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

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

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

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

Through an interagency agreement, the Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) maintain joint responsibility for the program. The Division of Medicaid maintains responsibility for the administration and supervision of the waiver. DOM formulates all policies, rules, and regulations related to the waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. The Mississippi Department of Rehabilitation Services is responsible for operational functions and for maintaining a current MDRS program Medicaid provider number.

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.

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

The Independent Living Waiver program will not restrict a beneficiary's freedom to choose providers. The beneficiary has the right to modify or cancel services at anytime. The beneficiary should notify the IL counselor/registered nurse when a change in providers, services, etc is requested/made.

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.

When the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services as specified in Section 66.11, Due Process Protection.

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).

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain initial approval, the following forms must be submitted to the HCBS division of the Bureau of Long Term Care:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care
- HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

DOM 260 HCBS Physician Certification

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the client meets the medical criteria for nursing facility care. The physician's signature must be dated within thirty (30) days of the submission of the form. The beneficiary must be recertified by the physician on an annual basis. Certification is valid 364 days from the date of the physician's signature.

HCBS 305 Assessment

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

DOM 301 HCBS Plan of Care

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

HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

The HCBS 105 form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

At the time of initial certification, the HCBS 305 Assessment form, the DOM 301 Plan of Care form, and the HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged form must be completed jointly by the TBI/SCI counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all four (4) documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial, retain a copy of all forms and forward originals to the IL counselor/registered nurse to retain as part of the case record.

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.

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.

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)

- 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.

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.

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.

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.

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.

Service	Code	Modifier	Billing Unit
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

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.

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

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

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

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

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. The IL counselor/registered nurse 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 IL counselor/registered nurse is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.