Administrative Code

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

Table of Contents

Title 23: Division of Medicaid

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

Part 208 Chapter 2: HCBS Independent Living Waiver

Rule 2.1: General

A. Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.

B. The IL HCBS Waiver is operated jointly by the Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) through an interagency agreement with services available statewide.

C. The Division of Medicaid maintains responsibility for the administration of the waiver and formulates policies, rules, and regulations. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. The MDRS is responsible for operational functions and maintaining a current Medicaid provider number.

D. The average cost for a waiver applicant/participant must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicaid and Medicare Services (CMS) for the current waiver year. The State may refuse entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the facility and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State.

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

History: Revised 01/01/2013

Rule 2.2: Eligibility

A. Eligibility is limited to individuals age sixteen (16) or older who:

1. Exhibit severe orthopedic and/or neurological impairments that render the individual dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living.

2. Are able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants (PCAs), counselors, case managers or others involved in their care.

3. Are certified as medically stable by their physician. Medicaid defines medical stability as

the absence of all of the following:

a) An active, life-threatening condition (sepsis, respiratory, or other condition requiring systematic therapeutic measures),

b) Intravenous drip to control or support blood pressure, and

c) Intracranial pressure or arterial monitoring,

B. Clinical eligibility for waiver services is determined through a comprehensive Pre-Admission Screening (PAS) tool that includes but is not limited to the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services.

C. Pre-admission screening data, entered into a scoring algorithm generating a numerical score, is compared to a set numerical threshold and determines clinical eligibility.

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

1. SSI,

2. Low Income Families and Children Program,

3. Disabled Child Living at Home,

4. Children Under Age Nineteen (19) Under 100% Federal Poverty Level,

5. Disabled Adult Child,

6. Protected Foster Care Adolescents,

7. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

8. IV-E Foster Children and Adoption Assistance Children,

9. An aged, blind, or disabled individual who meets all factors of eligibility if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible, or

10. Working Disabled.

Source: Miss. Code Ann. § 43-13-121; §53-13-115; Section 1915(c) of the Social Security Act 42 CFR§435.217; 42 CFR§441.301(b)(6)

History: Revised 01/01/2013

Rule 2.3: Covered Services

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

A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities:

1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs, preferences, and goals.

2. Must assist waiver applicant/participants in gaining access to 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 to which access is gained.

3. Are responsible for ongoing monitoring of the provision of services included in the participant's plan of care.

4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required. More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.

5. Are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).

B. Case Management must be provided by Registered Nurses (RN) and Rehabilitation Counselors who must meet the following qualifications:

1. The Registered Nurse must:

a) Have a current and active 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

b) Have at least one (1) year of experience with the aged and/or individuals with disabilities; and

c) Not have a history of a criminal offense which precludes him/her from working with the vulnerable population; and

d) Not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion list.

2. The Rehabilitation Counselor must:

a) Possess at a minimum a Bachelor's degree in Rehabilitation Counseling or other related field; and

b) Have one (1) year of experience working with individuals with disabilities; and

c) Be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population; and

d) Not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.

3. Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Counselor. MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

4. MDRS must verify provider qualifications upon hire and at least annually.

C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care 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.

1. PCA services must be provided in accordance with the approved plan of care, cannot be purely diversional in nature, and must include:

a) Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living.

b) Food shopping and assistance with preparation of meals, but not the cost of the meals.

c) Housekeeping chores essential to the health of the beneficiary, when specified in the approved plan of care.

d) Support for community participation by accompanying and assisting the participant 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.

2. A personal care attendant must be chosen by the participant as someone with whom they

are comfortable providing their personal care or chosen from a list of available, eligible/qualified personal care attendants. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS Rehabilitation Counselors and Registered Nurses must certify and document that the PCA meets the requirements.

3. A personal care provider must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The educational program must be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants cannot be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the participant and Rehabilitation Counselor/Registered Nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care provider must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and Rehabilitation Counselor/Registered Nurse to be adequate in fulfilling the responsibilities of personal care. The training, to be conducted by the participant/caregiver and the Rehabilitation Counselor/Registered Nurse, or an agency permitted by law to train nurse aides, must include:

   a) The purpose and philosophy of self-directed services by the disabled,

   b) Disability awareness,

   c) Employee-employer relationships and the need for respect for the participant's privacy and property.

   d) Basic elements of body functions,

   e) Infection control procedures,

   f) Maintaining a clean and safe environment,

   g) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.

   h) Meal preparation and menus that provide a balanced, nutritional diet.

4. The individual who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) 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 shall be deemed to meet the classroom training requirements. Competency certification for these personal care providers by the participant and Rehabilitation Counselor/Registered Nurse is required. A personal care attendant that has satisfactorily provided personal care

attendant service for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.

5. Personal care services can be furnished by family members provided they are not the spouse or the parent or step-parent of a minor child. Only qualified family members not legally responsible for the waiver participant can be employed as the personal care attendant. Family members must meet provider standards and be certified competent to perform the required tasks by the participant and the Rehabilitation Counselor/Registered Nurse. There must be adequate justification for the family member to function as the attendant such as lack of other qualified attendants in the remote area.

6. Minimum requirements include:

   a) Must be at least 18 years of age;

   b) Must be a high school graduate, have a GED or demonstrates the ability to read and write to complete required forms and reports of visits;

   c) Must be able to follow verbal and written instructions;

   d) Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;

   e) Must be certified as meeting the training and competence requirement by the participant and the Rehabilitation Counselor/Registered Nurse;

   f) Must be able to communicate effectively and carry out directions;

   g) Must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession 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.

   h) Must receive training in the areas of the Vulnerable Person's Act, care giver boundaries and dealing with difficult patients upon hire and annually thereafter.

7. MDRS must verify the competency for all personal care attendant as needed.

8. If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six (6) consecutive months, the participant is reevaluated for the need for waiver services to determine if the waiver can meet the needs of this participant.

9. MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants for employment decisions and/or actions and service provision to consumers of the department's services. MDRS must verify that any potential personal care attendant is not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

10. If a waiver participant chooses the Participant Directed Care Service option for managing personal care attendants, the Financial Management Service provider is responsible for obtaining the criminal background check. The FMS provider must verify that the personal care attendants employed by the waiver participant are not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

1. The need for use of such items must be documented in the assessment/case file and approved on the plan of care.

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

3. Specialized medical equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS must certify and document that providers meet the criteria/standards in the waiver document.

4. Requests for specialized medical equipment and supplies must be evaluated by the MDRS counselor or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for specialized medical equipment and/or supplies for approval.

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

E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the Independent Living Waiver program.

1. Transition Assistance services include the following:

a) Security deposits required to obtain a lease on an apartment or home.

b) Essential furnishings required to occupy and use a community domicile. Televisions or cable TV access are not essential furnishings.

c) Moving expenses.

d) Fees/deposits for utilities and service access for a telephone.

e) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

2. Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars ($800.00) per lifetime. These expenses must be included in the approved plan of care.

3. To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

a) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid;

b) Have no other source to fund or obtain the necessary items/supports;

c) Be moving from a nursing facility where these items/services were provided;

d) Be moving to a residence where these items/services are not normally furnished.

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

5. Transition Assistance must be completed by the day the participant relocates from the institution.

6. 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 service.

7. Transition Assistance services must be provided by a Registered Nurse and/or a Rehabilitation Counselor.

F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

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

2. Environmental accessibility adaptations include the following:

a) Installation of ramps and grab bars.

b) Widening of doorways.

c) Modification of bathroom facilities.

d) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

3. Environmental accessibility adaptations exclude the following:

   a) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.

   b) Adaptations which add to the square footage of the home.

4. Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for environmental accessibility adaptation.

5. Providers rendering environmental accessibility adaptation services must:

   a) Meet all state or local requirements for licensure/certification including, but not limited to, building contractors, plumbers, electricians or engineers.

   b) Provide services in accordance with applicable state housing and local building codes.

   c) Ensure the quality of work provided meets standards identified below:

      1) All work must be done in a fashion that exhibits good craftsmanship.

      2) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions.

      3) The contractor must obtain all permits required by local governmental bodies.

      4) All non-salvaged supplies and/or materials must be new and of best quality, without defects.

      5) The contractor must remove all excess materials and trash, leaving the site clear of debris at completion of the project,

      6) All work must be accomplished in compliance with applicable codes, ordinances, regulations and laws.

7) The specifications and drawings cannot be modified without a written change order from the case manager.

8) No accessibility barriers can be created by the modification and/or construction process.

6. MDRS must certify and document that providers meet the criteria/standards in the waiver.

G. Financial Management Service (FMS):

1. FMS is a support service to assist the waiver participant who chooses the Participant-Directed Personal Care service. Participant-Directed Personal Care service recognizes the waiver participant as the employer of record.

2. The waiver participant performs budgetary and employer functions and has the ability to negotiate salaries and benefits with the personal care attendants.

3. The FMS agent assists the waiver participant with employer and budget authority by ensuring federal, state and local employment taxes and labor and worker's compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner as related to the personal care attendant.

4. The FMS agent ensures that the necessary employer related duties and tasks, including payroll, are carried out. The service must ensure initial orientation and ongoing training is provided related to responsibilities of being an employer and adhering to legal requirements for employers.

5. The FMS provider must:

a) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS related responsibilities on behalf of the participant.

b) Provide assistance determining personal care attendant wages and benefits.

c) Provide assistance in hiring by verifying employees' citizenship status, conducting criminal background checks, and verifying the employee is not on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion lists.

d) Verify and maintain documentation of employee qualifications, citizenship status, and documentation of services delivered.

e) Provide education on recruiting, hiring and terminating employees as well as identifying the need for special skills and determining duties and schedules.

f) Ensure appropriate payment by:

1) Collecting timesheets,

2) Processing timesheets,

3) Processing payroll and payables, and

4) Making withholdings for and payment of applicable and federal, state and local employment related taxes.

g) Provide quarterly written reports to the waiver participant of all expenditures and the status of the waiver participant's budget.

h) Maintain a separate account for each waiver participant.

i) Make services available only to those persons deemed eligible and referred by MDRS,

j) Establish contact with the participant within five (5) working days of the referral from MDRS,

k) Conduct a face-to-face visit to initiate the FMS process within five (5) working days of establishing contact with the participant,

l) Conduct at least one (1) face-to-face meeting annually with each participant to review and update the overall function of the FMS,

m) Ensure Division of Medicaid (DOM) access to the participant's case files.

n) Employ staff members with knowledge, experience and abilities to sufficiently carry out the FMS component of service.

o) Have Medicaid provider agreements with the Division of Medicaid with the following requirements.

1) Have a minimum of five (5) years of billing and payroll experience relevant to participant-directed medical care,

2) Have a working knowledge of disability etiquette, psychology, and social aspects of disability, vulnerable persons act including reporting requirements, HCBS waivers, especially the plans of care, and W-2 employee tax reporting requirements. If the FMS lacks a working knowledge of disability etiquette, psychology and social aspects of disability, vulnerable person's act and home and community based waivers, training must be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.

p) Develop and maintain policies and procedures for the delivery of Financial Management Services.

q) Have qualifications verified by DOM initially and monitored annually or more frequently as indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §440.180; 43-13-117(15); CFR §440.180(b)(9);Section 37-33-157 of the Mississippi code of 1972 ; CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.4: Prior Approval/Certification

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility requiring the beneficiary meet nursing facility (NF) level of care.

B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.

C. The physician must certify the participant is appropriate for Medicaid long term care services.

D. The plan of care is the fundamental tool which ensures the health and welfare of participants in the Independent Living Waiver.

1. A participant's plan of care must be based on a comprehensive preadmission screening process and is developed based on the waiver participant's goals, preferences and needs.

2. The case manager/counselor must engage the participant and other interested parties as requested by the participant in developing the plan of care that best meets the needs of the participant.

3. Plans of care must be approved by a Medicaid Program Nurse prior to services being provided.

4. Development of the plan of care must include an emergency preparedness plan.

5. The Plan of Care must be developed at the time of the PAS, updated quarterly, annually and as needed.

6. The Pre-Admission Screening (PAS) and the Plan of Care must be completed jointly by the Rehabilitation Counselor and Registered Nurse on initial certifications.

7. The PAS and the Plan of Care must be completed by the Rehabilitation Counselor or a combination of the Rehabilitation Counselor and the Registered Nurse at re-certification.

E. The application along with the Plan of Care must be submitted to the Division of Medicaid for approval after the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS.

F. A participant can only be enrolled in one (1) HCBS waiver program at a time.

G. Added services must be prior approved by the Division of Medicaid.

H. MDRS is responsible for implementation of the plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for plan of care implementation. Monitoring the implementation of the plan of care includes on site review activity, record reviews, annual recertification reviews, participant phone calls from the Medicaid agency, and other strategies as needed.

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

History: Revised - 01/01/2013

Rule 2.5: Freedom of Choice

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

B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed of any feasible alternatives under the waiver, and

2. Given the choice of either institutional or home and community-based services.

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

History: Revised - 01/01/2013

Rule 2.6: Quality Management

A. Providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services (CMS).

B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.

C. All reports of abuse, neglect or exploitation, as defined below, must be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS and the Department of Human Services (DHS). The potential abuse, neglect, or exploitation must be reported to the Division of Medicaid/Long Term Care within twenty-four (24) hours.

1. Abuse (A) is defined as willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

2. Neglect (N) includes, but is not limited to, a single incident of the inability of a vulnerable person living alone to provide for himself and/or failure of a caretaker to provide what a reasonably prudent person would do.

3. Exploitation (E) is the illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person and includes acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

D. The Department of Human Services (DHS), Division of Aging and Adult Services is responsible for investigating allegations of Abuse, Neglect and Exploitation. The Division of Medicaid and DHS have a Memorandum of Understanding (MOU) allowing a free flow of information between the two (2) agencies to ensure the health and welfare of waiver participants.

E. Quality Management Strategy for the waiver includes the following:

1. Level of care determination consistent with the need for institutionalization,

2. Plan of care consistent with the participant’s needs,

3. Providers must meet the provider specifications of the CMS approved waiver, including licensure/certification requirements,

4. Critical event/incident reporting mechanism for participants and caregivers to report concerns/incidents of abuse, neglect, and exploitation,

5. Division of Medicaid retention of administrative authority over the waiver program,

6. Division of Medicaid retention of financial accountability for the waiver program.

F. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.

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

History: Revised – 01/01/2013

Rule 2.7: Participant Direction of Services

A. Participants are encouraged to make choices in regards to participant needs, goals, preferences and desires with all aspects of the services provided.

B. Participants have the choice of two (2) options for personal care service:

1. Co-Participant personal care service, the traditional personal care services, is a viable choice for participants who do not desire to be become the employer of record with budgetary control. Mississippi Department of Rehabilitation Services is recognized as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority, excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance.

2. Participant-Directed personal care service allows the participant to exercise employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant has the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues.

   a) The FMS provides assistance to the participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS must submit claims for attendant services to the Division of Medicaid for payment and is responsible for assisting with, including but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. The participant must be given detailed information about all providers except Personal Care Service, and the participant has the opportunity and is encouraged to choose the provider they feel most comfortable and can best meet their needs.

   b) The FMS must:

      1) Provide support for financial management when the participant is the employer of the personal care attendant.

2) Assist participant in verifying personal care attendant citizenship status.

3) Collect and process timesheets of personal care attendants.

4) Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.

5) Verify the personal care attendant is not listed on the Mississippi Nurse Aide Abuse Registry.

6) Verify the personal care attendant is not listed on the Office of Inspector General (OIG) exclusion list.

7) Ensure the participant receives initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

8) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant.

9) Provide assistance determining employee wages and benefits.

10) Verify and maintain documentation of employee qualifications and documentation of services delivered.

11) Conduct criminal background checks on personal care attendants.

12) Assist the participant with recruitment of personal care attendants.

13) Maintain a separate account for each participant's participant-directed budget.

14) Track and report participant funds, disbursements and the balance of participant funds.

15) Process and pay invoices for personal care attendant services approved in the service plan.

16) Provide participant with periodic reports of expenditures and the status of the participant directed budget.

c) FMS providers must have a Medicaid provider agreement with the Division of Medicaid. The Division of Medicaid is responsible for oversight of the FMS entities by compliance reviews conducted on an annual basis or more often if needed. Reviews are instigated in the event of a complaint regarding management of funds. Any participant under-utilization or over-utilization of services must be reported to the Division of Medicaid.

d) Waiver participant's failure to comply with participant directed service guidelines will result in a corrective action plan. Repetitive non-compliance disqualifies a waiver participant for the Participant-Directed Service option.

e) A waiver participant can change from the Participant-Directed Personal Care service to the Co-Participant Directed Personal Care service at any time at their request.

f) Immediate termination of the Participant-Directed personal care service option occurs if the following circumstances arise, including, but not limited to:

1) The participant's/employer's health or welfare is immediately jeopardized,

2) The personal care attendant is convicted of criminal offenses precluding him/her from working with the vulnerable population,

3) The participant/employer has not implemented an acceptable corrective action plan as required to continue Participant-Direction,

4) The waiver participant declines to the degree he/she is no longer able to express his/her ideas and wants verbally or nonverbally,

5) The waiver participant fails to provide adequate justification for underutilizing or over utilizing personal care services,

6) Fraud and/or abuse of funds, or

7) Unsafe environment for care providers.

Source: CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.8: Monitoring Safeguards

A. MDRS case managers are required to provide each waiver participant with written information regarding their rights as a waiver participant at the initial assessment.

B. Case managers must provide the participants information at the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect or exploitation is alleged.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.9: Additional Dispute Resolution Process

A. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

B. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services.

C. MDRS must inform the participant at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes.

D. MDRS must inform the participant of their rights which address disputes, complaints/ grievances and hearings.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.10: Financial Accountability

A. Claims for waiver services are based on state payment for waiver services that have been rendered to waiver participants as authorized by the plan of care, accurately billed by qualified waiver providers, and in accordance with the approved waiver.

B. The DOM conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. DOM denies payment for services when a waiver participant or applicant is not Medicaid eligible on the date of service.

D. DOM conducts post utilization reviews to ensure the services provided were on the participant's approved plan of care.

E. Records documenting the provision of services must be maintained by the operating agency (if applicable) and providers of waiver services for a minimum of three (3) years.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

Source: 45 CFR § 92.42, Miss Code 43-13-121

History: Revised 01/01/2013

Rule 2.11: Hearing and Appeals

A. The Division of Medicaid 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.

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

C. The NOA must include:

1. A description of the action the provider has taken or intends to take,

2. An explanation for the action,

3. Notification that the participant has the right to file an appeal,

4. Procedures for filing an appeal,

5. Notification of participant's right to request a Fair Hearing,

6. Notice the participant has the right to have benefits continued pending the resolution of the appeal, and

7. The specific regulations or the change in Federal or State law that supports or requires the action.

D. The waiver 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.

E. The waiver 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.

F. 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.

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

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

I. The participant has the right to appeal a local hearing decision by requesting a State hearing; A State hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.

J. At the State hearing level, DOM issues a determination within ninety (90) days of the date of the initial request for a hearing.

K. The waiver 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.

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

Source: 42 CFR Part 431, Subpart E Item 1-F; 42 CFR §431.210, Miss Code 43-13-121

History: Revised 01/01/2013