



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 10/01/06</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: HCBS/Independent Living Waiver</b>	<b>Section: 66.02</b>	
<b>Subject: Eligibility</b>	<b>Pages: 1</b>	<b>Cross Reference:</b>

The Independent Living (IL) Waiver provides services to beneficiaries who, but for the provision of such services, would require the level of care found in a nursing facility. The waiver is jointly administered by the Division of Medicaid and the Mississippi Department of Rehabilitation Services, through an interagency agreement.

Eligibility is limited to individuals with severe orthopedic and/or neurological impairments that render the individual dependent upon others, assistive devices, other types of assistance, or a combination of these to accomplish the activities of daily living.

In addition, individuals must be certified as medically stable 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
- Intracranial pressure or arterial monitoring

The eligible individual must be able to communicate effectively with caregivers, personal care attendants, case managers, and others involved in their care.

Individuals must be Medicaid eligible either as an SSI recipient or meet the 300% of the SSI Federal benefit rate required as the institutional income limit for individuals entering a nursing facility.



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The number of beneficiaries enrolled in the Independent Living (IL) Waiver program is limited. Availability is based on program attrition/growth. Two waiting lists are maintained for the IL program.

- **Billy A. IL Waiver Referral List**

The Mississippi Department of Rehabilitation Services (MDRS) maintains the Billy A. IL Referral List for individuals who wish to apply for the IL Waiver program. An individual may apply for waiver services when his/her name rises to the top of the list and a slot is available.

- **NF Resident Master List**

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

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

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

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



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**A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add services listed on the approved plan of care requires prior approval.**

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<b>Section: HCBS/Independent Living Waiver</b>	<b>Section: 66.06</b>	
<b>Subject: Covered Services</b>	<b>Pages: 3</b>	
	<b>Cross Reference:</b>	

The Independent Living Waiver provides the following services:

- Case Management
- Personal Care Attendant
- Specialized Medical Equipment and Supplies
- Transition Assistance

### **Case Management**

Case Management services assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services. Case Management services are provided by MDRS IL counselors/registered nurses who meet minimum qualifications listed in the waiver document standards. Responsibilities include, but are not limited to, the following:

- Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care
- Provide ongoing monitoring of the services included in the beneficiary's plan of care
- Develop, review, and revise the plan of care at intervals specified in the waiver document
- Conduct monthly contact and quarterly face-to-face visits with the beneficiary
- Document all contacts, progress, needs and activities carried out on behalf of the beneficiary

### **Personal Care Attendant**

Personal Care Attendant (PCA) services are support services provided in the beneficiary's home. Services may include assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. Services may also include assistance with preparation of meals, but not the cost of the meals. When specified in the plan of care, services may include housekeeping chores essential to the health of the beneficiary.

Personal care attendants must meet minimum requirements as specified in the waiver document. MDRS IL counselors and registered nurses are responsible for certifying and documenting that the PCA meets the training and competency requirements.

Personal care services may be furnished by family members **provided they are not legally responsible for the individual**. The parent (or step-parent) of a minor child and an individual's spouse are considered legally responsible for an individual. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the IL counselor/registered nurse. There must be adequate justification for the relative to function as the attendant, e.g., lack of other qualified attendants in remote areas.

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## **Specialized Medical Equipment and Supplies**

Specialized medical equipment and supplies include devices, controls, or appliances that will enhance the beneficiary's ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan. The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.

Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under the Medicaid State Plan. **Items not of direct medical or remedial benefit to the beneficiary are excluded.**

Equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver document.

## **Transition Assistance**

Transition Assistance services are services, provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the Independent Living Waiver program. Transition Assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved plan of care. **Transition Assistance Services are capped at \$800.00 one-time initial expense per lifetime.**

### **1. Eligibility**

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

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

### **2. Services**

Transition Assistance Services include the following:

- Security deposits required to obtain a lease on an apartment or home
- Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items (Items such as televisions, cable TV access or VCR's are not considered furnishings)

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- Moving expenses
  - Fees/deposits for utilities or service access such as telephone, electricity, etc.
  - Health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy

### **3. Exclusions**

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

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Waiver providers must meet applicable quality assurance standards. The standards are part of the waiver document approved by the Centers for Medicare and Medicaid Services. The standards are issued to all new waiver providers, and providers are notified when revisions are made.

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

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<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: HCBS/Independent Living Waiver</b>	<b>Section: 66.08</b>	
<b>Subject: Documentation/Record Maintenance</b>	<b>Pages: 1</b>	<b>Cross Reference:</b>

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

**Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth for applicable waiver quality assurance standards.** In addition, waiver providers are required to submit copies of all service logs/documentation of visits.

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

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

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: Current:</b>	<b>Date: 10/01/06 Date:</b>
<b>Section: HCBS/Independent Living Waiver Subject: Beneficiary Cost Sharing</b>	<b>Section: 66.09 Pages: 1 Cross Reference: 2.0 Benefits Beneficiary Information 3.08</b>	

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

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

Refer to Section 2.0, Benefits, for information on Medicaid benefits and Section 3.08, Beneficiary Information, for information on beneficiary cost sharing.

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<b>Section: HCBS/Independent Living Waiver</b>	<b>Section: 66.10</b>	
<b>Subject: Reimbursement</b>	<b>Pages: 1</b>	<b>Cross Reference:</b>

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

Covered services under the Independent Living Waiver are reimbursed according to reimbursement methodology listed below.

<b>Service</b>	<b>Code</b>	<b>Modifier</b>	<b>Billing Unit</b>
Case Management	T2022	U2	Monthly
Personal Care Attendant	S5125	U2	15-minute unit
Specialized Medical Equipment and Supplies	T2029	U2	Manually priced/approved (based on a quoted, pre-approved price)
Transition Assistance	T2038	U2	One-time initial expense per lifetime up to \$800.00

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<b>Section: HCBS/Independent Living Waiver</b>	<b>Section: 66.11</b>	
	<b>Pages: 1</b>	
<b>Subject: Due Process Protection</b>	<b>Cross Reference:</b>	

The MDRS IL counselor/MDRS regional supervisor must provide written notice to the beneficiary when any of the following occur:

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

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

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

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

