, or attempt to obtain, pecuniary benefit for any relative or any business with which he is associated.

(2) No public servant shall be interested, directly or indirectly, during the term for which he shall have been chosen, or within one (1) year after the expiration of such term, in any contract with the state, or any district, county, city or town thereof, authorized by any law passed or order made by any board of which he may be or may have been a member.

(3) No public servant shall:

(a) Be a contractor, subcontractor or vendor with the governmental entity of which he is a member, officer, employee or agent, other than in his contract of employment, or have a material financial interest in any business which is a contractor, subcontractor or vendor with the governmental entity of which he is a member, officer, employee or agent.

(b) Be a purchaser, direct or indirect, at any sale made by him in his official capacity or by the governmental entity of which he is an officer or employee, except in respect of the sale of goods or services when provided as public utilities or offered to the general public on a uniform price schedule.

(c) Perform any service for any compensation for any person or business after termination of his office or employment in relation to any case, decision, proceeding or application with respect to which he was directly concerned or in which he personally participated during the period of his service or employment.

(4) Notwithstanding the provisions of subsection three (3) of this section, a public servant or his relative:

(a) May be a contractor or vendor with any authority of the governmental entity other than the authority of the governmental entity of which he is a member, officer, employee or agent or have a material financial interest in a business which is a contractor or vendor with any authority of the governmental entity other than the authority of the governmental entity of which he is a member, officer, employee or agent where such contract is let to the lowest and best bidder after competitive bidding and three (3) or more legitimate bids are received or where the goods, services or property involved are reasonably available from two (2) or fewer commercial sources, provided such transactions comply with the public purchases laws.

(b) May be a subcontractor with any authority of the governmental entity other than the authority of the governmental entity of which he is a member, officer, employee or agent or have a material financial interest in a business which is a subcontractor with any authority of the governmental entity other than the authority of the governmental entity of which he is a member, officer, employee

or agent where the primary contract is let to the lowest and best bidder after competitive bidding or where such goods or services involved are reasonably available from two (2) or fewer commercial sources, provided such transactions comply with the public purchases laws.

(c) May be a contractor, subcontractor or vendor with any authority of the governmental entity of which he is a member, officer, employee or agent or have a material financial interest in a business which is a contractor, subcontractor or vendor with any authority of the governmental entity of which he is a member, officer, employee or agent: (i) where such goods or services involved are reasonably available from two (2) or fewer commercial sources, provided such transactions comply with the public purchases laws; or (ii) where the contractual relationship involves the further research, development, testing, promotion or merchandising of an intellectual property created by the public servant.

(5) No person may intentionally use or disclose information gained in the course of or by reason of his official position or employment as a public servant in any way that could result in pecuniary benefit for himself, any relative, or any other person, if the information has not been communicated to the public or is not public information.

(6) Any contract made in violation of this section may be declared void by the governing body of the contracting or selling authority of the governmental subdivision or a court of competent jurisdiction and the contractor or subcontractor shall retain or receive only the reasonable value, with no increment for profit or commission, of the property or the services furnished prior to the date of receiving notice that the contract has been voided.

SECTION 2: OSDP PROGRAM OVERVIEW

2.0 Independent Living (IL) Waiver

The statutory basis for this program is §1915 c (7) (B) of the Social Security Act. The Independent Living (IL) Waiver is a Medicaid Home and Community-Based Services (HCBS) program operated by MDRS and administered by the Mississippi Division of Medicaid.
The IL Waiver allows Mississippi to provide services that are not available under the regular Medicaid State Plan program. Waiver applicants/members receive services through the IL Waiver and through other non-waiver service providers that are necessary to provide a safe alternative to nursing facility (NF) placement.

Requirements of the program include:

1) Must be 16 years of age or over;
2) Exhibit severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living;
3) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care;

4) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) an active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) intravenous infusions to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

For additional information, refer to: Application for 1915(c) HCBS Waiver: MS.0255.R07.00 at https://medicaid.ms.gov/providers/waivers

Authority: 42 CFR 430.25 Waivers of State Plan Requirements

2.1 Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI)

The statutory basis for this program is § 1915 (c) (7) (B) of the Social Security Act. The TBI/SCI Waiver is a Medicaid Home and Community-Based Services (HCBS) program operated by MDRS and administered by the Division of Medicaid.

The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver provides cost-effective in-home support services to Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) members who would require institutionalization in a Nursing Facility (NF).

Persons served on this waiver must:

1) Have a traumatic brain injury or spinal cord injury as defined below. Traumatic brain injury is defined 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. Spinal cord injury defined 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 of the above three. The extent of injury must be certified by their physician or nurse practitioner. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that results (intentionally or unintentionally) from medical intervention, is excluded.

2) Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of the following: (a) an active, life-threatening condition (e.g., sepsis, respiratory, or other condition requiring systematic therapeutic measures) (b) intravenous drip to control or support blood pressure (c) intracranial pressure or arterial monitoring.

There is no maximum age limit for this waiver. This waiver is limited to individuals who are able to direct their own care or have a legal representative who they have chosen to direct their care.

For additional information, refer to: Application for 1915(c) HCBS Waiver: MS.0255.R05.00 at https://medicaid.ms.gov/providers/waivers

2.2 Hospice and IL or TBI/SCI Waiver Concurrent Services

Hospice and IL or TBI/SCI Waiver concurrent services are authorized by Mississippi Administrative Code Title 23: Medicaid, Part 205: Hospice Services, Chapter 1: Program Overview, Rule 1.1: General.

Applicants/members may receive non-duplicative IL or TBI/SCI waiver services in coordination with in-home hospice services. Since the programs offer similar services, it is imperative that the hospice provider and OSDP staff work together with the applicant/member and/or designated representative to assure the applicant/member's needs are met without duplicating services.

SECTION 3: REFERRALS

3.0 Information and Referrals

The Mississippi Department of Rehabilitation Services' (MDRS) Office of Special Disability Programs (OSDP) has an information referral system in place. This system provides:

- Individuals with disabilities information about services;
- The opportunity to be referred to other appropriate services and programs;
- The opportunity to be placed on the referral list for OSDP programs.

Referrals for OSDP Programs are placed on the Referral List based on the date of their request for services. All referrals must be placed in the AACE Referral Database within three (3) days of request.

Within Appendix B of the IL and TBI/SCI Waivers, MDRS agrees to reserve capacity for each waiver year for individuals transitioning from nursing facilities (NF) and other home and community-based services (HCBS) waivers. Nursing home transition members must have been in the nursing facility for over thirty (30) days.

Due to the reserve capacity, individuals transitioning from a nursing facility (NF) and other HCBS waivers are placed at the top of the list for HCBS Waiver Referrals (IL Waiver and TBI/SCI Waiver) and are expedited in the transition to the home and community.

The State reserves capacity within the waiver for individuals transitioning from institutional long term care settings to a home and community-based service (HCBS) setting. Individuals must have resided in the institutional setting for a minimum of thirty (30) days with at least one of those days being covered in full by Mississippi Medicaid. If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the State reserves the right to reassign the reserve capacity for others awaiting services.

DOM evaluated the number of service referrals along with the waiver limits and determined that the reserve capacity will be twenty-five (25) IL waiver slots and fifteen (15) TBI/SCI waiver slots for the calendar year.

Legal Basis

Under the authority of §1915(c) of the Social Security Act.

SECTION 4: PROGRAM OVERVIEW OF NON-WAIVER SERVICES

4.0 Non-Waiver Program Services

MDRS provides non-waiver programs to individuals who are not eligible under the Independent Living Waiver or the Traumatic Brain Injury/Spinal Cord Injury Waiver. The non-waiver programs include the State Attendant Care program, TBI/SCI Trust Fund and the IL Grant program.

4.1 State Attendant Care Program (SAC Program)

In 1985, the Mississippi Legislature created the State Attendant Care (SAC) Fund. This state funded program provides personal care services to individuals who have severe disabilities and are not eligible to receive these services through other sources.
Requirements of the program include:

1) Must have a severe physical or mental impairment which limits his/her ability to obtain, maintain or advance employment.
2) Cannot be eligible to receive duplicate services under any other program.
3) No age restrictions.

4.2 Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Trust Fund Services

As established by the Mississippi Code of 1972 amended, § 37-33-251, 253, 257, 259, and 261, the TBI/SCI Trust Fund was enacted.

Effective from and after July 1, 1997, the TBI/SCI Trust Fund enables individuals who have sustained a traumatic brain injury/spinal cord injury to resume the activities of daily living and reintegrate into the community with as much dignity and independence by providing services, regardless if they qualify for waiver services and as soon as possible.

Requirements of the program include:

1) Must have sustained a traumatic brain or traumatic spinal cord injury which is as a result of external trauma and is verified by a physician;
2) Must be medically stable; and
3) Any Mississippi resident, regardless of age.

4.3 Federal Independent Living Grant (IL Grant) Services

MDRS receives a federal grant from the Administration for Community Living (ACL) in

the U.S. Department of Health and Human Services (HHS), in accordance with the Workforce Innovation and Opportunity Act.

Through a federal grant from the ACL, the Office of Special Disability Programs provides funding for solutions that help individuals with disabilities maintain independence in their environments.

Requirements of the program include:

1) Must have a severe physical or mental impairment which limits his/her ability to obtain, maintain or advance employment.
2) No age restrictions.
3) Services provided must not duplicate services allowable under any other federal mandate.

For additional information, please refer to: (WIOA, (Public Law 113-128).

4.4 Financial Needs Analysis

While there is no federal requirement to consider the financial need of individuals when providing services, OSDP does consider the financial need of individuals for purposes of determining the extent of their participation in the cost of OSDP services. Proof of income is required to determine the amount a client must contribute, if any, to the cost of services. A Financial Needs Analysis form must be completed during the application process for any Non-Waiver client requesting services who does not currently receive Medicaid or Social Security benefits. The individual is responsible for informing OSDP of any changes in financial circumstances and providing appropriate documentation within 30 days of the date of such changes. Failure to do so may result in the termination of paid Independent Living services.

A client whose net income exceeds the Financial Needs Analysis is not required to help pay for services if:

1) The client is eligible for Medicaid or Social Security benefits (SSI or SSDI)
2) The OSDP Regional Manager grants and exception because the client's financial participation would prevent the client from receiving the necessary service (i.e., a TBI client that has a high medical bill and would be unable to afford the cost of services).

SECTION 5: APPLICATION

5.0 Application for OSDP Services

Any individual with a disability can apply for services with the Office of Special Disability Programs (OSDP). The Case Manager is responsible for completing and reviewing the content of the application with the individual and assuring his/her understanding of the application. If the individual is under the age of 18 or someone who in the best judgment

of the Case Manager, cannot understand the content of the application, then it should be discussed with a parent or legal guardian. A copy of the application should be given to the applicant.

5.1 Request for OSDP Services

The application process begins with the Request for OSDP Services intake form which is completed at the initial home visit. All relevant personal and financial information in addition to the person's disability, family support, etc. is gathered at this time. This process is completed for waivered and non-waivered services through OSDP and is one component to assist the case manager in determining eligibility.

5.2 Statement of Understanding

All applicants whether applying for waivered services, State Attendant Care, IL Grant or TBI/SCI Trust Fund are required to read and sign the Statement of Understanding. The purpose of this form is ensure that the applicant has:

a) The presence of a significant mental or physical disability;

b) The presence of a severe limitation in ability to function independently in the family or community; and

c) A reasonable expectation that OSDP services will significantly assist in the ability to function more independently in the home or community or to engage or continue in employment.

5.3 Health Information Portability and Accountability Act (HIPAA)

MDRS is required by law to maintain the privacy of a person's health information and to provide a notice of its legal duties and privacy practices with respect to an applicant/persons protected health information. This applies to all applicants whether applying for waivered or non-waivered services through MDRS.

5.4 Authorization for the Use/Disclosure of Protected Health Information

The purpose of the Authorization for the disclosure form is to give MDRS the legal authority to access an applicant's protected health information to determine eligibility. Case Managers are required to obtain a completed form with signatures prior to attempting to access the applicant's protected health information.

5.5 Opportunity to Register to Vote

The National Voter Registration Act of 1993 requires that MDRS assist individuals applying for public assistance and applicants in registering to vote. The intent of the Act was to enhance voting opportunities for every American and increase representation in the electorate.

5.6 Estate Recovery

Federal and State law requires that the Division of Medicaid have an Estate Recovery plan in place. Under this program, the Division of Medicaid becomes a creditor against the estate of a deceased Medicaid recipient under certain conditions. During the initial application process the Counselor must inform the client about Estate Recovery.

Estate Recovery provisions apply to individuals enrolled in Home and Community Based Services beginning July 1, 2001.

5.7 Application Completion

In order to complete the application, the Case Manager must enter an AACE case note documenting the initial home visit within three (3) business days. The applicant's case file must be created within five (5) business days of the home visit and will contain the original signed application forms and the case note. It is essential that the case file be stored in a secure location.

SECTION 6: WAIVER ELIGIBILITY

6.0 IL Waiver Eligibility

The basic eligibility criteria for IL waiver enrollment include:

- age - 16 years of age or older;
- financial eligibility – the member must be eligible for Medicaid as described in the waiver;
- medical necessity – the member must meet the level of care criteria for nursing facility (NF) care.

The waiver specific criteria the member must meet is based on his/her choice of services and service planning. They must:

- have a severe orthopedic and/or neurological impairment; that renders the member dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living;
- choose home and community-based services in lieu of nursing facility care/informed choice;
- have an on-going need for waiver services;
- need assistance with one or more of the activities of daily living such as dressing, bathing, eating, toileting, transferring;
- Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) an active, life-threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) intravenous infusions to control or support blood pressure; (c) intracranial pressure or arterial monitoring;

- be able to communicate effectively with caregivers, Direct Care Workers (DCW), Case Managers, and others involved in their care; and
- be at risk of nursing facility placement if services were not available.

6.1 TBI/SCI Waiver Eligibility

The basic eligibility criteria for TBI/SCI waiver enrollment include:

1. Must have a certified traumatic brain or spinal cord injury. See Spinal Cord/Traumatic Brain Injury Verification form.

    - Traumatic brain injury is defined 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 deficit.

    - Spinal cord injury is defined as a traumatic injury to the spinal cord or the cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

2. Must be certified as medically stable by the primary care physician.

Medical stability is defined as the absence of the following:

a. An active, life-threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);
b. IV drip to control or support blood pressure;
c. Intracranial pressure or arterial monitoring

3. Certified as meeting nursing home level of care by their primary care physician.

4. Be at risk of nursing home placement in the absence of waiver services;

5. Meet the special income and assets limits (up to 300% of the Supplemental Security Income federal benefit rate) SSI.

SECTION 7: WAIVER ASSESSMENT

7.0 InterRAI Assessment

All members applying for Medicaid long-term care must complete an interRAI assessment for clinical eligibility determination.

Members enrolled in Medicaid long term care must be recertified annually. Members desiring continued waiver services must be recertified by submission of a new interRAI assessment at least ten (10) days, but no more than ninety (90) days, prior to the expiration

of the current assessment.

An initial interRAI assessment must be completed by a certified OSDP Case Manager and Registered Nurse. Both the Case Manager and the RN must pass a certification course prior to performing interRAI assessments.

SECTION 8: PLAN OF SERVICES AND SUPPORTS (PSS)

8.0 Plan of Services and Supports (PSS)

The Plan of Services and Supports (PSS) is a fundamental tool used to ensure the health and welfare of the members served under the waiver programs. The OSDP Case Manager/RN, together with the potential member, will develop a PSS based on assessment results. The PSS is used to address services needed and activities/tasks necessary for the individual to maintain and independent lifestyle in their home and community. This includes necessary change requests made to the PSS for increase/decrease in services or the addition of new services based upon the individual’s health and safety.

SECTION 9: CASE MANAGEMENT

9.0 Case Management

Case management services are defined as services assisting members in accessing needed waiver and non-waiver services, as well as needed medical, social, educational and other services regardless of the funding source for these services. Case management services are provided by MDRS Case Managers and Registered Nurses (RN) who meet minimum qualifications listed in the waiver. Case Managers and RNs are responsible for initial assessments, whereas the Case Manager continues to follow the services through monthly contacts, quarterly reviews and annual recertifications.

SECTION 10: PERSONAL CARE SERVICES

10.0 Personal Care Services

Personal care services are provided to waiver members by direct care workers (DCWs). DCWs provide non-medical support services to eligible members by assisting with their activities of daily living in order to keep them independent in their home and communities.

SECTION 11: RESPITE SERVICES

11.0 Respite Services

Respite services are services offered to assist members who are unable to care for themselves or because of the absence of, or the need to provide relief to the primary

caregiver on a short-term basis. The level of such assistance provided to the member will be determined by their assignment to one of the four “tiers” by their primary physician.

a) Services must be provided in the member’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 MS Dept. of Rehabilitation Services (MDRS).

SECTION 12: ELECTRONIC VISIT VERIFICATION (EVV)

12.0 EVV

EVV technology is used to document direct care worker (DCW) time worked for members in their homes. HHA eXchange provides the platform for DCWs to clock in and clock out on their mobile device at the member’s GPS-enabled location. Personal care services are also indicated as tasks performed on the HHA eXchange app.

DCWs are authorized to work the daily approved hours on the member’s plan of services and supports (PSS). Data is captured for each shift worked and stored in HHA Exchange, in order to provide time and attendance reporting for payroll purposes.

SECTION 13: TRANSITION ASSISTANCE SERVICES

13.0 Transition Assistance Services

Transition Assistance Services are services provided to a Mississippi Medicaid eligible nursing facility resident to assist in transitioning them from the nursing facility into one of the MDRS waiver programs (IL waiver or TBI/SCI waiver). Transition assistance is a one-time initial expense required for setting up a household. Services may include security deposits, essential furnishings, utility set up fees or health and safety measures.

Transition assistance services are capped at $800.00 one-time initial expense per lifetime. The expenses must be included on the approved PSS.

SECTION 14: CASE SERVICE RECORD

14.0 Case Service Record

Case Managers will maintain an active case file folder for each OSDP member. Each folder contains up-to-date information pertaining to the member’s health, services received, requests for services and DCW tasks/activities. All records will be entered into the electronic database (AACE) as well as printed and filed in the member’s file folder.

SECTION 15: CASE RECORD CLOSURES

15.0 **Case Record Closures**

A member's case shall be closed when it is determined that planned services are completed or that additional services are unnecessary. There must be adequate documentation in the case record showing that all requests are completed and/or unnecessary. The member must be notified of the pending closure and in agreement prior to the case being closed.

SECTION 16: ASSISTIVE TECHNOLOGY

16.0 **Assistive Technology**

Assistive Technology (AT) is defined as the application of technology to alleviate barriers that interfere with the lives of individuals with disabilities and is intended to help the participant maintain or enhance his or her ability to function personally, socially, and/or vocationally.

MDRS Rehabilitation Engineers and Rehabilitation Technologists are available to provide consultation on all AT referrals as well as perform initial evaluations and assessments, and set-up AT equipment, provide follow-up evaluations, design and fabricate original items, and provide specifications and final inspections for AT services. When necessary, referrals will be made to outside sources.

All Assistive Technology (AT) needs and/or requests are first evaluated by the OSDP Case Manager or DOM staff (if applicable) to determine if the person could benefit from a referral to MDRS AT staff for evaluation and recommendation. If a Durable Medical Equipment (DME) item is needed and covered by a 3rd party (such as insurance), the Case Manager will coordinate the purchase directly through the person's vendor of choice and provide monthly progress on such equipment. If the AT need is a non-covered DME item, a vehicle modification, or an Environmental Accessibility Adaptation (EAA), the Case Manager will refer the person to MDRS AT staff for evaluation and recommendation.

SECTION 17: AUTHORIZATION OF SERVICES

17.0 **Authorization of Services**

All services purchased for an OSDP member will be authorized either simultaneously with, or prior to, such purchase. Authorizations and purchases should be pre-planned and approved by the Case Manager or another member of the OSDP staff, unless in case of emergency. Authorizations must include all required documentation and invoice information to be paid and processed.

SECTION 18: DME/SMS AND SUPPLIES

18.0 **DME/SMS and Supplies**

Durable Medical Equipment (DME) and Specialized Medical Supplies (SMS) are provided based on the medical needs of each member. DME and SMS are only available through waiver funds after all comparable benefits/third party providers the member is eligible for, including insurances, have been used to meet the member's needs.

SECTION 19: PROSTHETIC AND ORTHOTIC APPLIANCES

19.0 **Prosthetic and Orthotic & Appliances**

The provision of prosthetic and orthotic devices and appliances is an appropriate OSDP Service. These services are provided to improve a member's ability to function more independently in their home and community. All services purchased through OSDP will be pre-authorized by the Case Manager or another member of the OSDP staff before the purchase of the item.

Title 32: REHABILITATION SERVICES
Part 1: OFFICE OF SPECIAL DISABILITY PROGRAMS (OSDP)
Subpart 2: PROCEDURE MANUAL

OFFICE OF SPECIALTY DISABILITY PROGRAMS
PROCEDURE MANUAL

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SECTION 1: GENERAL PROCEDURES

1.0 Non-Discrimination

MDRS staff will adhere to the practice of not excluding any individual or group of individuals from ineligibility of services based on age, color, religion, gender, gender identity, national origin, type of disability, marital status, sexual orientation or military status when carrying out OSDP operations.

Individuals eligible for services in the State will not be discriminated by OSDP staff based on their geographic residence in Mississippi when applying for services.

1.1 Confidential Nature of Member Information

Health Information Portability and Accountability Act

The Office of Special Disability Programs (OSDP) will abide by HIPAA guidelines. All information that the Mississippi Department of Rehabilitation Services (MDRS) and OSDP obtains, collects and in possession of MDRS/OSDP to determine eligibility, continue eligibility, or directly connected with the administration of programs, is confidential.

MDRS/OSDP may disclose general information about policies, procedures, or other methods of determining eligibility, and any other information that is not about or does not specifically identify a member.

All information that MDRS acquires in reference to a member or any individual on the member's case file is confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about a member or any individual on the case file, steps should be taken to reasonably be sure the individual receiving the information is either a member or an individual authorized to receive confidential information (i.e., personal representative).

Telephone identity outside of a face-to-face contact can be established by an individual who identifies himself as a member using his knowledge of the following:

- Date of birth
- Medicaid number
- Social Security Number
- Other identifying information

Telephone identity outside of a face-to-face contact can be established by an authorized representative by using their knowledge of the member's:

- Date of Birth

- o Medicaid number
- o Social Security number
- o Other identifying information
- o The knowledge of the same information about the consumer's representative

Identity of attorneys or legal representatives is established by a completed and signed Authorization for the Use/Disclosure of Protected Health Information form or a document containing all of the following information:

- o The applicant's full name (including middle initial)and one of the following:
    - Date of Birth
    - Medicaid Number
    - Social Security number
- o A description of the information to be released,
- o A statement specifically authorizing MDRS to release this information,
- o The purpose of the release,
- o An expiration date of the release and the purpose of the release,
- o A statement about whether refusal to sign the release affects eligibility for delivery of services,
- o A statement describing the applicant's or member's right to revoke the authorization to release information,
- o The date the document is signed, and
- o The signature of the applicant/member.

1.2 Appointment of a Designated Representative

The member or a legally authorized representative (LAR) for the member has the option of designating or changing a designated representative (DR) to assist with the responsibilities to assist the member in directing their services/care.

- The OSDP Case Manager must document the decision on the Appointment of a Designated Representative Form.
- Documentation of this should also be maintained in the member's case file only.
- For waiver members only, electronic documentation will be entered in LTSS under the Person Profile box, Profile Overview and then Representative.

1.3 Measures for Detecting and Preventing Waste, Fraud and Abuse

A. The following procedures are used to detect and prevent waste, fraud and abuse. The Case Management Verification Report is used to verify that monthly contacts, quarterly review visits and recertification visits are completed each month. The Case Manager also verifies that the direct care workers (DCWs) are working the hours that are approved on the Plan of Services and Supports (PSS).

B. The Case Management team and the OSDP Billing staff ensure that services billed and paid under the State's plan are:

1. Provided to an eligible beneficiary,
2. Medically necessary,
3. Provided at the appropriate level of care,
4. Appropriately documented, specifically including the assignment of diagnosis and procedure codes submitted by providers and that may be used by the Division of Medicaid to calculate payment and reimbursement.

C. For members who are eligible for Medicare or Medicaid and have any other third-party resources, the OSDP Case Manager must explore all available benefits. The Case Manager must document any available benefits in the case file. All comparable benefits and third-party resources are explored and utilized prior to authorizing for member services;

D. The MDRS Program Evaluation Division conducts case file audits; and,

E. The Assistive Technology delivery receipt is signed by the member to verify recommended equipment is received as ordered. The original form is maintained in the case file.

SECTION 2: OVERVIEW OF PROGRAMS

2.0 Independent Living Waiver (IL)

The Independent Living Waiver (IL) program provides home and community-based services to waiver applicants/members who:

1) Are 16 or older who exhibit severe orthopedic and/or neurological impairment that render the member dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living.

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

3) Must be medically stable. Medical stability is defined as the absence of any of the following: (a) An active, life threatening condition (sepsis, respiratory, or other

conditions requiring systematic therapeutic measures); (b) IV drip to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

In addition, the goal of the Independent Living Waiver program is to provide waiver applicants/members with a meaningful choice regarding long-term care services. This goal is accomplished by facilitating the development and utilization of services that allow waiver applicants/members to avoid premature nursing facility (NF) placement and provide current NF residents an opportunity to return to the home and community. It is accomplished through the utilization of a comprehensive Long Term Support Services (LTSS) assessment process and is designed to fill two primary functions: 1) determine eligibility for Medicaid Long Term Care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.

Waiver applicants/members receive services though the IL Waiver and through other non-waiver service providers that are necessary to provide a safe alternative to nursing facility (NF) placement. The Independent Living Waiver allows Mississippi to provide services that are not available under the regular Medicaid State Plan program.

2.1 Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver

The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver provides cost-effective in-home support services to Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) members who:

1) Have sustained a traumatic brain or traumatic spinal cord injury which is verified by a physician, and
2) Are medically stable.

There are no age restrictions for this program.

Traumatic Brain Injury" means 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.

"Spinal Cord Injury" means an acute traumatic insult to the spinal cord, not of a degenerative or congenital nature, but caused by an external trauma resulting in any degree of motor or sensory deficit.

Members who have brain or spinal cord injury at birth do not qualify for this program.

The goal of the TBI/SCI Waiver program is to provide members seeking Long Term Care assistance, meaningful choices to allow residency in their own homes and communities. This goal is accomplished through the utilization of a comprehensive Long Term Support Services (LTSS) assessment process and is designed to fill two primary functions: 1) determine eligibility for Medicaid Long Term Care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.

The program offers an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization in a Nursing Facility (NF). Waiver services complement and/or supplement the services that are available to members through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

2.2 Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Trust Fund

The Traumatic Brain Injury/Spinal Cory Injury Trust Fund program provides services to injured members as soon as possible after the injury, regardless if they are Medicaid recipients or qualify for waiver services.

Requirements of the program include:

1) Must have sustained a traumatic brain or traumatic spinal cord injury which is verified by a physician and
2) Must be medically stable and
3) Any Mississippi resident, regardless of age
4) Must not be eligible to receive duplicate services under any other program.

"Traumatic Brain Injury" means 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.

"Spinal Cord Injury" means an acute traumatic insult to the spinal cord, not of a degenerative or congenital nature, but caused by an external trauma resulting in any degree of motor or sensory deficit.

The goal of this program is to enable members who have sustained a traumatic brain injury/spinal cord injury to resume the activities of daily living and reintegrate into the community with as much dignity and independence as possible. For those persons who cannot achieve complete independence, supportive services are needed in order for them to live as normally as possible.

The TBI/SCI Trust Fund program awards sub-grants to organizations throughout the state to support programs that focus on the awareness and prevention of these conditions.

The Mississippi Department of Rehabilitation Services is required by the TBI/SCI Trust Fund to conduct an annual survey of nursing homes in the state to determine the number of members fifty-five (55) years of age and under who reside in such homes due to a spinal cord injury or traumatic brain injury. All members identified in such a survey shall be evaluated by the OSDP Case manager and any member who may benefit from rehabilitation services shall be given an opportunity to participate in an appropriate rehabilitation program for which he may be eligible.

Also, a requirement of the TBI/SCI Trust Fund is the Advisory Council on Spinal Cord Injuries and Traumatic Brain Injuries created within the MS Department of Rehabilitation

Services. The Advisory Council must be composed of a physician with expertise in areas related to the care and rehabilitation of members with spinal cord injuries or traumatic brain injuries or the prevention of spinal cord and traumatic brain injuries, a professional in a clinical rehabilitation setting, a representative designated by the Mississippi Head Injury Association, a representative designated by the Mississippi Paralysis Association, three (3) members with spinal cord injuries or traumatic brain injuries, and three (3) family members of members with spinal cord or traumatic brain injuries.

The TBI/SCI Trust Fund is to provide the cost of care for spinal cord and traumatic brain injury as a payer of last resort, therefore, a member must seek assistance from all available resources prior to receiving Trust Fund assistance.

Fees and surcharges on moving traffic violations are collected under subsections (1) and (2) of §99-19-73, Mississippi Code of 1972 and are deposited into a special fund that is created in the State Treasury and designated to the Spinal Cord and Head Injury Trust Fund.

2.3 Federal Independent Living (IL) Grant

Through a federal grant from the Administration for Community Living (ACL), the Office of Special Disability Programs provides IL Grant funding for solutions that help members with disabilities maintain independence in their environments.
Requirements of the program include:

1) Must have a severe physical or mental impairment which limits his/her ability to obtain, maintain or advance employment.
2) No age restrictions.
3) Services provided must not duplicate services allowable under any other federal mandate.

This program provides necessary services including but not limited to home modifications (environmental accessibility adaptations), vehicle modifications, orthotics and prosthetics, durable medical equipment (DME), specialized medical supplies (SMS) and assistive technology aids (hearing aids and other communication devices).

2.4 State Attendant Care (SAC) Program

This state funded program provides personal care services to members who have severe disabilities and are not eligible to receive these services through other sources. Members cannot be eligible to receive duplicate services under any other program. By receiving these services, a member is able to live at home instead of a nursing facility.
Requirements of the program include:

1) Must have a severe physical or mental impairment which limits his/her ability to obtain, maintain or advance employment.
2) No age restrictions.
3) Must not be eligible to receive duplicate services under any other programs.

The only services provided under the SAC Program are personal care services and case

management.

SECTION 3: REFERRAL INTAKE

3.0 Information and Referral

The Mississippi Department of Rehabilitation Services, Office of Special Disability Programs has an information and referral system in place.

This system provides:

- Individuals with disabilities information about services;
- The opportunity to be referred to other appropriate services and programs;
- The opportunity to be placed on the referral list for OSDP programs.

3.1 Receiving and Screening Individuals Receiving Services

A. The initial request for services may be made by:

- Self referral
- Relative
- Hospital
- Nursing facility staff
- Physician
- Friend, etc.

B. The OSDP staff must determine if the referral is appropriate.

The OSDP staff must review the referral for key information necessary for appropriate screening, such as:

1. Does the individual need assistance with a service provided by OSDP?

2. Does the individual meet the technical/medical criteria for OSDP programs? (Age, Impairment, Medical Stability)

3. If a waiver referral, does the individual have Medicaid? (Check Envision to determine)

4. If not, does the individual appear to meet the financial eligibility criteria for Medicaid, if applying through the waiver?

5. Does the individual have other comparable benefits that would provide the requested service?

6. If referred by another party, does the individual or his/her designated/legal

representative actually wish to be placed on the referral list?

7. Is the individual able to direct his/her own care and control of his/her personal resources, finances, etc.?

3.2 Screening Referrals for Specific OSDP Programs

A. The staff member accepting the initial referral must determine which of the following programs should be reflected on the referral based on the information received:

- Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Trust Fund;
- Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver;
- Independent Living (IL) Waiver;
- State Attendant Care (SAC) Program;
- Independent Living (IL) Grant.

B. Individuals should be informed of the services available through all programs and the current availability of specific programs including referral list procedures, if applicable.

C. If an individual requests to be placed on the HCBS Referral List after being informed of eligibility criteria, whether or not he/she appears eligible, the individual must be placed on the Referral List.

D. If an individual is requesting services that only a specific program can address such as Direct Care Worker (DCW) services, the program that provides that service must be checked on the referral so that the individual will be placed on that Referral List.

E. All referrals received are:

- Entered into the AACE Referral Module as soon as all the information is gathered in order to place the individual in the referral module.

- Do not enter partial information in the Referral Module. Only enter a referral in AACE, if you have all of the necessary and required information needed to determine an appropriate referral.

F. All referrals are organized by:

- The date of referral with the oldest date at the top of the list and the most recent date at the bottom of the list.

G. Individuals may be placed on more than one referral wait list, if they are eligible.

H. If a current referral wants additional services for a different program type, a new referral will be taken and entered for the new requested program.

I. If a current referral wants additional services for the same program type, the Case Manager will update the referral with the new requested services and enter a referral note.

3.3 Information to be Discussed When Contacting a Referral

When the initial contact is made with the referral, the OSDP Case Manager or Case Manager Assistant will complete/discuss the following:

- Explain basic program eligibility requirements;
- Explain services/options available;
- Confirm their desire to continue with the application process;
- Review and discuss their rights and responsibilities;
- Review and discuss eligibility criteria and responsibilities;
- Get information about financial eligibility;
- Obtain third-party resources (comparable benefits) including if they are receiving Home Health through Medicare and other formal and informal support systems;
- Present and review information about Medicaid Estate Recovery Program and document that this was presented and discussed (for Home and Community Based Services (HCBS) waiver applicants only).

3.4 Releasing Referrals from the Referral List

A. Referrals for OSDP Programs are placed on the Referral List in AACE based on the date (oldest to most recent) of their request for services.

B. MDRS/OSDP will maintain separate Referral Lists for individuals requesting services from the following programs:

- IL Waiver
- TBI/SCI Waiver
- TBI/SCI Trust Fund
- SAC Program
- IL Grant

C. As allocation allows, referral names will be released from the Referral List for individuals requesting services via the IL Waiver, TBI/SCI Waiver, SAC Program, TBI/SCI Trust Fund, and IL Grant.

D. On the date the referral is released, all referrals released will be assigned to an OSDP Case Manager for the area in which the individual will be served.

E. All referrals must be contacted, scheduled for a home visit and/or closed within fourteen (14) days of being assigned to the OSDP Case Manager.

F. Any referral can apply for services when:

- Their name comes to the top of the list;
- MDRS/OSDP has funding available to support the slots that have been federally approved;
- Funding is available to support the requested services, including the waivers.

G. All referrals will remain in the AACE Referral Module until funds become available for appropriate services or a request to be closed by the potential client.

3.5 Referrals for Individuals Temporarily Out of Their County of Residence

A referral that is in a hospital or long-term care facility that is not located in their native county, will have his or her application processed by a Case Manager assigned to the county he or she is temporarily residing in. Once the participant is approved for services, the initial Case Manager will transfer the case to a Case Manager in the participant's permanent county of residence.

The OSDP District Managers in both districts will collaborate and coordinate with their OSDP Case Managers to complete the waiver application and transfer.

The Case Manager in the county where the individual temporarily resides will provide the following case management services:

- Interview the member along with the responsible party (if applicable);
- Arrange for and conduct the initial assessment;
- Assist the member along with the responsible party (if applicable) with completing the application process;
- Obtain medical documentation such as Physician Certification, medical documents that indicate diagnosis, TBI/SCI Verification of the document (if applicable), etc.
- Discuss with Social Workers, etc. the services that the applicant will need and then the possible need for his or her assistance with obtaining required documents;
- Forward current information obtained by the OSDP Case Manager that will receive the case and any additional information that comes after the case file has been transferred; and
- Perform additional services that the two Case Managers have agreed upon due to the location of the needed request.

The OSDP Case Manager for the county in which the individual will reside is responsible for determining whether the applicant is eligible for services. This includes but is not limited to scheduling a visit to the member's permanent residence to ensure that the home

is safe for the member to reside. In addition, the Case Manager will be initiating services following the development of the PSS and/or certification for waiver services.

3.6 Referrals or Applicants Who Want to Request or Apply for the IL or TBI/SCI Waiver While Residing in a Nursing Facility

A. Any individual who is residing in a nursing facility (NF), whose NF services are being paid by Medicaid and wants to transition from the NF to the home and community may request and apply for services through the IL Waiver or TBI/SCI Waiver.

B. Within the IL Waiver - Appendix B, MDRS agrees to reserve capacity for each waiver year for individuals transitioning from nursing facilities (NF) and other home and community-based services (HCBS) waivers.

C. Due to the reserve capacity, individuals transitioning from a nursing facility (NF) and other HCBS waivers are placed at the top of the list for HCBS Waiver Referrals (IL Waiver and TBI/SCI Waiver) and are expedited in the transition to the home and community.

   - Individuals need to have been in the NF for 30 days to be considered for expedited transition.
   - Transition services must be provided within 90 days of the nursing home discharge.

D. The nursing home resident that is eligible to transition from the NF to one of the HCBS Waivers due to the reserve capacity will:

   1. Have their name placed on the IL Waiver or TBI/SCI Waiver Referral List and the referral will be released immediately.

   2. The release of the referral is contingent on:

      - A waiver slot is available and;
      - MDRS/OSDP has funding available to support the slots that are federally approved.
      - Must have a home to transition to.

   3. Must reside in the nursing facility (NF) until they receive notification of certification for home and community-based services. If the individual leaves the nursing facility (NF) prior to notification of certification by MDRS, their name will be put on the IL Waiver or TBI/SCI Waiver Referral List based on the date of referral. Waiver services will not begin until a certification date is received.

E. If the reserve capacity is not utilized within three (3) months of the end of the waiver year, MDRS reserves the right to reassign the reserve capacity for others awaiting

services.

F. Persons whose NF stay is temporary or rehabilitative or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this expedited transition service.

3.7 Transitioning from a Nursing Facility to the Waiver Program

OSDP Case Managers must strongly stress to referrals that are transitioning from a nursing facility (NF) on a waiver program the importance of remaining in the (NF) until they receive notification of certification from the OSDP Case Manager for home and community-based services.

- If the individual leaves the (NF) prior to notification of certification by MDRS, their name will be put on the IL Waiver or TBI/SCI Waiver Referral List based on the date of referral.

- If they are currently, an applicant for waiver services and leave the nursing facility prior to notification of certification for home and community – based services, services will not begin until a certification date is received.

SECTION 4: SERVICES

4.0 Services Available to Applicants/Members

The services available to members are dependent on the needs of the person as well as the specific services available through the member's approved waiver or program. Services complement and/or supplement the services that are available to members through the Medicaid State plan, private insurance and other federal, state, and local public programs as well as the supports that families and communities provide.

The following table specifies the services available for each program type:

	IL Waiver	TBI/SCI Waiver	TBI/SCI Trust Fund	State Attendant Care Fund	IL Grant
Case Management	X	X	X	X	X
Direct care worker services	X	X		X	
Respite		X	X		
Specialized Medical Equipment & Supplies	X	X	X		X
Transition Assistance	X	X			
Environmental Accessibility Adaptations	X	X	X		X
Vehicle Modifications			X		X
Emergency Services			X		
Transitional Attendant Care Services			X		

Hospice Concurrent Services	X	X			

The Case Management Team (OSDP Case Manager and Registered Nurse, if applicable) strive to identify the needs of the applicant/member to provide cost-effective services as identified on the plan of services and supports (PSS). OSDP Case Managers are responsible for ongoing monitoring of the provision of services included on the member's plan of services and supports (PSS). Services are furnished by MDRS/OSDP, providers/un-paid resources/vendors for MDRS/OSDP and Division of Medicaid.

4.1 IL & TBI Waiver Services

Applicants/members who are interested in receiving services through the IL or TBI/SCI waiver must meet nursing home level of care. The purpose of these services and supports is to keep the individual independent in their home and communities. Service descriptions are detailed below:

1. **Case Management –** Activities that assist the waiver applicant/member in gaining access to needed waiver services and other State plan services, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained, and also to needed non-waiver services from other resources or other OSDP Programs;

2. **Direct Care Worker (DCW) Services –** Assistance provided to a waiver applicant/member to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Direct care worker services may include the following: bathing, personal grooming, dressing, personal hygiene, toileting, transferring, assisting with ambulation, assistance with housekeeping, food shopping, meal preparation, assistance with eating, and community participation. Prior approval must be obtained from the Case Manager when the member is unable to go with the DCW into the community.

3. **Respite Services** ***(TBI/SCI Waiver & Trust Fund only)*** **–** Respite services are provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Room and board will not be reimbursed in any private residence including the individual's place of residence or the private residence of the respite provider. Respite hours allowed are as follows:

   a. **In-home Companion Respite** - 288 hours per year allowed

   b. **In-home Nursing Respite** – 288 hours per year allowed

4. **Specialized Medical Equipment and Supplies:** Devices, controls, appliances or medically necessary supplies which enable the member to increase their ability to perform his/her activities of daily living; perceive, control, or communicate with the environment in which they live;

5. **Transition Assistance Services:** A one-time initial expense required for setting up a household that is provided to a Mississippi Medicaid eligible nursing facility resident to assist in transitioning from a nursing facility to a waiver or program.

6. **Environmental Accessibility Adaptations:** Physical adaptations to the home, required by the member's plan of services and supports, which are necessary to ensure the health, welfare, and safety of the member, or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. Such adaptations may include the following: ramps, grab-bars, widening of doorways, and bathroom modifications.

7. **Hospice and HCBS Waiver Concurrent Services:** Applicants/members enrolled in the IL Waiver who elect to receive hospice care may not receive waiver services, which are duplicative of services rendered through hospice. Applicants/members may receive non-duplicative waiver services in coordination with hospice services. Since the programs offer similar services, it is imperative that the hospice provider and the OSDP Case Manager work together with the applicant/member and/or designated representative to assure the applicant/member's needs are met without duplicating services.

4.2 TBI/SCI Trust Fund Services

The TBI/SCI Trust Fund has services available to individuals with traumatic spinal cord or brain injuries. The Trust Fund is the payor of last resort, therefore an individual must seek assistance from all available resources prior to receiving Trust Fund assistance. Monies deposited in the fund shall be expended and authorized by the Department of Rehabilitation Services as authorized and appropriated by the Legislature. Trust Fund services include:

1. **Case Management –** Activities that assist the applicant/member in gaining access to needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

2. **Respite Services *(TBI/SCI Waiver & Trust Fund only)* –** Respite services are provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Room and board will not be reimbursed in any private residence including the individual's place of residence or the private residence of the respite provider. Respite hours allowed are as follows:

    a. **In-home Companion Respite** - 288 hours per year allowed
    b. **In-home Nursing Respite** – 288 hours per year allowed

3. **Specialized Medical Equipment and Supplies –** Devices, controls, appliances or medically necessary supplies which enable the member to increase their ability to perform his/her activities of daily living; perceive, control, or communicate with the environment in which they live;

4. **Home Modifications (Environmental Accessibility Adaptations [EAA]) -** Physical adaptations to the home, required by the member's plan of services and supports, which are necessary to ensure the health, welfare, and safety of the member, or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. Such adaptations may include the following: ramps, grab-bars, widening of doorways, and bathroom modifications.

5. **Vehicle Modifications -** Modifications to the member's vehicle to make it accessible for them, either as a driver or passenger. For additional guidelines, refer to Section 13, Assistive Technology Services.

   Note: Lifetime CAP for Specialized Medical Equipment, Home Modifications, and Vehicle Modifications combined is $50,000 per individual lifetime.

6. **Emergency Services –** Emergency services are services provided to individuals that are of a short-term, urgent, time sensitive nature and are considered critical for the individual's survival, general health, and welfare. There is a $1,000 lifetime cap limitation per individual.

   Note: Any requests for emergency services must be submitted to the TBI/SCI Trust Fund Coordinator for approval.

7. **Transitional Attendant Care Services -** An individual of the member's choosing to assist them with their activities of daily living for up to twelve (12) months. During this twelve-month lifetime period, the member and the OSDP Case Manager should make every effort to explore other attendant care options.

4.3 State Attendant Care (SAC) Services

Services offered through the State Attendant Care program assist individuals with severe disabilities that are not eligible to receive services through other resources or programs. Available services include:

1. **Case Management –** Activities that assist the applicant/member in gaining access to needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

2. **Direct Care Worker (DCW) Services –** Assistance. provided to an applicant/member to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Direct care worker services may include the following: bathing, personal grooming, dressing, personal hygiene, toileting, transferring, assisting with ambulation, assistance with housekeeping, food shopping, meal preparation, assistance with eating, and community participation. Prior approval must be obtained from the Case Manager when the member is unable to go with the DCW into the community.

4.4 Independent Living Grant Services

A) **Advocacy/Legal Services** – Assistance and /or representation in obtaining access to benefits, services, and programs to which an individual may be entitled.

B) **Assistive Technology** – Any assistive technology device, that is, any item, piece of equipment or product system that is used to increase, maintain or improve functional capabilities of individuals with disabilities and any assistive technology service that assists an individual with a disability in the selection, acquisition or use of an assistive technology device.

C) **Children's Services** – The provision of specific IL services designed to serve individuals with significant disabilities under the age of 14. (Not provided by OSDP)

D) **Communication Services** – Services directed to enable individuals to better communicate, such as interpreter services, training in communication equipment use, Braille instruction, and reading services. (Not provided by OSDP)

E) **Counseling and Related Services** – These include information sharing, psychological services of a non-psychiatric, non-therapeutic nature, parent-to-parent services, and related services.

F) **Family Services** – Services provided to the family members of an individual with a significant disability when necessary for improving the individual's ability to live and function more independently, or ability to engage or continue in employment. Such services may include respite care. Record the service in the consumer's CSR on behalf of whom services were provided to the family.

G) **Housing, Home Modifications, and Shelter Services** – These services are related to securing housing or shelter, adaptive housing services (including appropriate accommodations to and modifications of any space used to serve or occupied by individuals with significant disabilities).

H) **IL Skills Training and Life Skill Training Services** – These may include instruction to develop independent living skills in areas such as personal care, coping, financial management, social skills, and household management. This may also include education and training necessary for living in the community and participating in community activities.

I) **Information and Referral Services** – Identify all individuals who requested this type of assistance. This is the only service (other than services to family members) that may be provided to all individuals, whether or not the individual has a disability. Some entities record this service using strokes on an answering pad without opening a CSR, others create a CSR or other such file for future contact and outreach.

J) **Mental Restoration Services** – Psychiatric restoration services including maintenance

on psychotropic medication, psychological services, and treatment management for substance abuse. (Not provided by OSDP)

K) **Mobility Training Services** – A variety of services involving assisting individuals to get around their homes and communities.

L) **Peer Counseling Services** – Counseling, teaching, information sharing, and similar kinds of contact provided to individuals by other people with disabilities. (Not provided by OSDP)

M) **Personal Assistance Services** – These include, but are not limited to, assistance with personal bodily functions; communicative, household, mobility, work, emotional, cognitive, personal, and financial affairs; community participation; parenting; leisure; and other related needs.

N) **Physical Restoration Services** – Restoration services including medical services, health maintenance, eyeglasses, and visual services. (Not provided by OSDP)

O) **Preventive Services** – Services intended to prevent additional disabilities, or to prevent an increase in the severity of an existing disability.

P) **Prostheses, Orthotics, and Other Appliances** – Provision of, or assistance in obtaining through other sources, an adaptive device or appliance to substitute for one or more parts of the human body.

Q) **Recreational Services** – Provision or identification of opportunities for the involvement of consumers in meaningful leisure time activities. These may include such things as participation in community affairs and other recreation activities that may be competitive, active, or quiet. (Not provided by OSDP)

R) **Rehabilitation Technology Services** – Any service that assists an individual with a disability in the selection, acquisition or use of applied technologies, engineering methodologies or scientific principles to meet the needs of the individual and address the barriers confronted by individuals with significant disabilities with respect to education, rehabilitation, employment, transportation, IL and/or recreation.

S) **Therapeutic Treatment** – Services provided by registered occupational, physical, recreational, hearing, language, or speech therapists. (Not provided by OSDP)

T) **Transportation Services** – Provision of, or arrangements for, transportation. (Not provided by OSDP)

U) **Youth/Transition Services** – Any service that develops skills specifically designed for youth with significant disabilities between the ages 14 and 24 to promote self-awareness and esteem, develop advocacy and self- empowerment skills and career exploration, including the transition from school to post school activities such as postsecondary education, vocational training, employment, continuing and adult

education, adult services, independent living or community participation. (Not provided by OSDP)

V) Vocational Services – Any services designed to achieve or maintain employment. (Not provided by OSDP)

W) Other Services – Any IL services not listed above in A-V. (Not provided by OSDP)

4.5 Hospice and IL or TBI/SCI Waiver Concurrent Services

Communication and Coordination

- DOM requires Hospice and the OSDP Case Manager to work collaboratively when providing services to the same applicant/member.
- The Hospice Case Manager and the OSDP Case Manager are required to have regular communication with one another.
- If the applicant/member is enrolled in the IL or TBI/SCI waiver program, they may also elect to receive hospice services. As soon as the OSDP Case Manager is notified that the applicant/member has elected hospice services, the OSDP Case Manager must contact the hospice provider so that services are coordinated.
- The Hospice provider and the OSDP Case Manager must have a person-centered planning conference regarding the joint hospice plan of care and plan of services and supports (PSS) before concurrent services can start.
- The conference must include participation of the applicant/member and/or designated representative.
- The joint hospice plan of care and waiver plan of services and supports (PSS) must be retained in the applicant/member's record by both the hospice and the OSDP Case Manager.
- The hospice and OSDP Case Manager must work for a common goal and not provide duplicate services.
- Ongoing communication and coordination must occur regularly between Hospice and the OSDP Case Manager during the time they are providing services to the same applicant/member.
- Written documentation of this ongoing communication and coordination must be retained in the applicant/member's case file.

4.6 Potential Duplicative Services

Services considered to be potentially duplicative in nature must be coordinated in the joint

hospice plan of care and waiver plan of services and supports (PSS) to avoid duplicative services and include, but are not limited to:

1) Hospice Aide/Homemaker and IL or TBI/SCI waiver direct care worker services;

2) Hospice in-patient respite and IL or TBI/SCI waiver institutional respite;

3) Hospice medical appliances and supplies and IL or TBI/SCI waiver specialized medical equipment and supplies;

4) Hospice physical therapy, speech-language pathology and occupational therapy, and IL or TBI/SCI waiver physical therapy, speech therapy and occupational therapy;

5) Hospice nursing care and IL or TBI/SCI waiver home health skilled nurse visits.

Care planning requirements

- The hospice provider is the primary provider and manages the joint hospice plan of care and IL or TBI/SCI waiver plan of services and support, when a person is receiving both hospice and waiver services;

- The joint hospice plan of care and IL or TBI/SCI waiver plan of services and support must be retained in the applicant/member's record by both hospice and the OSDP Case Manager;

- The joint hospice plan of care and IL or TBI/SCI waiver plan of services and support (PSS) must clearly identify the services the applicant/member receives, which entity is responsible for providing the services, and the frequency of the services to be provided; For example, the joint plan of care and IL or TBI/SCI waiver plan of services and support related to homemaker/aide/direct care worker services should be task oriented with a designation of which task would be provided by the hospice provider and which task would be provided by the IL or TBI/SCI waiver DCW;

- Each IL or TBI/SCI waiver service included in the joint hospice plan of care and IL or TBI/SCI waiver plan of services and support must be accompanied by documentation stating why the service is not covered under hospice;

- The frequency of hospice and IL or TBI/SCI waiver services must be coordinated in the joint hospice plan of care and IL or TBI/SCI waiver plan of services and support to avoid duplicative visits;

- The hospice provider and OSDP Case Manager must have a conference regarding the joint hospice plan of care and plan of services and support before concurrent services can start;

- The conference must include participation of the applicant/member and/or designated representative.

Service Utilization

- Hospice benefits must be fully utilized prior to waiver service utilization in instances of potential duplication.

- DOM will conduct retrospective reviews of waiver and hospice services.

- If duplication of services is found, DOM may seek recovery of Medicaid funds paid for those services.

IL/TBI/SCI Waiver Eligibility Requirements

- All certification/recertification requirements under 42 CFR, Part 418 must be met. Refer to Miss. Admin. Code Title 23, Part 205, Ch. 1, Rule 1.3. Continued Medicaid eligibility is determined by the regional office and waiver service changes must be communicated to the hospice provider.

- An applicant/member that is receiving in-home hospice and home and community-based service (IL or TBI/SCI) waiver services, but then chooses in-patient hospice care, must be discharged immediately from waiver services.

- IL or TBI/SCI waiver services will be suspended for applicants/ members receiving in-patient hospice respite services. If the applicant/member does not receive waiver services for more than thirty (30) days, the applicant/member must be discharged from the IL or TBI/SCI waiver.

SECTION 5: APPLICATION

5.0 Application For OSDP Services

The Case Manager must complete the official documentation for applicants who wish to apply for services under the Office of Special Disability Programs. This application process takes place at the initial home visit and includes completing the Request for OSDP Services intake form, the Statement of Understanding, Consent to Disclose, HIPPA, Statement to Permit Medicaid Payment form, Voter Registration and the Assessment forms. These documents/forms can be found on the T: drive. All completed forms are then placed in a new case file when the Case Manager returns to the office.

Additionally, Estate Recovery must be discussed at this time with waiver applicants.

5.1 Request for OSDP Services

The application process begins with the Request for OSDP Services Intake form which is

completed at the initial home visit. The purpose of this form is to gather all relevant personal and financial information in addition to the person's disability, family support, etc.

The Request for OSDP Services Intake Form is completed for waivered and non-waivered services through OSDP and is one component to assist the Case Manager in determining eligibility. This form needs to be filed in the applicant's case file when the Case Manager returns to the office.

The Application Documentation

The Application Documentation Page that is a part of the Request for OSDP Services intake form is very important to the overall case process. This information lays the foundation of the entire casework process.

Documentation

Reasons for seeking services:

In this section, the Case Manager should record information that they received during the initial application process regarding the individual's disability and their medical history to help the Case Manager determine what medical or other information should be requested from third parties. The history of the individual's adjustment or lack of adjustment to their impairment is very important, as well as their family support system.

5.2 Statement of Understanding

During the initial home visit for waivered, IL Grant, State Attendant Care and TBI/SCI Trust fund, the Case Manager will present the Statement of Understanding to the applicant. It is the Case Manager's responsibility to ensure the applicant comprehends the entirety of the form, which includes the following:

a) The presence of a significant mental or physical disability;

b) The presence of a severe limitation in ability to function independently in the family or community; and

c) A reasonable expectation that independent living rehabilitation services will significantly assist in the ability to function more independently in the family or community or to engage or continue in employment.

MDRS may obtain personal information from the applicant, their representative, services providers, and cooperating agencies for eligibility purposes with assurances that this information may not be divulged except:

d) To the applicant or their representative, when requested in writing, unless MDRS believes it harmful to do so;

e) For audit, evaluation, or research purposes;

f) To other programs for the applicants' benefit (e.g., DDS, Mental Health, DHS) or as required by federal law.

All services will be available to applicants regardless of race, gender, color, religion, marital status or national origin.

Once an applicant is determined eligible, the Case Manager will involve them in planning for their services and will review the plan annually. Services are dependent upon the availability of funds, and if there is any delay in the provision of services at any time, the person will be promptly advised. Persons will need to understand that they may also have to contribute toward program costs.

The person is advised during this time to keep scheduled appointments with their Case Manager and service providers. In the event that the person is not satisfied with decisions made by their Case Manager, they can appeal his/her decision in writing to the District Manager.

Additionally, persons may contact the statewide Client Assistance Project (CAP) with questions or concerns about services provided by OSDP. The CAP staff will work with each party to assist in resolving the problem.

Once the person acknowledges and signs the Statement of Understanding, the form will be filed in the applicant's case file when the Case Manager returns to the office.

TBI/SCI Trust Fund Statement of Understanding

TBI/SCI Trust Fund applicants sign an additional Trust Fund Statement of Understanding which notifies applicants that attendant care services provided through the Trust Fund are available only for a short term and will not exceed a maximum of twelve (12) months from the date of initiation of services.

During this twelve-month period, efforts will be made to enroll applicants in the TBI/SCI Home and Community-Based Waiver Services Program based on eligibility criteria established by Medicaid, availability of openings, and adequate funding.

In the event that enrollment in the Home and Community-Based Program is not possible, the person or their legal representative is responsible for seeking other resources that would address the attendant care services beyond the initial twelve-month service period. The form will be filed in the applicant's case file when the Case Manager returns to the office.

5.3 Health Information Portability and Accountability Act (HIPAA)

At the initial home visit, applicants are given the Notice of Privacy document. The Case Manager will review this document with the applicant to ensure that they understand their

health information protections. At this time, the applicant will sign the receipt of notice form which is then filed in the case file when the Case Manager returns to the office.

The Health Insurance Portability and Accountability Act of 1996, allows individuals to set boundaries on who has access to their protected health information. It is MDRS legal duty to maintain the privacy of a person's health information and to provide notice to an applicant. The Case Manager must verify the applicant comprehends their rights.

5.4 Authorization for the Use/Disclosure of Protected Health Information

The applicant signs this form to authorize the Case Manager to request and receive medical records on their behalf. The content of this form specifies:

a) For one time use and/or disclosure

b) One year from the effective date of signature/or upon revocation

c) Release to an attorney throughout the course of representation at his/her request.

Persons are under no obligation to sign this authorization. However, the Department of Rehabilitation may condition eligibility for benefits on the signing of this authorization if the information is necessary to determine a person's eligibility or enrollment in MDRS services, however not for the use or disclosure of psychotherapy notes.

Information disclosed pursuant to this authorization may be re-disclosed, by the recipient, to additional parties and may no longer be protected. If this authorization is signed by a personal representative, supporting documents must be attached to confirm the representative's right to make this request.

The specified information is necessary and related to the program of services and its confidentiality and privacy is to be respected by the recipient in accordance with all applicable federal and/or state laws and regulation on confidentiality. Use of copies, including electronic copies are also authorized.

The form will be filed in the applicant's case file when the Case Manager returns to the office.

5.5 Opportunity to Register to Vote

The following are instances in which a Case Manager should give applicants/members an opportunity to complete the mail-in Voter Registration Application at their home:

1. At the time of application,

2. At annual re-certifications,

3. Change of address, or

4. When requested.

Applicants/members must be given the opportunity to:

1. Complete the mail-in Voter Registration application at home and mail it in, or

2. Leave the completed form with MDRS staff.

3. Complete the portable Voter Registration form online.

If the member wishes to complete the form during the interview, the OSDP Case Manager should:

1. Review the form for completeness in the presence of the member.

2. If it does not contain all the required information and/or the required signature, return it to the member for completion.

Voter Registration forms must be transmitted to the appropriate county voter registrar within five (5) days of receipt from applicant/member. If the applicant or member is not of voter registration age, do not complete the voter registration form.

The Case Manager must document, in the case file, any action when the member asks to register to vote. Any questions regarding voter registration process, can be directed to www.MSVoterID.ms.gov or by calling (844) 678-6837.

5.6 Informing Applicants of Estate Recovery

All persons applying for IL Waiver or TBI/SCI Waiver services must be informed about Medicaid Estate Recovery. During the initial application process, the Case Manager must inform the person about Estate Recovery and document in the case file that this information was provided to them. In addition, all waiver recipients must be given the DOM's contact person and phone number to refer for more estate recovery information. At application, the fact that the person was informed of Estate Recovery has to be documented in the initial home visit case note.

In order for Estate Recovery to apply, the applicant/person must be eligible for Medicaid and be:

- age 55 and older, and,
- in a nursing facility or enrolled in a home and community-based services waiver program at the time of death.
- enrolled in hospice at the time of death.

The Estate Recovery law does not apply if, at the time of death, the applicant/person has:

- A surviving husband or wife, or
- A surviving dependent child or children under 21 years of age, or
- A surviving dependent child or children of any age who are blind or disabled, or
- An undue hardship condition that causes Estate Recovery not to apply.

Estate property is made up of real and personal property that the applicant/person owns at the time of death:

- Real property such as home, family business, farm or ranch;
- Cash reserves, stocks, bonds, automobiles, recreational vehicles, mobile home;
- Or any property with value owned by the beneficiary in full or in part

5.7 Application Completion

At the conclusion of the application process in which the applicant has signed the Request for OSDP Services, Statement of Understanding, Consent to Disclose, HIPAA, Statement to Permit Medicaid Payment form and Voter Registration forms, the Case Manager will ask the applicant if they have any questions or need any clarification. If the applicant agrees to move forward, the Case Manager will conduct the interRAI assessment with a registered nurse. The Case Manager will return to the office and enter a case note in AACE. The case note will contain a summary of the home visit and all relevant information gathered during the initial home visit. All forms will be filed in the applicant's case file and stored in a secure location.

SECTION 6: ELIGIBILITY FOR IL AND TBI/SCI WAIVER SERVICES

6.0 Independent Living (IL) Waiver Eligibility

The Independent Living (IL) waiver provides services to persons who, but for the provision of such services, would require the level of care found in a nursing facility. The IL Waiver is a Medicaid home and community-based waiver operated jointly with the Division of Medicaid.

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 DOM, has been achieved when the following criteria are met:

- Person/applicant is able to communicate effectively (verbally or non-verbally) with caregiver, Direct Care Workers (DCW), Case Managers and others;

- Person/applicant is medically stable as certified by their primary physician. Medical stability is defined as the absence of the following:

    - an active, life-threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);

- intravenous drip to control or support blood pressure;
- inter-cranial pressure or arterial monitoring; and
- 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.

Clinical eligibility for the IL waiver will be determined through the utilization of a comprehensive assessment which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services.

Persons/applicants must be Medicaid eligible either as an SSI recipient or meet the 300% of the Supplemental Security Income Federal benefit rate.

Note: All services are provided pursuant to an individualized plan of services and supports (PSS) approved by the Division of Medicaid.

Additional Eligibility for IL Enrollment:

The basic eligibility criteria include:

- age - 16 years of age or older;

Note: Elderly and Disabled (E & D) Waiver serves individuals 21 years of age and older. IDD Waiver serves children under age 21.

- financial eligibility – the person must be eligible for Medicaid as described in the waiver;
- medical necessity – the person must meet the level of care criteria for nursing facility (NF) care.

The waiver specific criteria the person must meet is based on his/her choice of services and service planning. They must:

- have a severe orthopedic and/or neurological impairment that renders the person dependent on others, assistive devices or other types of assistance, or a combination of the three to accomplish the activities of daily living.
- choose home and community-based services in lieu of nursing facility care/informed choice;
- have an on-going need for waiver services;

- need assistance with one or more of the activities of daily living such as dressing, bathing, eating, toileting, transferring;

- Be medically stable as certified by a physician or nurse practitioner. Medical stability is defined as the absence of any of the following: (a) an active, life-threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) intravenous infusions to control or support blood pressure; (c) intracranial pressure or arterial monitoring.

- be able to communicate effectively (verbally or non-verbally) with caregivers, DCWs, Case Managers, and others involved in their care, and

- be at risk of nursing facility placement if services were not available.

Enrollment in the Independent Living Waiver is limited to:

- the number of persons approved by the Centers for Medicare and Medicaid Services (CMS) or the availability of state funding

- persons are enrolled from the Independent Living Waiver Referral List on a "first come, first served" basis

- MDRS suspends enrollment into the waiver program when it is determined that the existing caseloads exceed funds within the current budget year.

6.1 Traumatic Brain Injury (TBI)/Spinal Cord Injury (SCI) Waiver

The Traumatic Brain Injury (TBI)/Spinal Cord Injury (SCI) waiver provides services to persons who, but for the provision of such services, would require the level of care found in a nursing facility. The TBI/SCI Waiver is a Medicaid home and community-based waiver operated jointly with the Division of Medicaid.

Eligibility Criteria:

1. Must have a certified traumatic brain or spinal cord injury. See Spinal Cord/Traumatic Brain Injury Verification Form.

   - Traumatic brain injury is defined 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 deficit.

   - Spinal cord injury is defined as a traumatic injury to the spinal cord or the cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

2. The extent of the injury must be certified by their physician or nurse practitioner.

3. Be medically stable as defined by the absence of the following:

    a. an active, life-threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);
    b. intravenous drip (IV) to control or support blood pressure;
    c. intracranial pressure or arterial monitoring

4. Certified as meeting nursing home level of care by their primary care physician or nurse practitioner;

5. At risk of nursing home placement in the absence of waiver services;

6. Meet the special income and assets limits (up to 300% of the Supplemental Security Income federal benefit rate) SSI.

This waiver is limited to individuals who are able to direct their own care or have a legal representative who they have chosen to direct their care.

Additional Eligibility for TBI Enrollment

The basic eligibility criteria include:

- age - no age limit;

- financial eligibility – the person must be eligible for Medicaid as described in the waiver;

- medical necessity – the individual must meet the level of care criteria for nursing facility (NF) care.

The waiver specific criteria the person must meet is based on his/her choice of services and service planning. They must:

- choose home and community-based services in lieu of nursing facility care/informed choice;

- have a severe traumatic brain and/or spinal cord injury verified by a physician or nurse practitioner;

- have an on-going need for waiver services;

- needs assistance with one or more of the activities of daily living such as dressing, bathing, eating, toileting, transferring;

- be at risk of nursing facility placement if services were not available.

Enrollment in the TBI/SCI Waiver is limited to:

- the number of persons approved by the Centers for Medicare and Medicaid Services (CMS) or the availability of state funding

- persons are enrolled from the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver referral list on a "first come, first served" basis.

- MDRS suspends enrollment into the waiver program when it is determined that the existing case loads exceed funds within the current budget year.

Note: All services are provided pursuant to an individualized plan of services and supports (PSS) approved by the Division of Medicaid.

6.2 Traumatic Brain Injury (TBI)/Spinal Cord Injury (SCI) Physician Verification

The Traumatic Brain Injury/Spinal Cord Injury Physician Verification form must be completed by the physician certifying that the person's injury was due to trauma and that their condition is medically stable.

The original copy of the TBI/SCI Verification form should be kept in the case file and a copy submitted to the DOM with the assessment.

It is necessary to use the verification form that is in the actual TBI/SCI Waiver.

(*See* Resource Guide for a copy of the TBI/SCI Verification form)

6.3 Pre-Admission Screening Appeals

Applicants/persons have the right to appeal long term care eligibility denials. If a person files an appeal and the case has not already been subject to the secondary review process, it will be handled in the manner described in Section 10.4. If the secondary review has already occurred, the case will be reviewed again by a supervisory level clinician who has not previously reviewed the case. Appeals will be processed in accordance with existing state policies.

6.4 Secondary Clinical Reviews

Secondary clinical reviews will be performed in the following circumstances:

- Individual scores below the clinical eligibility numerical threshold but falls into a DOM defined "automatic secondary review" range (score of 45-49)
- Individual is under the age of twelve (12) on the date of the screening
- Individual appeals the denial in accordance with Medicaid's appeal procedures

Secondary reviews will be performed by DOM Registered Nurses, Nurse Practitioners, Licensed Social Workers and/or physicians as deemed by DOM to be clinically appropriate. DOM reviewers may request additional supporting documentation from the OSDP Case Manager before making a determination. The OSDP Case Manager also may submit additional supporting documentation, in a format specified by DOM, for consideration during the secondary review.

In conducting the secondary review, the reviewer may consider all available information from the assessment as well as any additional documentation provided by the OSDP Case Manager or applicant/person. The reviewer also may consult with the OSDP Case Manager and/or the certifying physician.

Once the secondary review is completed DOM will notify the applicant/person and MDRS of its determination. If the secondary review upholds the finding of clinical ineligibility, the applicant/person retains the right to appeal.

6.5 Applicants without Medicaid Eligibility

The completed assessment will be adjudicated through application of an eligibility algorithm that generates a numerical score. The numerical score will be compared to a DOM defined threshold score of fifty (50) or greater. If a person's score is equal to or greater than the threshold of fifty (50), the applicant/person will be determined clinically eligible for Medicaid long term care.

Persons seeking applicable HCBS waiver programs that meet the threshold of fifty (50) or greater, or approved based on a secondary review will be referred to the requested HCBS waiver program. Each request will be considered individually and the applicant/person shall be admitted to the waiver as soon as possible. DOM/LTC will submit the required documentation for eligibility prior to admission as required for each HCBS waiver program. Financial eligibility requirements must be met at that time.

6.6 Appeal and Hiring Procedures for the Waiver

Decisions that result in services being denied, terminated, or reduced may be appealed. The person/legal representative has thirty (30) days from the date on the notice to appeal the decision. The person/legal representative can elect either a local or state hearing. **All appeals must be in writing.**

The consumer/legal representative is entitled to an initial appeal at the local level with the MDRS/OSDP Counselor and the immediate supervisor. The action will be explained at that time. The local hearing will be documented and become a permanent part of the consumer file.

If the consumer/legal representative does not agree with the decision made following the local hearing, he/she may appeal that decision by requesting a State level hearing within 15 days of the notice of the local hearing decision. The consumer/legal representative must submit this request in writing to the Division of Medicaid. Upon receiving the notification

from the Division of Medicaid that the consumer has requested a State level hearing, the OSDP Counselor/District Manager assigned will prepare a copy of the pertinent case file documentation used to reach the decision and send the copy to OSDP in the State Office. The copy of the documentation must be forwarded to the Division of Medicaid no later than five (5) days after MDRS has been notified that the consumer has requested a State level hearing.

The Division of Medicaid will assign a hearing officer. The consumer/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 of the Division of Medicaid. The Executive Director will make the final determination of the case, and the consumer/legal representative will receive written notification of the decision. The final administrative action including state or local will be made within ninety (90) days of the date of the initial request for a hearing. OSDP 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 or sexual harassment of the service providers. The OSDP Counselor/registered nurse is responsible for ensuring that the consumer receives all services that were in place prior to their receipt of the notice that informed them that an action will occur regarding services.

NOTE: *Refer to Resource Guide for appropriate notice of action forms.*

6.7 Continuation of Services

(42 CFR 431.231)

If the person requests a hearing within 10 days of the date on the notice and prior to services being terminated, the services that the consumer is currently receiving may continue during the hearing process until a decision is made. Services must also continue if:

- Action is taken without giving the consumer advance notice of action when required;

- MDRS/OSDP determines that the action resulted from reasons not supported by Federal and State law or MDRS/DOM policy;

- If the person is unable to be located, services that were terminated must be reinstated if the person is located and requests that services be reinstated. *Reinstatement occurs only if they are still certified for the waiver (same certification year).*

6.8 Termination of Services if the Person Does Not Appeal

If a person does not request an appeal or request that services continue, IL or TBI/SCI Waiver services will end on the termination date that is on the notice they received.

If the certification ends before the 10-day notification period expires, the Case Manager will continue services through the 10-day notification period.

SECTION 7: INITIAL ASSESSMENT

7.0 interRAI Assessment Determination Requirements

The new interRAI assessment process became effective on September 1, 2017. All applicants/persons applying for Medicaid long-term care on September 1, 2017 and beyond must complete an interRAI assessment for clinical eligibility determination. The interRAI assessment needs to be submitted to DOM within thirty (30) days of the Level of Care date.

Persons enrolled in Medicaid long term care must be recertified annually. Persons desiring continued waiver services must be recertified by submission of a new interRAI assessment at least ten (10) days, but no more than ninety (90) days, prior to the expiration of the current assessment. Failure to submit timely may result in a lapse in certification.

7.1 interRAI Assessment Requirements

An initial interRAI assessment must be completed by a certified OSDP Case Manager and Registered Nurse. In addition, the Registered Nurse must have a current, active, and unencumbered registered nurse license to practice in the state of Mississippi, or be working in Mississippi on a privilege with a valid compact RN license, and at least one year of experience with the aged and/or individuals with disabilities. The nurse must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The RN's name must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General's (OIG) exclusion list.

The requirements for completing the interRAI assessment are as follows:

- Conduct a face-to-face interview with the applicant/person to the extent feasible, given the person's physical and cognitive status;
- Obtain information from caregiver(s) and/or designated representative, to the extent practicable;
- Review medical records and other relevant medical documentation to verify medical conditions and services, to the extent practicable;
- Provide information to the applicant/person and their responsible party/designated representative about available Medicaid program placement options, to facilitate informed decision making;
- Provide information about alternative services/resources for persons who may not be eligible for Medicaid long term care; and
- Provide information about the secondary review process and appeal rights for persons who may not be eligible for Medicaid long term care.

7.2 Documentation of Informed Choice

When a person is determined likely to require a home and community-based waiver service, the person and/or the person's legal representative will be:

- Informed of any feasible alternatives under the waiver; and
- Given the choice of either institutional or home and community-based services.

The person and/or the person's legal representative will sign the acknowledgment form where long term services and supports options were presented and explained. They also will acknowledge participation in selecting the desired waiver and of being informed of the Medicaid Program's financial eligibility requirements.

The OSDP Case Manager must also sign the Informed Choice to acknowledge that the person and/or the person's legal representative was informed of the available long-term care options.

(*See* Resource Guide for the interRAI Informed Choice form).

The consumer cannot receive services from:

- More than one Medicaid Waiver program at a time, including waivers that are administered by the Department of Rehabilitation Services. This includes but is not limited to the Elderly and Disabled (E & D) Waiver and the Assisted Living (AL) Waiver.

- A Medicaid institutional program such as a nursing home facility.

7.3 Person's Choice and Comparable Benefits

Non – Waiver Services

The Case Management Team must document any available benefits and services the person is receiving before waiver funds are used to meet the person's needs. Example: If the person is eligible for Medicare and needs medical supplies/equipment. These services must be provided using Medicare resources before utilizing IL Waiver or TBI/SCI waiver funds.

The OSDP Case Manager is responsible for assisting the person in applying for and using all available non-waiver services.

The OSDP Case Manager must consider all third party resources including services provided by family members and other informal supports to reduce waiver expenditures. Non-waiver services must be considered in the development of the Plan of Services and Supports (PSS) and must not duplicate IL Waiver or TBI/SCI Waiver services.

7.4 Applicants Without Medicaid Eligibility

If the applicants' individual income exceeds the Supplemental Security Income federal benefit rate (FBR) per month, the applicant can apply for Medicaid through the Special Handicapped Coverage Group, 300% of SSI federal benefit rate which is the institutional income limit for persons entering a nursing facility. The special income level permits Medicaid to cover persons who would be eligible for Medicaid as if they were in a nursing facility. The Special Income Criteria allows eligibility for persons with gross income at or below 300 percent of current SSI.

The special handicapped coverage group only applies to persons who have been determined to meet the medical eligibility criteria for the waiver by DOM.

The Special Income Criteria:

- Allows eligibility for persons with gross income at or below 300 percent of current SSI.
- Allows states to provide home and community based waiver services to children without regard to their parents' income or assets and to married individuals without regard to their spouse's income.
- Requires states to impose a post-eligibility cost-sharing burden.
- When the 300 percent rule is a state's only option for providing Medicaid to higher income persons, it allows persons to achieve eligibility by diverting excess income into a Miller Trust (income trust account).

7.4.1 Applicants with Medicaid Eligibility Coverage

At the time of the initial intake, information on the applicant's Medicaid and/or financial status will be obtained. OSDP staff handling the initial intake must determine if the applicant is currently on Medicaid and should check LTSS to confirm the applicant's current status.

Applicant's who receive Supplemental Security Income (SSI) are already eligible for Medicaid and will not need to have a Medicaid eligibility decision.

It is the OSDP Case Manager's responsibility to assist the person in applying for Medicaid benefits.

7.5 Application Process for Medicaid Eligibility Determination

If the person does not have Medicaid coverage, their case record will be reviewed by the Division of Medicaid/Long Term Care (DOM/LTC) to determine if they meet the medical criteria for the waiver. If approved, the DOM will forward notification to the Medicaid regional office that the applicant has met medical certification for participation and would like to apply for coverage under the Home and Community based services Special Income

Category (300% of SSI).

DOM/LTC will approve the Level of Care (LOC) in LTSS. This will notify the OSDP Case Manager that the person's application for waiver services has been determined to meet the medical criteria for the waiver and will be certified pending approval for Medicaid coverage.

The OSDP Case Manager will inform the person in writing or by phone that he/she will need to go to their Medicaid Regional Office within 10 days to apply for Medicaid eligibility through the Special Handicapped Coverage Group.

The HCBS Division will maintain a case record in a pending status for 60 days from the date it was processed. If the applicant and/or their representative does not initiate appropriate action to obtain eligibility, failure to comply will result in closure of their case.

After the applicant completes the application at the Regional Office, they have 45 days to provide all requested information to complete the eligibility process. Failure to comply will result in closure of their case. Medicaid will inform the OSDP Case Manager that he/she has been approved.

Examples:

> Case record is approved 5/01/16, the applicant takes no action toward obtaining Medicaid eligibility by 07/01/16, case record will be disapproved and returned to the Case Manager.
>
> Case record approved 5/01/16, applicant waits until 06/29/16 to fill out application at the Regional Office, the "clock" restarts time -allows applicant 45 days to complete the eligibility process.

No services can be initiated under the waiver program until eligibility has been established. The DOM will submit an approved Overall Decision in LTSS. The effective date is now the Level of Care date.

7.6 Family Members and Informal Supports

As part of the initial assessment, the Case Manager determines the need for personal care services and the estimated hours necessary to meet those needs. The need for a particular task is determined based on a person's functional limitations to complete that task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports. Personal care hours cannot be authorized if there is not a need for these services.

The Plan of Services and Supports (PSS) should be developed considering the needs of the person and the stated intentions and willingness of the caregiver and other informal supports to provide unpaid care. The PSS will reflect hours of those needed tasks that will not be provided by another source or the caregiver as unpaid care. The caregiver should

be asked in all cases which services/tasks he or she will provide without payment.

A legally responsible person, such as a spouse or parent of a minor, may not be employed to be paid as a Personal Care Attendant.

Additionally, there must be adequate justification for the relative to function as the PCA, e.g., lack of other qualified PCAs in remote areas. PCA services may be furnished by family members provided they are not the parent (or stepparent) of a minor child, or their spouse. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.

7.7 Informal Support Providing Assistance With Activities of Daily Living

Activities of daily living necessary for daily functioning include eating, toileting, transferring, dressing, bathing, personal hygiene, ambulation and meal preparation as identified in the interRAI assessment. The activities of daily living are those tasks that do impact the person's health and safety.

7.8 Ensuring Health and Safety

The OSDP Case Manager and a Registered Nurse have the responsibility to ensure the person's health and safety and develop a Plan of Services and Supports (PSS) that includes all necessary elements to adequately meet the person's needs. Use of informal supports, third party resources and other community resources are an integral part of the overall development of the PSS. The use of third party resources ensures the most cost-effective and efficient use of funds to meet the person's needs.

The Case Manager must inform the family member or other non-paid supports of the importance of their contribution toward the Plan of Services and Supports.

7.9 Informing Applicant/Persons of Estate Recovery

All persons applying for IL Waiver or TBI/SCI Waiver services must be informed about Medicaid Estate Recovery. During the initial application process or quarterly home visits, the Case Manager must inform the person about Estate Recovery and document in the case file that this information was provided to them. In addition, all waiver recipients must be given the DOM's contact person and phone number to refer for more estate recovery information. At application, the fact that the person was informed of Estate Recovery should be documented in the initial home visit case note.

7.10 What is Estate Recovery?

In order for Estate Recovery to apply, the applicant/person must be eligible for Medicaid and be:

- age 55 and older, and,
- in a nursing facility or enrolled in a home and community based services waiver program at the time of death.
- enrolled in hospice at the time of death.

The Estate Recovery law does not apply if, at the time of death, the applicant/person has:

- A surviving husband or wife, or
- A surviving dependent child or children under 21 years of age, or
- A surviving dependent child or children of any age who are blind or disabled, or
- An undue hardship condition that causes Estate Recovery not to apply.

Estate property is made up of real and personal property that the applicant/person owns at the time of death:

- Real property such as home, family business, farm or ranch;
- Cash reserves, stocks, bonds, automobiles, recreational vehicles, mobile home;
- Or any property with value owned by the beneficiary in full or in part

7.11 interRAI Instrument Components

The interRAI consist of nineteen (19) sections, some of which have two (2) or more subsections. The table below lists the sections:

Section
A. Identification Information
B. Intake and Initial History
C. Cognition
D. Communication and Vision
E. Mood and Behavior
F. Psychosocial Well-being
G. Functional Status
H. Continence
I. Disease Diagnoses
J. Health Information
K. Oral and Nutritional Status
L. Skin Condition
M. Medications
N. Treatments and Procedures
O. Responsibility
P. Social Supports
Q. Environmental Assessment
R. Discharge Potential & Overall Status
T. Assessment Information

7.12 **interRAI Certification Periods**

Clinical eligibility will be granted for a period of one year. HCBS waiver persons desiring continued waiver services must be recertified by submission of a new interRAI assessment at least ten (10) days (but no more than ninety (90) days) prior to date of expiration of the current interRAI assessment. Failure to submit the assessment to the DOM timely will result in a lapse in certification. If there is a lapse in certification, all services must stop for the person until DOM has approved the recertification application packet.

7.13 **interRAI Re-Certification**

A re-assessment of a person's functional limitations and functional capacities as they relate to activities of daily living and their impairment must be completed annually for persons enrolled in the waiver. The re-certification re-assess' their need for services that will be developed on the PSS to maintain them in his/her own home.

It is the responsibility of the OSDP Case Manager to complete the annual re-certification. It is performed in the home and again gives the Case Manager the opportunity to visually re-assess if the person continues to meet the medical criteria for the waiver program.

In order to assure that the PSS is reassessed annually as required by the waiver requirements, the Case Manager must:

1. Begin the re-certification process no sooner than 90 days prior to the certification end date/expiration of the current LOC date;
2. Complete the development of the re-certification PSS and verify all aspects of eligibility and;
3. Complete all necessary procedures no sooner than 90 days prior to the expiration of the current PSS and submit all information to OSDP Nurse Administration no later than 60 days prior to the expiration of the current LOC date.
4. Enter information in the OSDP program certification page to reflect the date of reassessment.

In addition to the above, the Case Manager must run their tickler file from AACE which will ensure timely recertifications.

Note: Case Managers must ensure that the person understands that all services provided through the HCBS Waiver programs are subject to the approval of the Division of Medicaid.

SECTION 8: PLAN OF SERVICES AND SUPPORTS (PSS)

8.0 **Home and Community-Based Services – Plan of Services and Supports (PSS)**

The Plan of Services and Supports (PSS) is the fundamental tool by which the health and

welfare of the member served under the waiver is assured. It is the link between the assessment and delivery of services.

The OSDP Case Manager/Registered Nurse must, together with the potential member, develop a PSS based upon assessment results.

The Plan of Services and Supports is developed at an in-person meeting with the member/consumer by the OSDP Case Manager and RN.

The member's deficits identified on the interRAI assessment are addressed by the OSDP Case Manager and Registered Nurse to develop a written plan of services and supports. The PSS is used to address those services and activities to overcome or enrich the effect of the deficits in accomplishing the activities of daily living and maintaining an independent lifestyle in the community.

The medical and physical limitations are considered simultaneously with the independent living potential of the member to avoid institutionalization.

Applicable non-waivered services, services provided by other funding sources, are included in the PSS and subsequently monitored as non-waivered services.

The need for any services on the PSS must be addressed in one or more of the assessment areas (ex. Home Modification and Specialized Medical Supplies).

Note: There are no pre-determined or fixed limits on the number of services or the number of units of any particular service.

The Plan of Services and Supports is subject to periodic reviews and updates. The purpose of these reviews is to determine the appropriateness and adequacy of the services provided and to ensure that the services furnished are consistent with the nature and severity of the member's disability.

Plan of Services and Supports must be submitted for the initial certification and annually for each re-certification. Added services must be approved by DOM. Sufficient documentation must be submitted to justify the added service request.

8.1 The Case Management Team at the Service Planning Meeting

The OSDP Case Manager leads the Case Management Team. Those included in the Case Management Team are the Case Manager, member or their designated representative and the Registered Nurse.

The Case Management Team is involved and is responsible for planning through the assessment of the member's needs during the development of the Plan of Services and Supports. The Case Management Team is responsible for:

- Considering all available assessment information

- Estimating costs for the types and amounts of services identified as necessary to meet the member's needs
- Determining that the member can be served safely in the community
- Identifying the waiver and non-waiver services to be used to meet members' needs
- Documenting the PSS and other supporting documentation
- Determining that the services identified on the PSS are necessary as an alternative to institutional care and appropriate to meet the needs of the consumer.

The Case Management Team must make all the determinations listed above for the initial and each subsequent PSS.

If the OSDP Case Manager/RN has doubts about the adequacy or appropriateness of the PSS to meet the needs of the applicant in the community, these concerns should be expressed and documented during the assessment/re-assessment process.

The OSDP Case Manager may involve other members such as the District Manager or other OSDP Administrative staff in the process.

Refusal of a member to sign the PSS should be documented in the case file notes for the assessment meeting.

8.2 Revising the Plan of Services and Supports (PSS) – Increasing/Decreasing Services – Requesting Approval

Within the certification year, it may be necessary to revise the PSS due to changes in the needs of the member. The Case Manager should request a service change in the PSS, such as hours, days or SMS services, when there is significant improvement or decline in the member's condition and the PSS does not reflect their current needs.

The OSDP Case Manager must obtain appropriate documentation to support the need to change services. The request must be submitted for review and approval to their District Manager prior to any changes made to the PSS.

The Case Manager must:

- Review DCW Task Assignment Sheet and HHA Exchange to determine tasks the DCW is currently performing
- Determine the reason(s) for the request to change services and review specific information from the member indicating that the member's condition requires a change in services (***Example:*** *If care was being provided as unpaid care by a family member, determine why this person is now unable to provide the care; OR determine if the member has had a significant change in their medical condition.)*
- Obtain the member's consent to request current medical information, if additional documentation is needed, to support the change in their medical condition. Include this information, if obtained, prior to submitting the request for approval
- Submit all supporting documentation, case notes, and a copy of the PSS for review

and approval to the District Manager. ***NOTE:*** *The District Manager, at their discretion, has the option of submitting the request to the OSDP Administrative RN for additional review of medical documentation.*

Once the District Manager has reviewed the request, determined if funds are available, he/she will notify the Case Manager in writing of the approval/disapproval

If the disapproval is based on documentation submitted, a request will be made to the Case Manager to submit or clarify documentation prior to final decision.

If the request has been approved, the District Manager will instruct the Case Manager to submit a change request for the current PSS to reflect the change(s) in services.

The DCW cannot work the additional hours until the above procedure has been completed.

The Case Manager will send a MDRS Notice of Action to the member informing he/she of the changes in services.

8.3 Revising the Plan of Services and Supports (PSS) – Adding New Services – Requesting Approval

The Case Manager may request approval for added service(s) that were not included on the Plan of Services and Supports after it has been determined that the member has an unmet need for these items. **The request must be submitted for review and approval to the District Manager prior to any changes being made to the PSS.** When an added service is requested, the Case Manager must proceed as follows:

- Evaluate the necessity of the added service and obtain appropriate documentation to support the request for additional services to the PSS

- Obtain a doctor’s prescription for the service item needed

- AT Referral needed if driving evaluation, home/vehicle modifications or DME is not covered under insurance

- Investigate all comparable benefits (Medicaid, Medicare, Home Health, any other third-party resources)

- Upon receipt of necessary documents (AT report, specs, quotes, prescriptions), submit to District Manager by entering program certification page information to request funding and attach all necessary documents in AACE.

- Complete and submit the following to your District Manager for approval and review of documentation to verify appropriate need for additional service item(s):

    - Case note justification
    - Approved Adaptive Aid form

- Copy of the Prescription(s)
- Copy of Quotes
- AT Specification Report (if applicable)

The District Manger will review the request and enter the approval date on the program certification page in AACE. If there are questions regarding the documentation, a request will be made to the Case Manager to submit or clarify documentation prior to a final decision.

- The District Manager will instruct the Case Manager to complete a Change Request to add the new service to the current PSS. The OSDP RN will review requests and submit them to DOM.

- After approval is received from DOM, OSDP state office will notify the Case Manager and District Manager via a Notice of Determination that the service has been approved.

- The Case Manager will send a Notice of Action to the member to inform them of the change to the PSS.

- Funds will then be distributed to the Case Manager to plan and authorize for the added service.

8.4 Time Frame for Authorizing for Approved Supplies/Equipment

Within five (5) working days of receiving approval to purchase services, the services must be planned on the PSS, authorized and purchased. If supplies/equipment cannot be authorized due to unusual circumstances such as special supply needs or the availability of a supply, the member must be notified and given the reason. Case notes must be documented to reflect the delay in services.

8.5 Re-Authorizing for Supplies Currently Planned and Approved on the PSS

If the member has existing supplies when it is time to re-authorize for the supplies, the Case Manager must document that the member has existing supplies on hand, and they do not require delivery at this time. The vendor must be contacted so that they will not deliver surplus supplies.

Stock piling of medical supplies should not occur. Supplies needed on an on-going basis should be delivered so that there is not more than the one-month supply in the member's home at a time. The delivery date of the supplies must be documented.

8.6 Emergency Service Changes to the PSS

If the member experiences an emergency or crisis that the OSDP Case Manager/RN in their judgment feels requires additional DCW hours, the Case Manager must provide the additional care to meet the member's needs. The Case Manager must then verbally notify

the District Manager by the next workday of the change. The Case Manager must then, within (7) seven workdays, submit to OSDP Program Administration via the District Manager:

- The Case note or rationale for the service change or any other reports/documentation; the service and amount of additional services needed; the anticipated begin and end date for the service. It must be signed by the OSDP Case Manager
- Documentation of medical necessity/prescription, AT evaluation, Adaptive Aid, Medical Supply forms
- A copy of the PSS identifying the change

The OSDP Case Manager may procure adaptive aids and medical supplies not currently authorized on the PSS in emergencies that are defined as only situations that place the consumer's health and/or safety at risk. If procuring emergency adaptive aids and medical supplies, the Case Manager must:

- Submit a copy of the PSS identifying the change and the consumer's signature or verbal consent, indicating that the change was an emergency
- Verbally inform the Regional Manager by the next workday after purchasing the necessary item
- Submit the following documentation to OSDP Administration via the Regional Manager:
    - the revised PSS showing the change and the member's signature showing that the purchase was needed;
    - Case note/rationale explaining why the emergency purchase was necessary; and
    - Physician prescription or medical necessity indicating that the supply is an emergency.

SECTION 9: CASE MANAGEMENT

9.0 Case File Documentation of Monitoring Services

A. Required documentation of Case Management monitoring activities, include, but not limited to:

1. All initial and re-certification Plan of Services and Supports (PSS) must include all the services (both waivered and non-waivered) that the member is receiving that are adequate to meet their needs.

2. Case notes/records in which the OSDP Case Manager documents the appropriateness and adequacy of the services the member is receiving should be included in the member's case file.

3. Information regarding the member's complaints regarding services being provided.

4. Documentation of any actions taken in a crisis.

5. Monthly contacts should include, but are not limited to:

   a) OSDP Case Manager's evaluation of health, welfare and safety of members,
   b) Correspondence received from Medicaid or SSI,
   c) Contact with member/caregiver,
   d) List at least three (3) activities the DCW is performing;
   e) Satisfaction of services being provided;
   f) List all waivered and non-waivered services the member is receiving.
   g) If a specific problem was identified, was a follow-up conducted or resolution obtained?

6. Quarterly Reviews are assessed to see if they were done every three (3) months and the following documentation is required at a QR visit:

   a) Describe the progress towards achieving the goal identified on the PSS.
   b) Describe, in detail, the member's appearance safety and home environment.
   c) List all waivered and non-waivered services the member is receiving.
   d) List the services that were identified during the visit with the member and satisfaction of services being provided (include the status of all pending service requests).
   e) Describe any medical changes in the member's condition, hospitalizations, or emergency room visits etc.).
   f) Information regarding any letters or correspondence from Medicaid/Medicare the member received.
   g) List anyone present during the visit.
   h) List DCW(s), hours worked, ADL's performed by DCW and if the member is satisfied with their services.
   i) Information regarding the use of unauthorized restraints or seclusion observed or reported by the member. If so, explain.
   j) Information regarding any dissatisfaction expressed by the member pertaining to the services he/she has received. If member did express any dissatisfaction of services, provide how they will be addressed and resolved.
   k) Summarize the visit.

B. If problems are identified, the OSDP Case Manager is responsible for taking appropriate steps, including, but not limited to:

1. Making a determination if the PSS requires a change to address new needs,

2. Referring any suspected case of abuse, neglect, or exploitation to the Department of Human Services, the Attorney General's Office, and the MDRS/OSDP State Office,

3. Referring any potential fraud to the Attorney General's Office,

4. Encouraging the member to comply with the PSS in those situations in which the member is unwilling to allow the DCW or other providers to deliver services as identified in the PSS or otherwise is refusing to comply with his/her PSS.

9.1 Registered Nurses

Qualifications of the Registered Nurse:

1. Must have a valid license to practice as a Registered Nurse in the State of Mississippi,

2. Must have at least one year of experience with the aged and/or individuals with disabilities,

3. Must not have a history of a criminal offense which precludes him/her from working with a vulnerable person,

4. Must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General exclusion list,

5. Must complete the application for employment by Ability Works.

Proof of R.N. licensure can be validated by:

1. Checking the Mississippi Board of Nursing website at www.ms.gov/msbn.

2. Go to the Nurse Inquiry link,

3. Enter either the License Number and Last Name or,

4. Enter the last 4 digits of the SSN and the Last Name,

5. Print out the Nurse Details and keep it in your file.

6. Frequency of verification is ongoing and annually.

9.2 Case Manager/RN Roles

The case management team consists of the OSDP Case Manager and a Registered Nurse (RN).

A. Case Management activities that require a Registered Nurse:

1. Initial/Readmission assessment for IL and TBI/SCI Waiver.

2. Quarterly home visits and Direct Care Worker (DCW) certifications, as deemed appropriate by the OSDP Case Manager; (Case managers are allowed to conduct quarterly reviews, DCW certifications, and annual re-certifications without the RN component, if appropriate.)

3. Assist Case Manager in monitoring services delivered to participants at quarterly home visits.

4. Assist in evaluating/monitoring services delivered.

B. The Case Manager and the RN responsibilities include, but are not limited to:

1. Initial Evaluation is conducted by the Case Management Team using a Long Term Services & Supports (LTSS) assessment to ensure the needs of the participant are fully captured. The level of care is certified by a physician.

2. Long-term care options are explained by the Case Manager prior to enrollment and the participants indicate their choice of waiver services or institutional services by evidence of their signature and initials placed by their service choice. Participant signs and attests to their choice of placement on an Informed Choice form.

3. Train DCWs and have them demonstrate competency to perform each activity of daily living task to the participant, Case Manager, and RN (if applicable) prior to rendering any waivered services.

4. Must see the DCW demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and case management team to be adequate in fulfilling the responsibilities of personal care.

5. Must certify and verify competency of the DCW to perform the required tasks for the participant.

6. The initial Plan of Services and Supports (PSS) is developed at the time of the completion of the LTSS assessment with the case management team.

C. Case Managers review and approval of RN time logs include the following procedures:

1. OSDP contract nurse (RN) time logs must be reviewed and verified by the Case Manager, as they are responsible for ensuring that their RN is complying with all established policies and procedures.

2. The RN time log must accurately reflect the name of each IL or TBI/SCI waiver participant in the time order of the home visit completed that day. An intentional misrepresentation of hours worked constitutes fraud in accordance with MDRS policy.

3. Time in and time out of visit on each date must be documented by the RN.

4. At no time will pre-signed time logs be submitted for payment. All time logs must be signed in blue ink by the RN and Case Manager at the end of each day worked.

5. Case Managers will review, approve and sign the original time log in blue ink for each day worked and submit in accordance with the payroll schedule. It is the Case Manager's responsibility to ensure that all participants listed on the RN time log are correct and in the order of when the home visits were completed.

6. RNs are paid hourly for in-home visits. They are paid per visit if completing virtual assessments/visits.

7. All OSDP RN time logs are subject to review. All RN time logs are to be filed in a 3-ring binder by fiscal year for each case manager.

SECTION 10: PERSONAL CARE SERVICES

10.0 Personal Care Attendant/Attendant Care Services

Personal Care Attendant services are service components of the following programs/funds:

1. State Attendant Care (SAC);

2. Independent Living (IL) Waiver;

3. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver;

4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Trust Fund -
   12 month Transitional Program.

Personal Care Attendant services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

Personal care services may include, but are not limited to, Activities of Daily Living (ADLs) such as:

1) Assistance with bathing (sponge, tub) personal grooming, dressing, personal hygiene, toileting, transferring, and ambulation.

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

3) Food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;

4) Support for community participation by accompanying and assisting the person as necessary to access community resources; participate in community activities, including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.

Personal care services are non-medical, hands-on care of both a supportive and health related nature. The provision of personal care services is recorded on the PSS and is not purely diversional in nature.

Personal care attendant services may be furnished by family members provided they are:

1) NOT the parent (NOR step-parent) of a minor child NOR their spouse.

2) NOT the executor of the person's estate NOR the person with durable/medical power of attorney.

3) Qualified family members who are NOT legally responsible for the member.

4) Certified competent to perform the required tasks by the member and the OSDP Case Manager/Registered Nurse (if applicable).

5) Adequately justified to function as the attendant, e.g., lack of other qualified attendants in remote areas.

   There must be adequate justification for the relative to function as the DCW, e.g., lack of other qualified DCWs in remote areas. DCW services may be furnished by family members provided they are not the parent (or step-parent) of a minor child, or their spouse, or reside in the home with the person. Only qualified family members who are not legally responsible for the person may be employed as the personal care attendant. Family members must meet all provider standards, and must be certified competent to perform the required tasks by the person and the case manager/registered nurse.

MDRS verifies the competency for all direct care workers (DCW).

Skilled services that may be performed only by a health professional, such as a nurse, are not considered personal care services. Examples of such skilled services include, but are not limited to, catheter care, wound care, ventilator care, etc.

Payment will NOT be made for services furnished to a person by anyone legally responsible for the person. Services are often supplemented by informal, unpaid care provided by other family members and friends. This practice is commendable and often necessary to reduce costs and assure quality and continuity of care.

10.1 Choosing a Personal Care Attendant/Direct Care Worker (PCA/DCW)

The person's choice of attendants is not limited unless:

- The Case Manager has specified that a particular attendant should not be employed; or
- The Case Manager or RN has determined that the attendant is not providing adequate care.

If an attendant is hired and later identified as being inappropriate or undesirable, they must meet with OSDP staff to discuss the issues and try to resolve the problem. If the problems cannot be resolved through discussion, the Case Manager will document the discussion in AACE case notes and take appropriate action.

A current DCW should not continue employment if:

- There is evidence to indicate that the DCW has abused, neglected, or exploited the person whom they are caring for and/or others;
- The DCW has been providing inadequate care and the issues have not been able to be resolved; or
- It is discovered that the DCW is the spouse or the individual legally responsible for the person.
- The DCW's name shows up on the OIG or the Nurse Abuse Registry.

10.2 Individual Requirements to be Considered for Employment and Certification as a Personal Care Attendant (PCA)/Direct Care Worker (DCW)

1. Must be at least 18 years of age.

2. Must be a high school graduate, have a GED, or demonstrate the ability to read and write adequately to complete any required forms and reports of visits.

3. Must be able to follow verbal and written instructions.

4. Have the ability to communicate effectively and carry out directions.

5. No known physical/mental limitations that prevent lifting, transferring or providing any other assistance to the person.

6. Must be certified as meeting the training and competence requirement by the person and the Case Manager/RN.

7. Completed training/instruction in the areas of the Vulnerable Person's Act, caregiver boundaries, and dealing with difficult patients upon hire and annually thereafter.

8. Must demonstrate the ability to comprehend and comply with basic verbal/written instructions at a level determined by the Case Manager and RN in fulfilling the responsibilities of the attendant.

9. A DCW may be certified by the Case Manager and the RN at the time of the initial assessment. However, the DCW cannot begin providing services to the person until MDRS has received an approved Overall Decision from the Division of Medicaid and the DCW has been certified. If another funding source will be paying for the services, such as TBI/SCI Trust fund, the DCW can begin providing services after certification.

10. DCW cannot begin working with the member until the entire application for employment has been processed by State Office. Upon completion of the interview and a contingent job offer, a background check will be conducted for all potential new hires recommended for employment. The background check will be processed through the federal and state bureaus of investigation and must be clear of any felony convictions or certain misdemeanors which include, but are not limited to, possession and/or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

10.3 Situation in Which a New DCW Certification May Not be Required

1. If a DCW has previously been certified to provide services for a particular person and their employment ended, but within twelve (12) months of the last day they were employed for the person, the person desires to re-employ that same DCW, they do not have to be re-certified unless the person's condition has changed since the last day that they worked for them. However, the Case Manager must work with the person and the DCW to complete a new Task Assignment Sheet so that there will be a clear understanding of the tasks the person is needing and requesting assistance with. The Case Manager must also ensure the DCW understands how to utilize Electronic Visit Verification (EVV) in the HHA Exchange mobile application. This mobile app allows clocking in and out at the appropriate member location, indicates which tasks were performed and signing off on the shift that was worked. In addition, the HHA Exchange mobile application is the tool that is used for payroll processing. The case file must document this.

   If it has been more than 12 months since the DCW was employed to work for a member, they must be re-certified.

2. If a DCW was certified to provide services for a member and another person wishes to employ them as their DCW, the DCW must be certified to work for each individual person. A copy of all DCW certification information must be in the person's case file that the DCW is providing services to and attached in AACE.

3. If a DCW was certified to provide services for a member but is no longer working for them, and a different person has requested to employ this particular DCW, even if within 12 months of the last day of employment as a DCW, they must be certified to work for the new member.

10.4 Personal Care Attendant (PCA)/Direct Care Worker (DCW) Training Responsibilities of the OSDP Case Manager

Training shall be conducted by the person receiving services (or caregiver), the OSDP Case Manager and Registered Nurse (if applicable). Training shall include the purpose and philosophy of self-directed services by person with disabilities, disability awareness, employee-employer relationships, and the need for respect for the person's privacy and property.

The Case Manager must provide orientation regarding the training program, which must be completed prior to being certified. The Case Manager/RN (if applicable) should provide orientation to the functional requirements for a DCW in the person's home, on or before the service initiation date for DCW Services, in order to:

- Provide them necessary training to deliver the personal care tasks and document that the orientation/training was provided or initiated;
- Determine if the individual is competent to deliver the authorized personal care tasks and document competency on the Provider Competency Form.

The Case Manager/RN (if applicable) will provide information to the DCW on the following:

- Information about the person's condition and how it may affect the performance of tasks;
- Tasks to be performed, work schedule, safety and procedures;
- Changes in the person's condition in which they should contact the Case Manager to report the problem.

If more than one attendant is needed to provide the service, the individuals identified as attendants should be certified at the same time.

The Case Manager will provide information to the DCW on the following:

- The maximum number of DCW hours per day and the number of days per calendar week the person is certified/approved to receive DCW services.
- A calendar week begins on Sunday and ends on the following Saturday.
- In order to protect the health, safety and well-being of the DCW and the person, the DCW is not to provide services for the person over forty (40) hours per calendar week without prior approval from the Case Manager. The DCW may contact the District Manager for prior approval if the Case Manager is unavailable. Failure to do so may result in termination.
- In the event of an emergency which requires services to be provided to the person

beyond 40 hours in a calendar week, and before the DCW continues to provide services for the person beyond the 40 hour limit, the DCW and the person shall make every effort to secure care for the person by contacting the person's backup DCW or a member of the person's support system (i.e., family member or friend).

If neither a backup DCW, nor a person within the person's support system are available to provide services during a time of emergency and the DCW must work beyond the calendar week limit of 40 hours over the weekend, the DCW is required to contact the Case Manager no later than 10:00 a.m. the following Monday. Failure to do so may result in termination.

- Discuss with the DCW how to access the HHA Exchange mobile application for electronic visit verification (EVV) to be performed for each shift.

- Inform the DCW of the pay periods and the amount to be paid.

- Inform the DCW that services cannot be rendered while the person is in the hospital.

The DCW will be instructed to provide information to the Case Manager on the following:

- To provide at least a 5 day notice if they decide to no longer work for the person.

- If the condition of the person changes (improves or declines).

- Any suspicion or instances of abuse, neglect, or exploitation of the person.

10.5 Flexibility to Change PCA/DCW Tasks Assigned

The person and the Case Manager can modify the initial schedule and change the personal assistance tasks assigned that are included on the DCW Task Assignment Sheet to a mutually agreeable schedule that will meet the person's needs. This does not change the number of hours that have been approved as needed. Only DCW tasks that are allowed on the IL Waiver or TBI/SCI Waiver can be provided and paid for. If additional hours are needed, the procedures outlined in Section 12.2 must be utilized. The schedule modification can be ongoing; for example, the person's scheduled tub bath daily can be changed to 4 times per week; or tasks assigned Monday, Wednesday and Friday can be changed to Monday, Tuesday and Wednesday. Flexibility allows the person's tasks to meet the particular needs of the person, considering changes in their condition and wants. Hours are based solely on hours assumed to be provided within the home environment. Flexibility is not intended to be for convenience or to be applied to justify the absence of an attendant or break in services.

OSDP has a backup system to assure the provision of all DCW services on the schedule agreed and approved without service break; even if there are unexpected changes in

personnel.

If the member notifies the Case Manager that the DCW has not provided services as mutually agreed, the Case Manager must contact the DCW to find out the problem of which endangered the health and safety of the member.

10.6 Approval of EVV Entries (Waiver Programs)

The DCW is responsible for completing their time entries for each shift in the HHA Exchange mobile application for waiver members. The Case Manager/Assistant will monitor this EVV system daily to check for completed shifts, tasks performed, GPS locations and appropriate signatures. Insufficient EVV data or pre-billing errors will be confirmed through the member and/or the DCW and corrected by the Case Manager/Assistant in HHA Exchange.

EVV data that passes the system's compliance is sent to AbilityWorks payroll department for payment of the confirmed shifts within the established time frame for each DCW.

DCW will utilize a DCW missed EVV Service Note only in circumstances in which the DCW was unable to clock in/out or if the mobile application fails. DCW missed EVV Service Notes must be utilized whenever a manual change in the HHA Exchange system takes place by the Case Manager or the Case Manager Assistant. The member, DCW and Case Manager must sign and date each DCW missed EVV Service Note.

10.7 Approval of Timesheets (Non-Waiver Program)

Timesheets are still required to be submitted for members on the State Attendant Care and TBI/SCI Trustfund programs. These non-waiver programs do not utilize EVV entries. Paper timesheets are received by the Case Manager and processed for payment and billing.

SECTION 11: RESPITE CARE SERVICES

11.0 Respite Care Services

Respite Care Services are a service component of the TBI/SCI Trust fund and the TBI/SCI Waiver. Respite care services gives short-term, temporary relief to the usual caregiver because of the absence or need for relief of the caregiver. Respite provides all the necessary care that the usual caregiver would provide during that time period to the member. Respite care enables the member to remain in their current living situations and provides services to the family member. Respite care services and DCW services are not the same.

Goals of Respite:

- Reduce stress and help maintain family relations

- Assist and strengthen the family as a unit
- Contribute to good physical and emotional health
- Provide the caregiver time to rest, relax, and re-create

Respite care may be provided in the individual's home or place of residence, foster home or institution – Medicaid certified Hospital, Medicaid certified Nursing Facility, Group Home and Licensed respite care facility.

A DCW, Nurse Aide/Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN) or Registered Nurse (RN) may provide respite care services. The primary care physician determines the level of respite care that the member requires. This is documented by his/her physician by completion of the Respite Tier-Determination Form (see OSDP Insight – Respite Tiers).

Tier 1 – DCW
Tier 2 – CNA
Tier 3 – LPN
Tier 4 – RN

All respite care providers must be certified as meeting the skill level determined to be required by the physician, by the OSDP Case Manager and the Registered Nurse (Case Management).

When respite care is provided, payment for other duplicative services is precluded.

The Tier determination level should also be reflected on the authorization for services so that the appropriate pay level (tier) is verified.

Limitation: A member is allowed a maximum of 288 respite hours per year which is scheduled at the discretion of the member and regular caregiver. Institutional Respite is only for TBI/SCI waiver members (720 hours or 30 days in a facility per year). However, the OSDP Case Manager must be notified when it becomes necessary for the individual to use respite services that have been planned on the PSS for waiver cases and ILP for all IL cases.

11.1 Certifications Required for Respite Providers

1. In Home Companion (DCW)

- Must be at least 18 years of age.
- Must be a high school graduate, have GED, and/or demonstrate ability to read and write adequately to complete required forms and reports of visits and follow verbal and written instructors.

- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the member. If the individual indicates any physical/mental limitations, statement must be received form their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

- Must demonstrate their ability to perform each task of assistance with the activities of daily living to the recipient, IL Case Manager and Registered Nurse prior to rendering any services under the waiver.

- An individual that has satisfactorily provided in-home companion respite services for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the member, the IL Case Manager and the Registered Nurse.

2. Certified Nursing Assistant (CNA)/Aide

- Must be at least 18 years of age.

- Must have satisfactorily completed a nurse aide training program for a hospital, nursing facility or in home health agency (copy of certification) or

- Was continuously employed for twelve months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities.

- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the member. If the individual indicates any physical/mental limitations, statement must be received from their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

3. Licensed Practical Nurse (LPN)

- Must be at least 18 years of age.

- Must have satisfactorily completed a Licensed Practical Nurse Program (Copy of Certification in the State of Mississippi).

- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the member. If the individual indicates any physical mental limitations, statement must be received from their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

4. Registered Nurse (RN)

- Must be at least 18 years of age.
- Must have RN License in the State of Mississippi.
- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the member. If the individual indicates any physical/mental limitations, statement must be received from their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

SECTION 12: DIRECT CARE WORKER (DCW) PAYROLL/TIME AND ATTENDANCE

12.0 Direct Care Worker (DCW) Payroll/Time and Attendance Report

In order for Payroll to process time entry data for DCWs, the Case Manager must rectify any issues on the HHA Exchange's Call Dashboard. After all entries have been validated and cleared of error, the AbilityWorks payroll staff will send each Case Manager a Time and Attendance Report. This report shows total hours that the DCW worked on each day in that pay period. The Case Manager should review the report, sign/date if all the entered data is correct and send it back to Payroll. Once a Time and Attendance report has been verified and signed off on by a Case Manager, no changes can be made in HHA Exchange for that pay period. Each DCW is paid based on the verified Time and Attendance Report data.

SECTION 13: TRANSITION ASSISTANCE SERVICES

13.0 Transition Assistance Services

Transition Assistance Services are services which assist Mississippi Medicaid eligible nursing facility residents who are being discharged from the facility onto a waiver program. This assistance is a one-time initial expense required for setting up a household. The expenses must be included on the approved PSS. Transition Assistance Services are capped at a one-time initial expense per lifetime.

Transition Assistance Services include:

- Security deposits that are required to obtain a lease on an apartment or home.
- Essential furnishings and moving expenses required to occupy and use a community domicile.
- Set up fees or deposits for utility or service access (e.g. telephone, electricity, heating).
- Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.

Essential items for an individual to establish his/her basic living arrangement includes such items as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Diversional or recreational items such as televisions, cable TV access, etc. are not considered furnishings.

Need for the service: All items/services covered must be essential to:

- Ensure that the individual can transition from the current nursing facility.
- Remove an identified barrier or risk to the success of the transition to a more independent living situation.

Eligibility:

Individual must be a current nursing facility resident whose services are being paid by Medicaid and want to transition on the Independent Living or Traumatic Brain Injury/Spinal Cord Injury waiver programs.

In order to provide sufficient time to coordinate and plan appropriate transition services, the transition service must occur within 90 days of
discharge but must be completed by the day the individual relocates from the institution. Person whose nursing facility stay is temporary or rehabilitative, or whose services are covered by Medicare or other
insurance, wholly or partially, are not eligible for this service. Transition services will be considered provided once the individual has transitioned from the nursing facility to the waiver.

Exclusions: Transition Assistance is not available to residents whose stay in a nursing facility is ninety (90) days or less.

13.1 Description of Transition Assistance Services

Deposits:

Deposits can include security deposits for rental and utilities including basic telephone service. Security deposits or utility deposits must be in the applicant's name.

Security deposits may be paid if the payment is specifically called a security deposit and not rent, the payment is for a one-time expense, and the amount of the payment is no more than the equivalent of two months rent. Transition assistance services cannot pay for rent.

Transition assistance services can be used to pay for arrears on previous utilities if the account is in the member's name and the member will not be able to get the utilities unless the previous balance is paid. Transition assistance services cannot pay the first month's payment on utilities.

Transition assistance services can be used to pay for a telephone since it is a basic need but minutes or services on the telephone cannot be paid.

Transition assistance services cannot pay for any charges for upgraded services beyond the basic service.

Transition assistance services funds can be used to pay for initial setup or reconnection fees to propane or butane service including the minimal supply of fuel if the utility company has a policy that requires a minimal supply of fuel to be delivered during the initial or reconnection service call. Transition assistance services funds cannot be used to top off a tank with fuel when the individual's home is connected and has a supply of butane or propane.

Transition assistance services can pay for pet deposits only if the pet is a service animal essential to the member.

Household Needs:

Household needs include basic furniture/appliances. This includes bedroom furniture, living room furniture, kitchen furniture, refrigerator, stove, washer, dryer, etc.

An applicant may request a specific brand or type of appliance, furniture or other transition assistance services item as long as the applicant's needs are met within the cost limit.

Transition assistance services items may be placed in someone's home other than the applicant only when furnishings are not available and are necessary for the applicant to transition to the community. Transition
assistance services cannot pay for items that would only be used by the other person.

If existing items are not usable and the lack of a usable basic/essential item creates a barrier keeping the individual from transitioning to the home and community, the item is considered a need.

House wares:

House wares can include pots, pans, dishes, silverware, cooking utensils, linens, towels, clocks and other small items required for the household.

Small Appliances:

Small appliances can include a microwave oven, electric can opener, coffee pot, toaster, etc.

Cleaning Supplies:

Cleaning supplies can include a mop, broom, vacuum, brushes, soaps and cleaning agents.

13.2 Services/Items Not Included in Transition Assistance Services

Transition assistance services does not include any items or services that will be included

under waiver services such as adaptive aids, minor home modifications and medical supplies/equipment.

Transition assistance services does not include any recreational items including television, games, computers, cable TV, exercise equipment, vehicles or other modes of transportation.

Transition assistance services will not cover the cost of repairs on the member's dwelling.

Transition assistance services funds cannot be used for food. The OSDP Case Manager may refer the member to the Department of Human Services for food stamp assistance and any local food pantry resources.

13.3 Preparing the Home for Transition

Preparing the home for transition can include the following services:

- Moving expenses which include the cost of moving the applicant's items from another location or delivery charges on large purchased items.
- Pest eradication, if the applicant's place of residence has been unattended and some type of extermination is needed.
- Allergen control, if the applicant's place of residence has been unattended or the applicant is moving into a place that poses a respiratory health problem or
- One time cleaning, if the applicant's place of residence has been unattended or the applicant is moving into a private home or apartment where pre-move-in cleaning should not be expected, e.g., a family friend has an empty house available but cannot provide the cleaning.

13.4 Transitioning Assistance Services Form – Estimated Cost of Items and Services

The OSDP Case Manager may use the Transition Assistance Services form to assist with planning and determining the services needed and estimated cost. The amounts must be reasonable estimates of the cost of basic items and services. The list may be used to assist the applicant in identifying specific needs, but the Case Manager will enter a description and amount only for the items and services identified by the applicant.

All services provided will be authorized in advance of such purchases. Only the Case Manager or another member of the OSDP/IL staff will authorize the purchase of services. Services can only be authorized after the purchases have been staffed with and approved by the District Manager. When making payments in AACE, enter all corresponding invoice numbers on the AACE payment page. A copy of the invoice and the AACE payment page must accompany the authorization when being sent to the State Office for payment to the vendor. A copy of the authorization, AACE payment page, and invoice will be filed in the member's file folder.

13.5 Changes to the Transitional Assistance Services

Supervisory approval is required to authorize delivery of transition assistance services after the nursing facility discharge.

13.6 Five Day Monitoring Required by Case Manager After Transition

The Case Manager must monitor the members within (5) five workdays of the discharge date to be sure that all services and items authorized were received and the member has transitioned successfully. If the member reports that any items have not been provided, the Case Manager must follow-up to resolve the issue.

Once the Case Manager confirms that all items/services have been delivered, the Case Manager pays the Authorization in AACE and submits the authorization and all documentation to OSDP Madison for reimbursement.

13.7 Failure to Transition from the Nursing Facility

While the Case Manager makes every effort to confirm that the member has definite plans to leave the nursing facility, there may be situations in which the member changes his mind or has a change in his health making it impossible for him to relocate to the community as planned. In this situation, the Case Manager must contact any vendor that has provided a service and stop the delivery of the services. No additional service should be provided/purchased.

MDRS via the Case Manager must attempt to return any item(s) purchased on behalf of the individual and collect a refund for the amount of the purchase. MDRS must also attempt to recoup security, utility and other deposits paid on behalf of the individual.

- If the Case Manager is unsuccessful in returning the item(s) for the amount or the deposits paid on behalf of the individual cannot be recouped, MDRS is responsible for paying for the item(s) or deposits paid. The Case Manager must attach to the authorization when submitting to State Office, case note documentation stating that the item(s) could not be returned, or the deposits could not be recouped. Any items obtained from the member may be used to serve individuals whose needs are similar to those of the individual for whom the items were purchased or must be dedicated to assisting other individuals to establish a home.

- If the Case Manager is able to return the item(s) or receives the deposits back, the refund for money must be made payable to: Mississippi Department of Rehabilitation Services. A claim will not be billed to Division of Medicaid.

- If the individual is only in the home for a few days and returns to the nursing facility, the individual can keep the item(s) purchased or donate them to other individuals to help establish a home. The Case Manager must work with the member to determine what item(s) they should keep and what items should be used for other members.

The Case Manager must explain the purpose and limitations of transition assistance

services to the individual when determining their need for the service(s).

The applicant may appeal a decision regarding a needed item or service, but transition services should not be delayed due to the appeal.

SECTION 14: ELIGIBILITY FOR SAC AND TBI/SCI TRUST FUND PROGRAMS

14.0 State Attendant Care Eligibility

The State Attendant Care Program is a special program created by the Mississippi Legislature in 1985 to provide personal care services to persons who have severe disabilities. The intent of the State Attendant Care Program is to provide a means for securing attendants for those not able to access personal care services under other programs.

Eligibility Criteria:

In order for an individual to be served under the State Attendant Care Program, the following eligibility criteria must be met:

- The presence of a significant mental or physical disability
- The presence of a severe limitation in ability to function independently in the family or community, and
- A reasonable expectation that independent living rehabilitation services will significantly assist in their ability to function more independently in the home or community.

14.1 Eligibility Criteria for the TBI/SCI Trust Fund Program

In order for an individual to be served under the TBI/SCI Trust Fund program, the following eligibility criteria must be met:

1. Must have a certified traumatic brain or spinal cord injury. *See* Spinal Cord/Traumatic Brain Injury Verification Form.

    - Traumatic brain injury is defined as an insult to the skull, brain or its covering after birth, resulting from external trauma which produces an altered state of consciousness or anatomic motor, sensory, or cognitive/behavioral deficits. (This **excludes** any birth trauma.)

    Note: Birth trauma is defined as a physical injury sustained by an infant during birth; and birth is defined as the entire separation of the infant from the maternal body (after cutting of the umbilical cord).

- Spinal cord injury is defined as a traumatic injury to the spinal cord or the cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

Note: This **excludes** brain injury and spinal cord injury **trauma** that results intentionally or unintentionally from medical intervention.

2. Must be certified as medically stable by the primary care physician. Medical stability is defined as the absence of the following:

   A. An active, life threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);

   B. IV drip to control or support blood pressure;

   C. Intracranial pressure or arterial monitoring

SECTION 15: APPLICATION FOR STATE ATTENDANT CARE AND TBI/SCI TRUST FUND

15.0 Application for State Attendant Care (SAC) and TBI/SCI Trust Fund Services

The Case Manager must complete the official documentation for applicants who wish to apply for services under the OSDP SAC/Trust Fund Services. This application process takes place at the initial home visit and includes completing the request for OSDP Services intake form, the Statement of Understanding, Consent to Disclose, HIPAA, Voter Registration, and Functional Assessment Forms. All completed forms are then placed in a new case file when the Case Manager returns to the office.

15.1 Request for State Attendant Care (SAC) and TBI/SCI Trust Fund Services

The application process begins with the Request for OSDP Services intake form which is completed at the initial home visit. The purpose of this form is to gather all relevant personal and financial information in addition to the person's disability, family support, etc.

The Request for OSDP Services form is completed for waivered and non-waivered services through OSDP and is one component to assist the case manager in determining eligibility. This form needs to be filed in the applicant's case file when the Case Manager returns to the office.

The Application Documentation

The Application Documentation Page that is a part of the Request for OSDP Services intake form is very important to the overall case process. This information lays the

foundation of the entire casework process. The Case Manager should also inform the individual that they will not be eligible for services through another program.

Reasons for Seeking Services:

In this section, the Case Manager should record information that they received during the initial application process regarding the individual's disability and their medical history to help the Case Manager determine what medical or other information should be requested from third parties. The history of the individual's adjustment or lack of adjustment to their impairment is very important, as well as their family support system.

15.2 SAC Statement of Understanding

During the initial home visit for State Attendant Care, the Case Manager will present the Statement of Understanding to the applicant. It is the Case Manager's responsibility to ensure the applicant comprehends the entirety of the form, which includes the following:

a) The presence of a significant mental or physical disability

b) The presence of a severe limitation in ability to function independently in the family or community; and

c) A reasonable expectation that independent living rehabilitation services will significantly assist in the ability to function more independently in the family or community or to engage or continue in employment.

MDRS may obtain personal information from the applicant, their representative, services providers, and cooperating agencies for eligibility purposes with assurances that this information may not be divulged except:

d) To the applicant or their representative, when requested in writing, unless MDRS believes it harmful to do so

e) For audit, evaluation, or research purposes

f) To other programs for the applicants' benefit (e.g., DDS, Mental Health, DHS) or as required by federal law.

All services will be available to applicants regardless of race, gender, color, religion, marital status or national origin.

Once an applicant is determined eligible, the Case Manager will involve them in planning for their services and will review the plan annually. Services are dependent upon the availability of funds, and if there is any delay in the provision of services at any time, the person will be promptly advised. Persons will need to understand that they may also have to contribute toward program costs.

The person is advised during this time to keep scheduled appointments with their Case Manager and service providers. In the event, that the person is not satisfied with decisions made by their Case Manager, they can appeal his/her decision in writing to the District Manager.

Additionally, persons may contact the statewide Client Assistance Project (CAP) with questions or concerns about services provided by OSDP. The CAP staff will work with each party to assist in resolving the problem.

Once the person acknowledges and signs the Statement of Understanding, the form will be filed in the applicant's case file when the Case Manager returns to the office.

15.3 TBI/SCI Trust Fund Statement of Understanding

TBI/SCI Trust Fund applicants sign an additional Trust Fund Statement of Understanding which notifies applicants that attendant care services provided through the Trust Fund are available only for a short term and will not exceed a maximum of twelve (12) months from the date of initiation of services.

During this twelve-month period, efforts will be made to enroll applicants in the TBI/SCI Home and Community-Based Waiver Services Program based on eligibility criteria established by Medicaid, availability of openings, and adequate funding.

In the event that enrollment in the Home and Community-Based Program is not possible, the person or their legal representative is responsible for seeking other resources that would address the attendant care services beyond the initial twelve-month service period. The form will be filed in the applicant's case file when the Case Manager returns to the office.

15.4 Health Information Portability and Accountability Act (HIPAA)

At the initial home visit, applicants are given the Notice of Privacy document. The Case Manager will review this document with the applicant to ensure that they understand their health information protections. At this time, the applicant will sign the receipt of notice form which is then filed in the case file when the Case Manager returns to the office.

The Health Information Portability and Accountability Act of 1996, allows individuals to set boundaries on who has access to their protected health information. It is MDRS legal duty to maintain the privacy of a person's health information and to provide notice to an applicant. The Case Manager must verify the applicant comprehends their rights.

15.5 Authorization for the Use/Disclosure of Protected Health Information

The applicant signs this form to authorize the Case Manager to request and receive medical records on their behalf. The content of this form specifies:

a) For one time use and/or disclosure

b) One year from the effective date of signature/or upon revocation

c) Release to an attorney throughout the course of representation at his/her request.

Person are under no obligation to sign this authorization. However, MDRS may condition eligibility for benefits on the signing of this authorization if the information is necessary to determine a person's eligibility or enrollment in MDRS services, however not for the use or disclosure of psychotherapy notes.

Information disclosed pursuant to this authorization may be re-disclosed, by the recipient, to additional parties and may no longer be protected. If this authorization is signed by a personal representative, supporting documents must be attached to confirm the representative's right to make this request.

The specified information is necessary and related to the program of services and its confidentiality and privacy is to be respected by the recipient in accordance with all applicable federal and/or state laws and regulation on confidentiality. Use of copies, including electronic copies are also authorized.

The form will be filed in the applicant's case file when the Case Manager returns to the office.

15.6 Opportunity to Register to Vote

The following are instances in which a Case Manager should give applicants/members an opportunity to complete the mail-in Voter Registration Application at their home:

1. At the time of application,
2. At annual re-certifications,
3. Change of address, or
4. When requested.

Applicants/members must be given the opportunity to:

1. Complete the mail-in Voter Registration Application at home and mail it in, or
2. Leave the completed form with MDRS staff.
3. Complete the portable Voter Registration Form online.

If the person wishes to complete the form during the interview, the OSDP Case Manager should:

1. Review the form for completeness in the presence of the member.
2. If it does not contain all the required information and/or the required signature,

return it to the member for completion.

Voter Registration forms must be transmitted to the appropriate county voter registrar within five (5) days of receipt from applicant/person. If the applicant or member is not of voter registration age, do not complete the voter registration form.

The Case Manager must document, in the case file, any action when the member asks to register to vote. Any questions regarding voter registration process, can be directed to www.MSVoterID.ms.gov or by calling (844) 678-6837.

15.7 Application Completion

At the conclusion of the application process in which the applicant has signed the Request for OSDP Services, Statement of Understanding, Consent to Disclose, HIPAA and Voter Registration forms, the Case Manager will ask the applicant if they have any questions or need any clarification. If the applicant agrees to move forward, the Case Manager will conduct the Functional Assessment. The Case Manager will return to the office and enter a case note in AACE. The case note will contain a summary of the home visit and all relevant information gathered during the initial home visit. All forms will be filed in the applicant's case file and stored in a secure location.

SECTION 16: FUNCTIONAL ASSESSMENT FOR STATE ATTENDANT CARE (SAC) SERVICES

16.0 Functional Assessment for SAC

A. Functional Assessment

If the member is requesting attendant care services through the State Attendant Care Program, a functional assessment must be completed.

As part of the Functional Assessment

- The Functional Assessment may be completed by the OSDP Case Manager and does not require the RN to be present
- The OSDP Case Manager determines the attendant care services the member needs
- The OSDP Case Manager determines the estimated hours necessary to meet those needs
- The need for the particular task is determined based on the member's functional impairment to complete the task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports.

- Attendant care hours should not be planned if there is not a need for these services.

B. Plan of Services and Supports

The non-waivered plan of services and supports should be developed and updated annually considering:

- The needs of the member

- The stated intentions and willingness of the caregiver to provide unpaid care.

C. Attendant Care Workers

- Family members, except spouses and those legally responsible, may be employed as the attendant under the SAC Program.

D. Upon Completion of the Functional Assessment

- Update the OSDP program certification page by entering the functional assessment date

- Enter the start and end date

- Enter the number of PCA hours authorized.

E. Monthly Contacts are Required

- The OSDP Case Manager is required to make monthly contacts with members receiving State Attendant Care services.

- The OSDP Case Manager is required to make a face-to-face visit annually each June. During this home visit, the Case Manager will complete a new Functional Assessment and review the PSS to ensure if it still meets the individual's needs.

F. The OSDP Case Manager must make attempts to assist the member in accessing other resources for this service (i.e., Medicaid waiver programs) for those requiring long term care.

G. Approval of Additional Attendant Care Hours

- Although the number of hours needed is determined during the functional assessment process, the number of hours an individual receives via the SAC program may be affected by the availability of state funds.

- Any additional hours given above what has been approved must be prior approved by the OSDP Office Director.

H. Process to Follow When Requesting an Increase in Attendant Care Hours

- The Case Manager is to staff the case with their District Manager and include a justification for the request to increase hours.
- Upon approval, the OSDP District Manager should email the request up to their Regional Manager with the justification for an increase.
- Upon approval, the Regional Manager should email the request to the OSDP Director.
- Upon approval by the Office Director, funds will be distributed appropriately.

I. Include the Following Information in the Email When Requesting Approval for the Service Increase:

- Name of member
- Age of member
- Disability
- Case note justification
- Current approved attendant hours/day
- Amount of money needed in order to amend the authorization
- Dates of service that the increase will cover

SECTION 17: FUNCTIONAL ASSESSMENT FOR TBI/SCI TRUST FUND SERVICES

17.0 Functional Assessment for TBI/SCI Trust Fund Services

A. Functional Assessment

If the member is requesting transitional attendant care services through the TBI/SCI Trust Fund program, a functional assessment must be completed.

As Part of the functional Assessment:

- The OSDP Case Manager determines the attendant care services the member needs

- The OSDP Case Manager determines the estimated hours necessary to meet those needs

- The need for the particular task is determined based on the member's functional impairment to complete the task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports.

- Transitional attendant care hours should not be planned if there is not a need for these services.

B. Plan of Services and Supports

The non-waivered plan of services and supports should be developed and updated annually considering:

- The needs of the member

- The stated intentions and willingness of the caregiver to provide unpaid care.

C. Attendant Care Workers

- Family members, except spouses and those legally responsible, may be employed as the attendant under the TBI/SCI Trust Fund Program.

D. Upon Completaion of the Functional Assessment:

- Update the OSDP program certification page by entering the functional assessment date

- Enter the start and end date

- Enter the number of PCA hours authorized.

E. Monthly Contacts are Required

- The OSDP Case Manager is required to make monthly contacts with members receiving transitional attendant care. If services continue past the twelve-month mark, a new face-to-face visit, including a functional assessment would need to be completed.

F. The OSDP Case Manager must make attempts to assist the member in accessing other resources for this service (i.e. Medicaid waiver programs) for those requiring long term care.

G. Time Limit on Transitional Attendant Care Services

- There is a twelve-month time limit on transitional attendant care services.
- During this time, the member or family members will be assisted with seeking other attendant care options.

H. TBI/SCI Verification Form

- The TBI/SCI Verification form must be completed by the treating physician.

I. Process to Follow When Requesting an Increase in Transitional Attendant Care Hours:

- The Case Manager is to staff the case with their District Manager and include a justification for the request to increase hours.
- Upon approval, the OSDP District Manager should email the request up to their Regional Manager with the justification for an increase.
- Upon approval, the Regional Manager should email the request to the OSDP Director.
- Upon approval by the Office Director, funds will be distributed appropriately.

J. Include the Following Information in the Email When Requesting Approval for the Service Increase:

- Name of member
- Age of member
- Disability
- Case note justification
- Current approved PCA Hours/Days
- Amount of money needed in order to amend the authorization
- Dates of service that the increase will cover

SECTION 18: ELIGIBILITY FOR IL GRANT SERVICES

18.0 Determining the Applicant's Disability

Determining the member's disability is the first major step in the process. This process begins with the Counselor's recording of medical history obtained from the consumer during the application process. Information regarding their impairment and illnesses including dates and types of treatments or services provided should be recorded. The names and addresses of physicians who have treated them, as well as hospitals and clinics where they may have been a patient are important so that the Case Manager may request, if needed, pertinent medical records. As much as possible, the Case Manager should try to determine the member's primary care physician for the impairment they are reporting.

18.1 Medical Information to Establish Eligibility for the Provision of Services

When an individual is in Application status, medical reports/examination, etc., are necessary to make an eligibility determination. When medical information is used as a basis to establish eligibility, the following guidelines shall be followed:

1. If a disability is reported and may be documented by medical records but does not cause substantial functional limitations to activities of daily living or the condition is stable, this impairment does not have to be recorded on the Certificate of Eligibility. The Case Manager's knowledge of this impairment and its stability, and the fact that it is not a factor to the rehabilitation process should be documented in Case notes or in the other section of the Certificate of Eligibility.

2. Medical information does not have to be signed if the diagnostician, medical groups, or clinic is clearly identified in the information. DDS reports, hospital/VA records data on letterhead stationery, faxes to Case Managers, copies of letter to other physicians, and letters to Case Managers are acceptable.

3. Medical data not readily identifiable, handwritten notes, office/clinic notes, or pages from charts would all require a signature if the physician or office is not identified.

4. Members' name must be on all medical data to ensure that there is no question concerning the identification of the consumer/member.

5. Medical information, if used to help determine eligibility, must contain an actual diagnosis.

6. Medical documentation must be in the file and dated on or before the date of the certificate of eligibility.

7. Medical reports completed by a Family Nurse Practitioner (FNP) or Physicians Assistant must be co-signed by a physician to be acceptable.

8. Medical reports completed/signed by the physician's office staff (i.e., secretary, nurse, etc.) are never acceptable.

A disability will generally be considered stable if the answer is "no" to all the following questions:

1. Has the member's condition changed in the past year?

2. Has the member been hospitalized during the past year as a result of his/her condition?

3. Has the member's medication or therapy been changed in the past year?

18.2 Documenting Eligibility for Services

At a minimum, the case file for each individual determined eligible for services must include the following information supporting the determination of eligibility:

- The medical, psychological, and other information supporting the presence of a most significant or significant physical disability.

- The Certificate of Eligibility that records the impairment, justification analysis of a severe (serious) limitation in their ability in to function, continue functioning or move towards functioning independently in the family or community or to continue in employment.

The existence of a DISABILITY must be based upon medical, psychiatric, and/or psychological reports.

The IL Case Manager may utilize other staff members (case reviews) in making eligibility decision. The final eligibility decision must be made and certified by the IL Case Manager the case is assigned to.

18.3 Eligibility Determination Extension

A determination of eligibility shall be made within 60 days from the date of application.

The 60-day period is consecutive calendar days and is counted in this manner. The 60-day period begins on the date the consumer or his/her representative signs the application for services.

A delay in determining eligibility for services may be extended if exceptional or unforeseen circumstances beyond the control of the Agency preclude making the eligibility determination within 60 days, and the Agency and the individual agree to a specified extension of time.

This agreement and extension must be documented as an eligibility determination extension. The extension must reflect the reason for the extension, the date in which the eligibility determination will be made, and that the individual agrees with the extension. Extensions cannot be more than 60 additional calendar days.

Under unusual circumstances, the Case Manager Assistant can complete and sign the extension. The reason must be documented.

It is the sole responsibility of the Office of Special Disability Programs, Mississippi Department of Rehabilitation Services to determine if an individual is eligible for services and to determine the nature and scope of the services to be provided.

SECTION 19: APPLICATION FOR IL GRANT SERVICES

19.0 Application for IL Grant Services

The Case Manager must complete the official documentation for applicants who wish to apply for services through IL Grant Services. This application process takes place at the initial home visit and includes completing the Request for OSDP Services Initial Intake form, the Statement of Understanding, Consent to Disclose, HIPPA, Voter Registration and the Functional Assessment. These completed are then placed in a new case file when the Case Manager returns to the office.

19.1 Request for OSDP Services/Initial Intake for IL Grant Services

The application process begins with the Request for OSDP Services/Initial Intake form which is completed at the initial home visit. The purpose of this form is to gather all relevant personal and financial information in addition to the person's disability, family support, etc.

The Request for OSDP Services/Initial Intake form is one component to assist the Case Manager in determining eligibility. This form needs to be filed in the applicant's case file when the Case Manager returns to the office.

Documentation:

Reasons for seeking services:

In this section, the Case Manager should record information that they received during the initial application process regarding the individual's disability and their medical history to help the Case Manager determine what medical or other information should be requested from third parties. The Case Manager should also note that the services being requested by the individual are not provided through the individual's insurance or another program.

19.2 Statement of Understanding

During the initial home visit for IL Grant services, the Case Manager will present the Statement of Understanding to the applicant. It is the Case Manager's responsibility to ensure the applicant comprehends the entirety of the form, which includes the following:

a) The presence of a significant mental or physical disability

b) The presence of a severe limitation in ability to function independently within the family or community and

c) A reasonable expectation that independent living rehabilitation services will significantly assist in the ability to function more independently within the family or community or to engage or continue in employment.

MDRS may obtain personal information from the applicant, their representative, services providers, and cooperating agencies for eligibility purposes with assurances that this information may not be divulged except:

a) To the applicant or their representative, when requested in writing, unless MDRS believes it harmful to do so

b) For audit, evaluation, or research purposes

c) To other programs for the applicants' benefit (e.g., DDS, Mental Health, DHS) or as required by federal law.

All services will be available to applicants regardless of race, gender, color, religion, marital status or national origin.

Once an applicant is determined eligible, the Case Manager will involve the applicant in planning for their services. Services are dependent upon the availability of funds. If there is any delay in the provision of services at any time, the individual will be promptly advised. Individuals will need to understand that they may also have to contribute toward program costs.

The individual is advised during this time to keep scheduled appointments with their Case Manager and service providers. In the event, that the person is not satisfied with decisions made by their Case Manager, they can appeal his/her decision in writing to the District Manager.

Additionally, persons may contact the statewide Client Assistance Project (CAP) with questions or concerns about services provided by OSDP. The CAP staff will work with each party to assist in resolving the problem.

Once the person acknowledges and signs the Statement of Understanding, the form will be filed in the applicant's case file when the Case Manager returns to the office.

Health Information Portability and Accountability Act (HIPAA)

At the initial home visit, applicants are given the Notice of Privacy document. The Case Manager will review this document with the applicant to ensure that they understand their health information protections. At this time, the applicant will sign the receipt of notice form which is then filed in the case file when the Case Manager returns to the office.

The Health Insurance Portability and Accountability Act of 1996, allows individuals to set boundaries on who has access to their protected health information. It is MDRS's legal duty to maintain the privacy of a person's health information and to provide notice to an applicant. The Case Manager must verify the applicant comprehends their rights.

19.3 Health Information Portability and Accountability Act (HIPPA)

At the initial home visit, applicants are given the Notice of Privacy document. The Case Manager will review this document with the applicant to ensure that they understand their health information protections. At this time, the applicant will sign the receipt of notice form which is then filed in the case file when the Case Manager returns to the office.

The Health Insurance Portability and Accountability Act of 1996, allows individuals to set boundaries on who has access to their protected health information. It is MDRS's legal duty to maintain the privacy of a person's health information and to provide notice to an applicant. The Case Manager must verify the applicant comprehends their rights.

19.4 Authorization for the Use/Disclosure of Protected Health Information

The applicant signs this form to authorize the Case Manager to request and receive medical records on their behalf. The content of this form specifies:

a) For one time use and/or disclosure

b) One year from the effective date of signature/or upon revocation

c) Release to an attorney throughout the course of representation at his/her request.

Persons are under no obligation to sign this authorization. However, MDRS may condition eligibility for benefits on the signing of this authorization if the information is necessary to determine a person's eligibility or enrollment in MDRS services, however not for the use or disclosure of psychotherapy notes.

Information disclosed pursuant to this authorization may be re-disclosed, by the recipient, to additional parties and may no longer be protected. If this authorization is signed by a personal representative, supporting documents must be attached to confirm the representative's right to make this request.

The specified information is necessary and related to the program of services and its confidentiality and privacy is to be respected by the recipient in accordance with all applicable federal and/or state laws and regulation on confidentiality. Use of copies, including electronic copies are also authorized.

The form will be filed in the applicant's case file when the Case Manager returns to the office.

19.5 Opportunity to Register to Vote

The following are instances in which a Case Manager should give applicants/members an opportunity to complete the mail-in Voter Registration Application at their home:

- At the time of application,
- At annual re-certifications,
- Change of address, or
- When requested.

Applicants/members must be given the opportunity to:

- Complete the mail-in Voter Registration Application at home and mail it in, or
- Leave the completed form with MDRS staff or
- Complete the portable Voter Registration form online.

If the individual wishes to complete the form during the interview, the OSDP Case Manager should:

1. Review the form for completeness in the presence of the member.

2. If it does not contain all the required information and/or the required signature, return it to the member for completion.

Voter Registration forms must be transmitted to the appropriate county voter registrar within five (5) days of receipt from applicant/person. If the applicant or member is not of voter registration age, do not complete the voter registration form.

The Case Manager must document, in the case file, any action when the member asks to register to vote. Any questions regarding the voter registration process, can be directed to www.MSVoterID.ms.gov or by calling (844)678-6837.

19.6 Application Completion

At the conclusion of the application process in which the applicant has signed the Request for OSDP Services, Statement of Understanding, Consent to Disclose, HIPPA and Voter Registration forms, the Case Manager will ask the applicant if they have any questions or need any clarification. If the applicant agrees to move forward, the Case Manager will conduct the Functional Assessment. The Case Manager will return to the office and enter a case note in AACE. The case note will contain a summary of the home visit and all relevant information gathered during the initial home visit. All forms will be filed in the applicant's case file and stored in a secure location.

SECTION 20: FINANCIAL NEEDS ANALYSIS FOR NON-WAIVER SERVICES

20.0 Participation of the Individual in Cost of Services

While there is no Federal requirement to consider the financial need of individuals when providing services, OSDP does consider the financial need of individuals for purposes of determining the extent of their participation in the cost of OSDP services. Proof of income is required to determine the amount a client must contribute, if any, to the cost of services. A Financial Needs Analysis form must be completed during the application process for any Non-Waiver client requesting services that does not currently receive Medicaid or Social Security benefits. The individual is responsible for informing OSDP of any changes in financial circumstances and providing the appropriate documentation within 30 days of the date of such changes. Failure to do so may result in the termination of paid independent living services.

1. Comparable Services and Benefits: OSDP must not expend funds on specific services unless the OSDP Case Manager and the client have made a good faith effort to secure comparable services and benefits from other sources to pay for the services.

2. Recipients of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicaid Benefits: including those receiving Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicaid benefits are exempt from the cost-sharing requirement for OSDP services due to their disability, regardless of income.

3. Exceptions to Policy: When necessary to address a participant/client's specific independent living needs, OSDP staff may request exceptions to established policies and procedures by submitting a request through the appropriate management chain to the OSDP Office Director or their designee. However, exceptions cannot be granted for policies and procedures that are governed by Federal or State law, statutes, or regulations.

20.1 Determining Financial Need

Documentation is required for the client's income and expenses. A client who is eligible for Social Security Disability Benefits (SSI and SSDI) shall provide proof of Social Security eligibility. A client receiving Medicaid benefits shall provide a copy of their Medicaid Card and/or Medicaid number. If a client refuses to provide the necessary documentation to complete the Financial Needs Analysis (FNA) Form, OSDP will presume that the client's income exceeds the established financial participation threshold. As a result, the client will be required to pay the full cost of any goods and/or services for which financial participation is required, provided that the FNA policy is in effect. For all other clients, documentation regarding the following must be received:

1. Income: Adjusted gross income indicated on the client's most recent income tax return (Form 1040, line 11)
   - *Documentation Required: most recent income tax return. If unavailable: check*

stub, bank statement, earnings statement, award letter, or a court order may be utilized.

2. Optional Additions: Monthly home mortgage or rental payments, prescribed diet and medications used by the client, debts imposed by court order, medical costs, and disability related expenses of the client. This information should be included in "Section II: Client/Family Income" under "4. Optional" of the Financial Needs Analysis Form.
   - *Documentation Required: Statement, canceled check, money order stub, contract, lease, itemized receipts, or a court order*

20.2 PSS Requirements

If the client's PSS needs to be developed before proof of income and expenses are received, the OSDP Case Manager shall not include services that require the client's participation in the cost. When proof of income and expenses are received, the OSDP Case Manager amends that PSS as needed.

20.3 Circumstances When Financial Participation Does Not Apply

A client whose net income exceeds the FNA is not required to help pay for services if:

1. The client is eligible for Medicaid or Social Security Disability Benefits (SSI or SSDI)
2. The OSDP Regional Manager grants an exception (if approved through the MDRS State Office) because the client's participation would prevent the client from receiving the necessary service

Example: A participant/client with a significant disability has a new Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI). The FNA indicates that the client must pay part of the service fee; however, due to ongoing medical expenses related to their disability, they are unable to afford the required contribution. The OSDP Regional Manager grants an exception, allowing OSDP to cover the full cost of the service so the participant/client can receive services identified in their Plan of Services and Support (PSS).

20.4 Determination and Application of Financial Participation

A. Categorization of Individuals

Each non-exempt individual shall be classified into one of the following categories for purposes of determining financial participation:

1. Independent: The individual is unmarried and was not claimed as a dependent on another person's US tax return for the prior year or has received a dependency override from a financial aid administrator under 20 U.S.C. § 1087 vv.

2. Dependent: The individual is unmarried and was claimed as a dependent on another person's US tax return for the prior year.
3. Married: The individual is legally married.

B. Determination of Available Income

Based on the individual's category, the following income sources shall be considered available resources:

1. Independent: Only the individual's income
2. Dependent: The income of the individual and the person(s) who claimed the individual as a dependent
3. Married: The income of the individual and their spouse (may include additional dependents)

C. Financial Needs Assessment (FNA) and Participation Threshold

1. The OSDP Case Manager shall determine the amount a client must contribute to the cost of services based on the client's net monthly income and family size, as related to the US Federal Poverty Guidelines for the current fiscal year.
2. The client's financial participation threshold shall be calculated annually by OSDP and set at 285 percent of the poverty guidelines published in the Federal Register by the US Department of Health and Human Services, as specified in Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.
3. When the client's income exceeds the financial needs analysis (FNA) level, including optional additions, the client shall contribute to the cost of applicable goods and services. The client's contribution shall not exceed the actual cost of the service or goods.

20.5 Completion and Use of Financial Participation Assessment

The Financial Needs Analysis Form shall be completed during the initial home visit/application process by the Case Manager. If the individual/guardian refuses to provide the required financial information or to accept their assessed contribution, OSDP shall not authorize non-exempt services. OSDP Case Managers should inform individuals that failure to provide complete and accurate financial information may result in the denial or delay of services subject to client contribution.

A. Payment Responsibilities and Limits

1. An individual shall pay their assessed percentage directly to the service vendor for each non-exempt service.
2. The participant/client's total contribution shall not exceed the amount determined on the Financial Needs Analysis Form.
3. Once the full contribution amount has been met, no further payments shall be required for subsequent non-exempt services within the service period.

B. Exceptions to Financial Participation

Exceptions may be granted for the following reasons:

1. Substantial change in financial circumstances, verified with current documentation
2. Urgent medical need, supported by documentation
3. The required participation exceeds the individual's calculated available income

If a request is being made for an exception, the Case Manager shall submit a written request to the Regional Manager to be reviewed by the State Office that includes:

1. Description and cost of the requested service
2. Current Financial Needs Analysis Form
3. Supporting documentation provided by the client/participant

Any approved exception shall apply ONLY to the specific service for which it is granted. All of participation requirements remain in effect.

20.6 Financial Needs Exemptions

Some services are exempt from the FNA (minus SSI/SSDI and Medicaid recipients) and client financial participation in the cost of services, as shown in the table below:

OSDP Service	FNA Applies
Assessment of Determining Eligibility and OSDP Needs	No
OSDP Case Management	No
Home Modifications (actual service)	Yes
Personal Care Attendant Services	No
Assistive Technology Devices and Services, including Hearing Aids (comparable benefits are not required but should be used if readily available to meet best value requirements)	Yes
Services for SSI/SSDI Recipients	No
Vehicle Modifications	Yes

20.7 Informing the Individual About Financial Needs Policy

The individual and/or their representative will be informed of OSDP policies and procedures related to determining financial need and participating in the cost of services during the initial interview/home visit by the Case Manager. The individual will be informed that OSDP will not pay for any service that is not pre-approved and authorized in writing by an OSDP official. The individual will also be informed that OSDP bases its rate of financial assistance on the provision of the lowest cost services that meet the needs

of the individuals, with consideration of the individual's informed choice.

SECTION 21: FUNCTIONAL ASSESSMENT FOR IL GRANT SERVICES

21.0 Functional Assessment for IL Grant Services

If the member is requesting IL Grant Services through MDRS, a Functional Assessment must be completed during the initial home visit.

As Part of the Functional Assessment:

- The OSDP Case Manager determines the services the member needs

- The OSDP Case Manager determines the functional limits of the member as well as the current services being provided through other sources including family and friends.

The Functional Assessment will be printed and filed in the member's case file upon return to office.

The OSDP Case Manager is required to make phone contact with the member every 30 days and provide an update on the member's requested service.

The OSDP Case Manager must make attempts to assist the member in accessing other resources for the requested services.

SECTION 22: CASE SERVICE RECORD

22.0 File Folder

Each member's folder will have a label affixed to the tab on the folder. The label will include: the person's name, address, phone number, county, and program type.

22.1 Case Notes

Entries made are to include a record of all Case Manager contacts with and/or on behalf of the person. Case notes should include at a minimum the monthly contacts, quarterly reviews, telephone conversations, letters and reports of progress. All case notes must be entered into the electronic case file (AACE), printed, and placed in the hard copy case file. All entries will be dated and the type of contact recorded. The nature of the case notes will be recorded in the Summary Section. AACE records the author of the case notes as the person logged in the system. If another staff is entering the case note on the Case Manager's behalf, the case notes will be signed by the Case Manager. Record the first initial and last name.

All documents in the person's file are considered medical records, including DCW certifications.

When corrections or late entries need to be added to documents, always write legibly and make every effort to enter documentation in a timely manner. Never use corrective tape, corrective liquid or other obliteration supplies to change or erase any part of the medical record.

For entry corrections:

- Draw a single line through the error making certain that the error entry, though crossed out, is still legible.
- Place date, time and initials as to when the entry was marked out.
- Enter correct information in a new entry on the next available line.

For late entries:

- Identify the new entry as a "late entry" in the medical record.
- Enter the current date and time when the entry is actually being made in the medical record, but also remember to document in the body of the entry when the event originally occurred.

22.2 Case Service Record Organization – IL & TBI Waivers

The case record should be organized in such a way as to allow for easy access of information. All materials should be filed in reverse chronological order (most recent on top) based on the date information was received.

The case file is deficient and out of compliance if it does not contain the following

information, at a minimum:

- Running Record – Case notes

    - Documentation of Quarterly Reviews (QR)
    - Recertification Notes
    - Monthly Contacts

***Some people correspond with their Case Manager via e-mail. If this occurs the e-mail shall become a part of case notes and filed accordingly.**

SECTION 1 - Application

- Referral Form
- Application for Services
- Statement of Understanding
- Consent to Disclose Form
- HIPPA
- Medical Records
- Voter Registration Form
- Certificate of Eligibility
- LTSS PSS
    - Added Services
    - Increasing and Decreasing Services

SECTION 2 - Case Notes

- Case Notes (including Monthly Contacts, QRs, AACE generated letters, NOAs, etc.)
- Yearly Waiver Approval Letter

SECTION 3 - Physician's Form

- Physician Certification of Medical Stability & Nursing Level of Care form
- TBI/SCI Verification form (if applicable)
- Respite Tier form (if applicable)
- Medical Necessity form (if applicable)

SECTION 4 – Direct Care Worker (DCW) Certification

- DCW Certification Packet (not application)
- DCW Change of Address forms
- DCW Task Assignment Sheets (as updated)
- DCW Annual Training forms/Certificate of Completion

SECTION 5 – Service Notes

- DCW Service Notes

SECTION 6 - Financial Documents

- Authorizations & AACE Payment Sheets
- EOBs
- All AT Referrals, forms and reports
- Quotes/Bids
- AT Related Prescriptions

22.3 **Case Service Record Organization – State Attendant Care & TBI/SCI Trust Fun**

The case record should be organized in such a way as to allow for easy access of information. All materials should be filed in reverse chronological order (most recent on top) based on the date information was received.

The case file maintained by the OSDP Case Manager should contain all assessment and eligibility information.

The case file is considered to be deficient and out of compliance if it does not contain the following information, at a minimum:

- Running Record – Case notes
    - Documentation of Quarterly Reviews
    - Monthly Contacts

***Some people correspond with their Case Manager via e-mail. If this occurs the e-mail shall become a part of case notes and filed accordingly.**

SECTION 1 - Application

- Referral Form
- Application for Services
- Statement of Understanding & Trust Fund Statement of Understanding (if applicable)
- Consent to Disclose Form
- HIPAA
- Medical Records
- Voter Registration Form
- Emergency Preparedness Form
- Certificate of Eligibility
- Hardcopy PSS

SECTION 2 - Case Notes

- Case Notes (including Monthly Contacts, QRs, AACE generated letters, NOAs, etc.)

SECTION 3 - Physician's Form

- Functional Assessment
- TBI/SCI Verification Form (Trustfund only)
- Respite Tier Form (Trustfund only, if applicable)
- Medical Necessity form (if applicable)

SECTION 4 – Direct Care Worker (DCW) Certification

- DCW Certification Packet (not application)
- DCW Change of Address forms
- DCW Task Assignment Sheets (as updated)
- DCW Annual Training forms/Certificate of Completion

SECTION 5 - Financial Documents

- Authorizations, AACE Payment Sheets and applicable timesheet
- EOBs
- All AT Referrals, forms and reports
- Quotes/Bids
- AT Related Prescriptions
- Respite Time Logs (Trustfund only)

22.4 Case Service Record Organization – IL Grant ONLY

The case record should be organized in such a way as to allow for easy access of information. All materials should be filed in reverse chronological order (most recent on top) based on the date information was received.

The case file maintained by the OSDP Case Manager should contain all assessment and eligibility information.

The case file is considered to be deficient and out of compliance if it does not contain the following information, at a minimum:

- Running Record – Case notes

***Some people correspond with their Case Manager via e-mail. If this occurs the e-mail shall become a part of case notes and filed accordingly.**

SECTION 1 - Application

- Referral Form
- Application for Services
- Statement of Understanding & Trust Fund Statement of Understanding (if applicable)

- Consent to Disclose form
- HIPAA
- Medical Records
- Voter Registration form
- Emergency Preparedness form
- Certificate of Eligibility
- Hard Copy PSS

SECTION 2 - Case Notes

- Case Notes (including Monthly Contacts, AACE generated letters, NOAs, etc.)

SECTION 3 - Physician's Form

- Medical Necessity Form (if applicable)
- Functional Assessment

SECTION 4 - Financial Documents

- Authorizations & AACE Payment Sheets
- EOBs
- All AT Referrals, forms and reports
- Quotes/Bids
- AT Related Prescriptions

SECTION 23: CASE RECORD CLOSURES

23.0 Case Record Closures for Independent Living Services

A member's case shall be closed when it has been determined by the Case Manager that planned services are completed, as appropriate, or that additional services are either unnecessary or inappropriate.

Cases may be closed at different stages in the rehabilitation process:

- From Applicant Status
- After eligibility from Pre-Service Listing
- After eligibility but prior to ILP development
- After ILP development but prior to ILP services being initiated
- After initiation of ILP services

There are two types of closure statuses:

- Closed Goals Met
- Closed Other Than Rehabilitated – Goals Not Met

There must be adequate documentation in the case record regarding the case closure. Documentation may be on AACE forms and case notes.

Required documentation generated from AACE includes the following:

- AACE Closure Report
- Closing Statement for Goals Met
- AACE Case Summary Report at closure
- AACE Case History Report

All documentation regarding case closure must be clearly **stated** and **written** in a manner that presents a thorough explanation of the reasons or situations regarding the closure. All closure documentation must be based on the contents of the case record.

Case records can be shredded, six (6) years after the date of the case closure.

23.1 Closure – Goals Met

Cases closed, as goals are met must meet the minimum criteria listed below:

- The individual has been determined eligible.
- The individual was provided an assessment for services.
- The individual was provided case management as an essential IL service.

There must be documented evidence that the Case Manager personally addressed the following issues with the individual or, as appropriate, the individual's representative:

- The member's ability to function independently in the home or community or continue in employment has improved.
- Individual's indication of agreement/disagreement with the decision to close their case.

The closing summary must be entered in AACE on the Case Closure page and must include:

- Indication that the individual agreed/disagreed with the decision.
- Indication that the provision of services contributed significantly to improving their ability to function or continuing functioning in the home and community.
- Information regarding benefits/insurance.

23.2 Case File Documentation for Closure – Goals Met

- Documentation throughout the case file must show that the services planned and provided did in fact contribute significantly to the member's ability to functioning more independently in the home or community.

- The case file should document the reason(s) any planned service(s) were not

provided or services closed not met.

- If counseling and guidance were planned, there must be documentation to indicate that this service was provided at appropriate intervals. Any delays or interruptions of services should be documented.

- There must always be documentation of essential counseling and guidance before a case can be closed as rehabilitated, Goals Met.

- Appropriate contact by agency staff should be documented as required (at least every 30 days and more often if warranted by member's disability or services being provided, ex. waiver services). Any reason for extended periods of time without contact should be documented.

- Documentation at case closure must show that the Case Manager personally contacted the consumer at the time of closure and that case closure was discussed.

- All documentation must indicate that the appropriate mode of communication was used.

23.3 Closures – Goals Not Met

There are two reasons for closures – goals not met:

1. Because eligibility requirements are not met and
2. For reasons other than eligibility criteria not met (often referred to as intervening reasons)

Ineligibility determination must be based on one of the following:

- No disabling condition

To close cases as "no disabling condition" medical documentation must indicate that the applicant does not have a severe physical or mental impairment.

- No serious limitations in their ability to function independently in the family or community or continue in employment

To close case as "no serious limitation in their ability to function", case documentation must show that the applicant's physical or mental condition does not cause serious limitations in their ability to function independently in the family or community.

- The delivery of IL Services will not significantly assist the individual to improve his or her ability to function, continue functioning or move towards functioning in the family or community.

- Disability is too severe/unable to benefit from IL services.

To close a case as “disability too severe” requires clear and convincing evidence of the severity of the disability. “Clear and convincing evidence” means that MDRS shall have a higher degree of certainty before it can conclude that an individual is incapable of benefiting from services in terms of improving their ability to function independently in the home and community. The clear and convincing standard constitutes the highest standard used in our civil system of law and is to be individually applied on the case-by-case basis. It would require evidence from more than one source. Also, a demonstration of clear and convincing evidence requires the exploration of the applicant’s abilities, capabilities, and capacity to perform in the home and community with any necessary supports in real life settings. Medical documentation is required if an applicant has a severe physical/mental condition.

Closures because eligibility requirements are not met, require full consultation with the applicant. This consultation must be recorded.

Written notification must include:

- The reason for the ineligibility determination
- Appeal rights
- Availability of the Client Assistance Program (CAP)
- Referral to other agencies and facilities

23.4 Closure Reasons Other Than Eligibility Criteria Not Met

Unable to locate or moved: This reason is used when the individual has moved without a forwarding address or is otherwise unavailable. Also, use this reason for persons who have left the state and show no intentions of continuing in their IL program or returning to the state in the foreseeable future.

The case file should indicate that a minimum of two (2) letters and two (2) telephone call attempts were made prior to closure. A telephone call with no answer is not considered an attempt. A home visit is also required before closure to be sure that they are not at the residence.

Does not want further services: This reason is used when the individual declines to accept, participate in, or use independent living services. Prior to closing a case for refused services, the documentation must indicate that the individual or his representative has communicated verbally or in writing that he/she does not want services.

Death: This reason requires case file documentation. Documentation may include copy of the obituary, case note indicating notification by family member, etc.

Unable to participate: This reason is used when an individual has entered an institution and will be unavailable to participate in an IL program for an indefinite or considerable period of time. An institution includes a hospital, a nursing home, a prison or jail, a treatment center, etc. Documentation may include a case note indicating notification by

member, family member, etc.

Does not require IL Services: This reason is used when an individual needs services that are more appropriately obtained elsewhere. Appropriate referral information is forwarded to the other agency so that agency may provide services more effectively.

Failure to cooperate: Using this closure reason indicates individual actions or non-actions that make it impossible to begin or continue an IL program. Failure to cooperate includes repeated failures to keep appointments for assessment or other services (Ex. medical appointments). Efforts by the Case Manager to overcome these actions or non-actions are required and must be documented in the case file. The case file must indicate that a minimum of three (3) legitimate (by letter and/or telephone call) attempts were made prior to closure for this reason. At least one of these attempts must be by the Case Manager. A telephone call with no answer is not considered an attempt.

SECTION 25: AUTHORIZATION OF SERVICES

25.0 Authorization of Services

All services purchased for OSDP/IL members will be authorized in AACE either simultaneously with, or prior to, such purchases. Only a Case Manager or other member of the OSDP/IL staff will authorize the purchase of services. Authorizations will be issued only after a case has been placed in Application Status. Authorizations are to be signed by the Case Manager in the top and bottom sections where indicated.

Any authorization with missing documentation will be sent back to the Case Manager for correction. *(Authorizations will not be held at the State Office due to missing or incorrect information.)*

All authorizations for SMS will be reviewed by the Case Manager, and then forwarded to the vendor, on the first day of each month.

Authorizations for SMS should **<u>not</u>** be printed for more than one month at a time for the following reasons:

a) The member's needs may change; therefore, the authorization will need to be amended.

b) Change in Case Managers. If transferred, a Case Manager cannot amend another Case Manager's authorization.

c) Overstock in supplies. If a member has too many supplies, the authorization should not be submitted for the following month; thus saving money.

The file copy will be placed in an outstanding authorization holding file until the original copy is received back from the vendor, paid in AACE or the authorization is cancelled.

All SMS payments must be paid in AACE then forwarded to State Office by the 15th of each month.

When making payments in AACE, enter all corresponding invoice numbers on the AACE payment page.

All authorizations for SMS or DME must include member's Medicaid, Medicare and private insurance information directly on the authorization. Also include the qualifying diagnosis and the ICD-10 code. Remember:

a) Medicare will not pay for adult diapers or blue pads, so an Explanation of Benefits (EOB) is not needed.
b) State Medicaid will provide adult diapers or pull ups and blue pads.

Check the dates of services rendered to the authorization date. If the date of service is prior to the authorization date, verify that a draft authorization was done, and note on the statement of account that a draft is in the file.

If for some reason the authorization was not issued in the electronic case file prior to or simultaneously with provision of services, the following should occur:

a) An authorization must be initiated and placed in DRAFT status.

b) The DRAFT authorization should then be forwarded to the District Manager with an explanation as to why the authorization that was verbally authorized was not issued simultaneously in the electronic file, AACE. This explanation can be entered in the comments section of the authorization.

c) The District Manager then must review the authorization and explanation and either approve or disapprove the issuance of the authorization.

d) If the District Manager approves the authorization, the authorization can then be issued in AACE and mailed to the vendor.

e) When the Authorization/Statement of Account is signed and returned to the Case Manager prior to submitting to Finance, DRAFT in file must be entered/written on the authorization. The dates of services should be recorded as the actual date the service was provided which in most case is prior to the authorization begin dates.

When checking the status of a vendor payment, the Case Manager must:

a) Check with his/her District Manager on the status of a vendor's payment

b) Managers will check to see if the authorization was received by the State Office

c) Managers can check with Finance after the above has been checked.

25.1 Time Limit for Filing Claims

Claims for covered services will be paid by DOM only when received within twelve (12) months of the dates of service.

The following are the only reasons allowed consideration for overriding the timely filing:

- Claims filed within twelve (12) months from the date of service but denied can be resubmitted with the internal control number (ICN) from the original denied claim recorded on the face of the resubmitted claim.

- Claims over twelve (12) months can be processed if the member's Medicaid eligibility has been approved retroactively by the Division of Medicaid. Proof of retroactive determination should accompany the claim and be filed within twelve (12) months from the date of the retroactive letter.

Claims submitted two (2) years from the date of service are not reimbursable unless the member's Medicaid eligibility is retroactive.

25.2 MDRS/OSDP Filing Claims to Medicaid

After receiving payment or denial from all third-party sources, MDRS is required to file a claim with DOM. The amount of the third-party payment must be indicated in the appropriate claim field. The claim is processed, and Medicaid either pays the balance due on the claim (the total Medicaid payment amount less the third-party payment amount) or makes no additional payment if the third-party payment is equal to or greater than the total amount due to Medicaid. In either situation, the member's history of services is updated.

SECTION 26: DURABLE MEDICAL EQUIPMENT (DME) AND SPECIALIZED MEDICAL SUPPLIES (SMS)

26.0 Durable Medical Equipment (DME) and Specialized Medical Supplies (SMS)

Specialized medical equipment and supplies are devices, controls, or appliances that enable individuals to increase their abilities to perform ADL's, or to perceive, control, or communicate with the environment in which they live. These services also include items necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan.

Specialized medical supplies are supplies that are medically necessary to meet the needs of the consumer. The Case Manager must document the necessity of the requested medical supply based on:

- Individual's disability or medical condition; and
- Evaluation of the medical supply to adequately support the member living in the most integrated setting possible in the community.

- Medical supplies are only covered after the member has exhausted any insurance, including Medicaid and Medicare, the consumer is eligible to receive.

Covered medical supplies include:

- Briefs
- Blue pads
- Underpads
- Catheters
- Gloves
- Drainage Bags
- Leg Bags
- Skin Barrier Products (medically prescribed)
- Ostomy Supplies (medically prescribed)

26.1 Specialized Medical Equipment and Adaptive Aids

Specialized medical equipment/adaptive aids are devices, controls, or appliances that increase a consumer's ability to:

- Perform Activities of Daily Living (ADLs)
- Perceive, control, or communicate with the environment in which they live
- Ensure safety, security, and accessibility.

Medical equipment/adaptive aids may:

- Assist with mobility and communication
- Compensate for conditions resulting in disability or loss of function
- Medical equipment/adaptive aids are only covered after the member has exhausted any insurance, including Medicaid and Medicare, the consumer is eligible to receive.

26.2 Medical Equipment/Adaptive Aids Covered

Medical equipment/adaptive aids consist of the following services:

Lifts:

- Wheelchair lifts
- Porch lifts
- Hydraulic, manual, or other electronic lifts
- Bathtub seat lifts
- Transfer bench

Mobility Aids:

- Manual/electric wheelchairs and necessary accessories

- Scooters
- Braces, crutches, walkers, canes
- Prescribed prosthetic devices
- Prescribed orthotic devices, orthopedic shoes and other prescribed footwear
- Portable ramps and
- Batteries and chargers

Positioning Devices:

- Customized seating systems
- Electric or manual hospital beds, tilt-frame bed, and necessary accessories
- Trapeze bars
- Egg crate mattresses, sheepskin, and other medically related padding

Communication Aids (including repair, maintenance and batteries):

- Augmentative communication devices
- Speech amplifies, aids and assistive devices
- Hearing aids

Control Switches/Pneumatic Switches and Devices:

- Sip and puff controls and
- Adaptive switches/devices

Environmental Control Units:

- Locks
- Electronic devices
- Voice activated, light-activated, oral motion-activated devices

Adaptive equipment for activities of daily living:

- Assistive devices:

    - Reachers
    - Holders
    - Shower chairs
    - Overbed tray tables

- Medically Necessary Durable Medical Equipment not covered in the State plan for the Mississippi Medicaid Program.

- Temporary rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential equipment, or temporary usage of the equipment.

26.3 Making Requests for Non-Covered Items

The request must include:

- The cost estimate/price quote
- Assistive Technology Report (if applicable) and
- Medical Prescription (if applicable)
- Justification case note explaining why member needs this item

26.4 Requesting Items that are Not on the List of Covered Mecical Equipment/Adaptive Aids

The Case Manager must submit a request to the District Manager for approval of an adaptive aid or medical equipment that is not on the current list. The Case Manager must forward the request to the District Manager. The District Manager will staff the case with the Registered Nurse and Program Director based on:

- How the request is related to the consumer's disability, and

- If the Medical equipment is:
  - Medically necessary
  - Cost effective and
  - Necessary to prevent institutionalization

26.5 Utilizing Comparable Benefits, Third-Party Providers Before Purchasing Adaptive Aid/Medical Equipment

All comparable benefits/third party providers the consumer is eligible for must be accessed before using the waiver or any other funding program to pay for adaptive aids or medical equipment. The Case Manager must work with the vendor to ensure that, if the consumer is eligible for Medicare, Medicaid, Home Health Services, or any other comparable benefit, the resources are used to meet the consumer's need for services. If the Case Manager determines the consumer qualifies for services provided by another resource, they must obtain documentation to support their eligibility for the resource.

26.6 Requesting Adaptive Aid/Medical Equipment that the Case Manager Thinks May Not Be Paid

The Case Manager must submit a request with supporting documentation to the District Manager for a decision. It is outside of the Case Manager's role to make decisions about the adaptive aids for which will or will not be covered. Decisions regarding such requests must be made by the Case Manager and must be made under OSDP procedures to ensure the member's due process rights are observed.

26.7 Documentation Required Justifying Cost-Effective Purchase of Adaptive Aid/Medical

Equipment

A price quote from at a minimum of two (2) vendors is required to purchase medical equipment/adaptive aid.

The quote must contain:

- Name of the adaptive aid/medical equipment
- A price quote
- Date of the quote
- Name of agency

DME exempt from obtaining two (2) quotes are:

- Prosthesis
- Orthotics
- Wheelchairs and accessories
- Hospital Beds and accessories
- Motorized Scooters
- Patient Lifts and
- Other medically prescribed, medically necessary DME

Regardless of whether the vendor is also the manufacturer, or the vendor is purchasing from a manufacturer or from a distributor/supplier, it is the responsibility of the vendor to clearly note whether a charge is the MSRP or cost. Vendors are entirely responsible for submitting correct documentation for DME at MSRP or cost. Vendors should be able to produce documentation to show the charges can be substantiated if audited. The Case Manager will provide information on vendors of specialized medical equipment and supplies so that the consumer can make an informed choice regarding vendor for services.

Quotes are not acceptable as an invoice.

26.8 Durable Medical Equipment Prior to Transition

Recommended/medically prescribed Durable Medical Equipment can be purchased within 60 days of a scheduled transition date if the item is an approved waiver service.

SECTION 27: PROSTHETIC AND ORTHOTIC APPLIANCES

27.0 Prosthetic and Orthotic Appliances

The provision of Prosthetic and Orthotic devices in an appropriate Independent Living Service.

OSDP staff will follow the same guidelines and procedures set forth in the OVR/OVRB Resource Guide and the Fee Schedule Amputee Clinic Section and fees for Orthotic

Procedures L0000-L4999, that specify guidelines regarding Prescriptions, Authorizations, Physical Therapy, Checkout Sessions, Appointments and Fees.

The IL Case Manager should provide the member receiving a prosthetic or orthotic device with sufficient information so the member can make informed choices regarding the provision of this service. In some instances, a physician or prosthetist may refer the member. A member who was originally referred to OSDP by a prosthetist should have the new appliance purchased from that company unless there are documented reasons to the contrary (Ex. The member chooses to use another prosthetic company).

If the individual has experienced recent physical problems or changes, a current evaluation and medical records should be obtained from the primary treating physician that documents their current condition.

Any member with amputations resulting from diabetes should be evaluated prior to a prosthetic fitting by an internist or their primary treating physician, to determine that there have been no exacerbations of the physical condition that would affect the successful fitting of a new appliance. The Case Manager may obtain current medical information from their primary treating physician that may reflect that there have been no exacerbations of their physical condition.

When determining if a prosthetic or orthotic appliance will benefit an individual in terms of improving their ability to function more independently in the family or community, the following should be considered:

1. Is the person medically ready to wear a prosthesis?
2. Will a prosthetic or orthotic fitting be beneficial in terms of functioning more independently in the home and community?
3. Prescription for the prosthetic or orthotic device
4. Recommendations for appropriate training in the use of the prosthesis or orthotic device.

(See L code fee schedule when purchasing orthotic and/or prosthetics.)

27.1 Determining Eligibility for Individuals with Hearing Impairments

To determine eligibility, the Case Manager must obtain a valid ENT report signed by a licensed Otolaryngologist. This report can be furnished by the member, or the Case Manager can authorize for a comprehensive ENT examination.

A. If the hearing loss is between 40-50 dB in the better ear and the speech discrimination scores are between 75% and 85%, this case would normally be served by the cross-over Case Manager.

B. If the hearing loss is 55dB or greater in the better ear and speech discrimination score is between 50% and 75%, this case would normally be served by the RCD.

27.2 Degrees of Hearing Loss

0 dB to 25 dB	Normal limits
26 dB to 40 dB	Mild loss
41 dB to 55 dB	Moderate loss
56 dB to 70 dB	Moderately severe loss
71 dB to 90 dB	Severe loss
91+	Profound loss

Difficulty in Speech Discrimination

90 to 100%	Normal limits
75 to 90%	Slight difficulty, comparable to listening over a telephone
60 to 75%	Moderate difficulty
50 to 60%	Poor discrimination, marked by difficulty in following conversation
Below 50%	Unable to follow running a speech

27.3 Completing Your ENT Report Form

1. Page one - Background information (should be completed by the Case Manager prior to the examination).
2. Page two - Audiogram and pure tones scores.

    (O): represents right ear
    (X): represents left ear
    [ ]: represents bone conduction (sound introduced in the temporal lobe).

MDRS uses the pure tone scores at [500hz, 1000hz, 2000 hz], which are referred to as the *Speech Range*, to determine if the member's loss causes serious limitation in their ability to function or move toward functioning on the home or community.

Pure Tone Averages are determined by adding the scores of these ranges and dividing by three. This is called a three-frequency average. If there is a presence of loss in at least one of the frequencies in the speech range that drops sharply at 4000 hrtz, the Case Manager should do a four-frequency average.

Several terms are used in the section:

- ***Air*** refers to the result of the test for air conduction using pure one averages.

- ***Bone*** refers to the results of the test for bone conduction.

3. Page three

    1) Additional test results – this is not a part of most routine ENT evaluations. If the physician recommends additional testing, the recommended procedure would be authorized in advance on a separate authorization.

    2) Hearing aid specifications – This section is also not needed as part of the ENT

evaluation. If the ENT group will be the "informed choice" vender, the recommended fitting should be listed in this section. If the ENT group is not the "informed choice" vendor, this section will not be completed.

3) Hearing for speech – This section is where the audiologist will score the speech discrimination test. SD scores are stated as percentages (%). The signature of the Audiologist is required at the bottom of this page.

4. <u>Page four</u> - Prognosis and recommendation by the diagnosis Otolaryngologist.

Terms used in this section:

- *Conduction* refers to the outer and middle ear.
- *Nerve* refers to the inner ear.
- *Mixed* refers to both the conduction and nerve areas.
- *Stable* means that the loss has stabilized and might be improved with surgery.
- *Progressive* means that the loss can be expected to become worse unless corrected by surgery.
- *Permanent* means that the loss has stabilized, but surgery will not benefit it.
- *Diagnosis* refers to the physician's medical opinion as to cause of hearing loss.
- *Prognosis* refers to the physician's medical opinion as to expected outcome of recovery.

If the ENT Physician recommends surgery or hearing aids, the Case Manager must still establish eligibility based on hearing loss in the better ear, OSDP is not bound by the ENT physician's recommendation if:

1) The member is not eligible for services.
2) The member does not elect to follow the recommended procedure.

27.4 Authorizing for ENT Evaluation

ENT Evaluations: Which CPT Codes to Use

For comprehensive Otological and Audiological visit for a *new patient* * to the same office, authorize:

- **99203** Otological evaluation
- **92557** Audiological evaluations
- **92507** Speech Therapy sessions
- **92508** Auditory Training

If the Otolaryngologist and the Audiologist are in different offices, the Case Manager would authorize for the CPT procedures on separate authorizations.

If the member is returning to the same Otolaryngologist, they are now considered to be an established patient, authorized:

- **99213** (office visit/outpatient visit/typically 15 mins).

***The fees listed in the fee schedule should always be used unless the vendor's usual and customary fee is less than that listed in the fee schedule**.

27.5 **Authorizations for Hearing Aids and Options**

MDRS prices for recommended hearing aids should be established according to the following guidelines:
<u>Markup</u>

Monaural Fitting – Vendor's invoice cost from manufacturer plus……………….$375.00
Binaural Fitting – Vendor's invoice cost from manufacturer……………….........$575.00
Additional for Digital Aids…………………………………………………...$200.00

The MDRS markup includes cost of impressions, postage, insurance, batteries, and a one-year warranty.

In keeping with the established policy for purchasing hearing aids and options, MDRS will pay the vendor's invoice cost for the hearing aid and options which are recommended and agreed upon by the Case Manager plus the appropriate markup for monaural or binaural aide.

Case Managers should obtain the factory cost (invoice) from the hearing aid dealer and authorize for the aid/aids.

The following statement should be on the authorization:

"INVOICE TO ACCOMPANY STATEMENT OF ACCOUNT"

Case Managers should receive an actual copy of the invoice with the Statement of Account from the hearing aid dealer and attach it to the Statement of Account when submitting for payment. A copy of the invoice should also be placed in the case file.

The following is a partial list of other optional and assistive devices with prices:

Ear-mold (when authorized separately)	$40.00
Telephone switch (when authorized separately)	$25.00
Bi-Cros (invoice price plus monaural markup)	
Hearing aid repairs (factory invoice cost plus)	$30.00

***Note:** Ear-mold(s) would not be authorized for in-the-ear aids.

If an option is listed as being more than these prices, the actual manufacturer's invoice cost for the option may be paid.

All Authorizations for hearing aids MUST include the make and model of the aid, monaural

or binaural markup, and cost of the aid. Example authorizations are given below:

Siemens BTE analog aid	$380.00
Monaural markup	$375.00
TOTAL	$755.00
Resound digital aid (x2)	$1,380.00
Binaural markup	$ 575.00
Additional markup	$ 200.00
TOTAL	$2,155.00

Digital/Programmable Hearing Aids

Digital/programmable hearing aids may be more appropriate for some types of hearing loss configurations; however, they are not required for the majority of members with hearing loss. These aids are more expensive and require much more time to adjust properly after the initial fitting. For these reasons, an additional markup of $200 has been allowed to compensate the vendor for up to 4 additional office visits to cover services rendered after the initial fitting.

Any Digital/programmable hearing aids in excess of $2,300.00, including markups must be staffed with the State Coordinator of Deaf Services (SCD) before an authorization is issued.

27.6 Reasons for Replacing Hearing Aids

a. If the aid is at least four years old
b. If the aid has been repaired at least once at the cost of the user*
c. If the aid now being worn is no longer appropriate for the member's hearing loss
d. If technology has improved to the point that a new aid is significantly better.

*If the member purchases an extended warranty, his/her out-of-pocket expenses are automatically considered to meet the requirements "for part b".

27.7 Member Participation

Member participation can be an appropriate way to utilize case service funds if the member can afford to participate in the payment of his/her hearing aids. If you do receive some amount of member participation by the member, MDRS is still ultimately responsible for the hearing aid payment.

27.8 Two (2) Week Follow-Ups/Thirty Day Follow-Up

The purpose of the two-week follow-up is to show that the vendor has successfully fitted the member with the prescribed hearing aid and has met with the member within two weeks to confirm his/her satisfaction with the fitting. The form should be included along with the initial authorization and sent directly to the vendor. Two weeks after the fitting, the form should be completed by the member in the hearing aid dealer's office, not sent to the member in the mail. Again, the two-week follow-up form is your confirmation that the member has received the proper services for which you are paying. If the member is not satisfied with

his hearing aid or the services of the vendor, the two-week follow- up serves as the member's mechanism to express his feelings in writing.

The thirty-day follow-up is conducted by the Case Manager with the member, thirty days after the initial fitting, to confirm that the member is still satisfied after thirty days. Most often, during a thirty-day follow-up session, the member will have questions and concerns about his new aids that only the Case Manager is qualified to answer.

SECTION 28: ABBREVIATIONS, ACRONYMS AND DEFINITIONS

28.0 Abbreviations, Acronyms and Definitions

AACE Accessible Automated Case Environment
ACB American Council of the Blind
ACT The Rehabilitation Act of 1973, as amended
ADA Americans with Disabilities Act
ADHD Attention Deficit Hyperactivity Disorder
ADL Activities of Daily Living
AW Ability Works
AFDC Aid to Families with Dependent Children
AGI Adjusted Gross Income
ALF Assisted Living Facility
AMRC Addie McBryde Rehabilitation Center for the Blind
ARC Association for the Rights of Citizens with Developmental Disabilities
AT Assistive Technology
AL Assisted Living
BEP Business Enterprise Program
BIA Brain Injury Association
BSC Basic Service Grant
CAP Client Assistance Program
C/E Certificate of Eligibility
CEC Comprehensive Evaluation Center
CEU Continuing Education Unit
CIL Center for Independent Living
CF Count Fingers

Core Services – IL services defined in Section 7 (17) of the Act means: information and referral services; IL Skills Training; peer counseling (including cross-disability peer counseling); and, individual and systems advocacy.

CSR – Member Service Record maintained for an eligible member receiving IL services and meeting the requirements of 34 CRF 364.53

CMI Chronic Mental Illness
CMN Certificate of Medical Necessity
CPM Certified Public Manager

CRP	Community Rehabilitation Program
CRC	Certified Rehabilitation Counselor
CRS	Case Review Schedule
CSAVR	Council of State Administrators for Vocational Rehabilitation
CSLR	Counselor
CCWAVES	Commission of Certification of Work Adjustment and Vocational Evaluation Specialists
CD	Member Directed
COLA	Cost of Living Adjustment
CVE	Certified Vocational Evaluator
DB	Decibel
D/B	Deaf-Blind
DCW	Direct Care Worker
DD	Developmental Disability
DDS	Disability Determination Services
DFA	Mississippi Department of Finance and Administration
DHS	Mississippi Department of Human Services
DM	District Manager
DMH	Mississippi Department of Mental Health
DOM	Division of Medicaid
DSU	Designated State Unit
E & D	Elderly & Disabled
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EVV	Electronic Visit Verification
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FHA	Federal Housing Administration
FOB	Fixed Object Device
FTE	The equivalent of one person working full-time for one year
HCBS	Home and Community-Based Services
HMO	Health Maintenance Organization
HIPPA	Health Insurance Portability and Accountability Act
HUD	Department of Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for persons with Mental Retardation
ID/DD	Intellectually Delayed/Developmentally Disabled
IDEA	Individuals with Disabilities Education Act
IPE	Individualized Plan for Employment
IL	Independent Living
ILP	Individualized Independent Living Plan
ILRC	Independent Living Rehabilitation Counselor
LIFE	Living Independence for Everyone
LPC	Licensed Professional Counselor
LOC	Level of Care
LSW	Licensed Social Worker
LTC	Long Term Care
MDRS	Mississippi Department of Rehabilitation Services

MRC Methodist Rehabilitation Center

Minority – Alaskan Natives, American Indians, Asian Americans, Black (African Groups) Americans, Hispanic or Latino Americans, Native Hawaiians, and Pacific Islanders.

MP&A	Mississippi Protection & Advocacy Systems
MPA	Mississippi Paralysis Association
NF	Nursing Facility
NOA	Notice of Action
NOD	Notice of Determination
NFB	National Federation of the Blind
NLP	No Light Perception
OBRA	Omnibus Budget Reconciliation Act
OSDP	Office of Special Disability Programs
OVR	Office of Vocational Rehabilitation
OVRB	Office of Vocational Rehabilitation for the Blind
OS	Left Eye
OD	Right Eye
OU	Both Eyes
PA	Prior Authorization
PCMS	Physician Certification of Medical Stability
PERS	Personal Emergency Response System
PERS	Public Employees' Retirement System
PCA	Personal Care Attendant
PSS	Plan of Services and Supports
PRTF	Psychiatric Residential Treatment Facility
RAM	Rehabilitation Association of Mississippi
RAMP	Rehabilitation Administration & Management Programs
RCD	Rehabilitation Counselor for the Deaf
RCF	Residential Care Facility
RID	Registry of Interpreters for the Deaf
REACH	Realizing that Empowerment through Accomplishment and Confidence building, it is Honorable to be Blind.

Reporting Year – The most recently completed Federal fiscal project year staring October 1 and ending September 30.

RM	Regional Manager
RN	Registered Nurse
RSA	Rehabilitation Services Administration
OSERS	Office of Special Education and Rehabilitative Services
SGA	Substantial Gainful Activity
SCI	Spinal Cord Injury
SE	Supported Employment
SFY	State Fiscal Year
SILC	Statewide Independent Living Council established in each State as required by Section 704 and 705 of the Act.

SILS	A State Independent Living services program funded under Part B, Chapter 1 of the Title VII of the ACT
SLD	Specific Learning Disability
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOICC	State Occupational Information Coordinating Committee
SPB	State Personnel Board
SPIL	State Plan for Independent Living
SRC	State Rehabilitation Council
SRT	Speech Reception Threshold
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
START	Success through Assistive Rehabilitation Technology
SWIB	State Workforce Investment Board
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TDD	Telecommunication Device for the Deaf
TTY	Teletypewriter for the Deaf
TWE	Trail Work Experience
UCL	Uncomfortable listening level
VA	U.S. Department of Veteran's Affairs
VE	Vocational Evaluation
VEWAA	Vocational Evaluation & Work Adjustment Association
VR	Vocational Rehabilitation
VSMS	Vineland Social Maturity Scale
VTI	Vocational Training Instructor
WAIS	Wechsler Adult Intelligence Scale
WC	Workers' Compensation
WEP	Work Experience Program
WIA	Workforce Investment Act
WIIA	Work Incentives Improvement Act
WIOA	Workforce Innovation and Opportunity Act
WISC	Wechsler Intelligence Scale for Children
WMS	Wechsler Memory Scale
WRAT	Wide Range Achievement Test

28.1 Definitions for Authorized Representative

If the applicant/member is an adult, their representative is a person who has the authority to make decisions about the member and includes a:

- Person the member has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney

with the authority to make health care decisions,

- Court – appointed guardian for the member, or
- Person designated by law to make health care decisions when the member is in an institution and is incapacitated or mentally or physically incapable of communication.

Legal Representative is any person who has been vested by law with the power to act on behalf of another individual. The term includes a guardian appointed by a court of competent jurisdiction in the case of an incompetent individual or minor; or a parent in the case of a minor; or a person acting under a valid power of attorney. Categories of legal representatives include:

- Conservator - an individual or corporation appointed by a court to manage the estate, property, and/or other business affairs of an individual whom the court has determined is unable to do so for him/herself.

- Power of Attorney - a document which authorizes a person (agent) to act on behalf of another person (the principal). The principal delegates this authority, establishes its parameters, and may terminate it. Its authority is also terminated by death, disability, or incompetence of the principal, unless it is "durable."

- Durable Power of Attorney - a power of attorney document which specifically states it is to (1) remain in effect despite the principal's subsequent incapacity or (2) take effect upon the principal's incapacity.

- Guardian - an individual or corporation appointed by a court to see to the needs of a person proven to be incapacitated or in need or continuing care or supervision. A guardianship may be "limited'", addressing only some types of need, an arrangement which is less restrictive than a full guardianship.

28.2 Definitions Vulnerable Adults and Children

<u>Definitions under MISS. CODE ANN. 43-47-5:</u>

"Vulnerable adult" shall mean a person eighteen (18) years of age or older or any minor not covered by the Youth Court Act who is present in the State and who, regardless of residence, is unable to protect his or her own rights, interests, and/or vital concerns and who cannot seek help without assistance because of physical, mental, or emotional impairment.

"Abuse" shall mean the willful infliction of physical pain, injury or mental anguish on a vulnerable adult, the unreasonable confinement of a vulnerable adult, or the willful deprivation by a caretaker of services which are necessary to maintain the mental and physical health of a vulnerable adult. Abuse shall <u>not</u> mean conduct which is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility.

"Neglect" shall mean either the inability of a vulnerable adult who is living alone to provide

for him/herself the food, clothing, shelter, health care, or other services which are necessary to maintain his/her mental and physical health, or failure of a caretaker to supply the vulnerable adult with the food, clothing, shelter, health care, supervision, or other services which are necessary to maintain his/her mental and physical health.

"Exploitation" shall mean the illegal or improper use of vulnerable adult or his/her resources for another's profit or advantage.

Definitions under MISS. CODE ANN, 43-21-105:

"Child" and "Youth" are synonymous, and each means a person who has not reached his/her eighteenth (18) birthday. A child who has not reached his/her eighteenth (18) birthday who is on active duty for a branch of the armed services and is married is not considered a child or youth for the purposes of this section.

"Abused child" means a child whose parent, guardian, custodian, or any person for his/her care or support, whether legally obligated to do so or not, has caused or allowed to be caused upon said child sexual abuse, sexual exploitation, emotional abuse, mental injury, non-accidental physical injury, or other maltreatment.

"Neglected child" means a child:

a) Whose parent, guardian, custodian, or any person responsible for his/her care or support, neglects or refuses, when able to do so, to provide for him/her proper and necessary care or support, or education as required by law, or medical, surgical, or other care necessary for his well-being; provided, however, a parent who withholds medical treatment from any child who in good faith is under treatment by spiritual means alone through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practioner thereof shall not, for that reason alone, be considered to be neglectful under any provision of this section; or
b) Who is otherwise without proper care, custody, supervision, or support; or
c) Who for any reason, lacks the special care made necessary for him by reason of his mental condition, whether said mental condition be mentally retarded or mentally ill; or
d) Who, for any reason, lacks the care necessary for his health, morals, or well-being.

28.3 Definitions – Notice of Actions/Hearings

Independent Living Waiver & Traumatic Brain/Spinal Cord Injury Waiver

For the purpose of this section (42 CFR 431.201)

Notice means a written statement explaining what action is being taken.

Action means a termination, suspension, or reduction of Medicaid eligibility or covered services.

Date of action means the intended date on which termination, suspension, reduction, transfer or discharge becomes effective.

Request for hearing means a clear expression by the applicant/member or his/her authorized representative that they want the opportunity to present his/her case to a reviewing authority.

The applicant/member must be informed in writing of a decision that will result in the following:

- Being determined ineligible for services
- The amount (quantity) of the service the client will receive
- The request for services being denied
- Being determined ineligible for continued services

28.4 Independent Living Member Achievements, Goals and/or Objectives

Self-Advocacy/Self-Empowerment – Goals involving either improvement in a member's ability to represent himself/herself with public and/or private entities or ability to make key decisions involving himself/herself.

Communication – Goals involving either improvement in a member's ability to understand communication by others (receptive skills) and/or improvements in a member's ability to share communication with others (expressive skills).

Mobility/Transportation – Goals to improve a member's access to his/her life space, environment, and community. This may occur by himself/herself or the use of public transportation.

Community Services – Goals that provide for a change in living situations with increased autonomy for the member. This may involve a member's goal related to obtaining/modifying of an apartment or house.

Educational – Goals of an academic or training nature that are expected to improve the member's basic knowledge or increase his/her ability to perform certain skills deemed to increase his/her independence consistent with IL philosophy.

Vocational – IL goals related to obtaining, maintaining, or advancing in employment.

Self-Care – Goals to improve/maintain a member's autonomy with respect to activities of daily living such as grooming and cleaning, toileting, meal preparation, shopping, eating, etc.

Information Access/Technology – Goals related to a member obtaining and/or using a computer or other assistive technology, devices, or equipment, also a member's goal of developing skills in using information technology, e.g. emerging computer screen-reading software.

Personal Resource Management – Goals related to a member learning to establish and maintain a personal/family budget, managing a checkbook, and/or obtaining knowledge of available direct and indirect resources related to income, housing, food, medical, and/or other benefits.

Other – IL goals not included in the above categories.