PUBLIC NOTICE
August 16, 2019

Pursuant to 42 C.F.R. Section 441.304(f), public notice is hereby given to the submission of the Independent Living (IL) Waiver amendment. The Division of Medicaid, in the Office of the Governor, will submit this proposed waiver amendment to the Centers for Medicare and Medicaid Services (CMS) for the IL Waiver effective October 1, 2019.

1. The proposed changes to the IL Waiver are to:

    a. Add the option for telephone interviews to supplement home visits as a method for completing participant quality surveys,

    b. Specify monthly Office of the Inspector General (OIG) and Nurse Aide Abuse Registry checks, and

    c. Update covered categories of eligibility to reflect updated category titles (no change in coverage).

2. The financial impact for the IL Waiver amendment is anticipated to be budget neutral.

3. 42 C.F.R. 441.304 requires the Division of Medicaid to submit a waiver amendment in order to make substantive changes to the waiver.

4. A copy of the proposed waiver changes will be available in each county health department office and in the Department of Human Services office in Issaquena County, for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

6. A public hearing on this waiver amendment will not be held.

Drew L. Snyder
Executive Director
Division of Medicaid
Office of the Governor

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Mississippi** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Independent Living Waiver

C. Waiver Number:MS.0255
Original Base Waiver Number: MS.0255.90.R1

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

10/01/19

Approved Effective Date of Waiver being Amended: 07/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The State is amending this waiver to make the following changes:

1. Add the option for telephone interviews to supplement home visits as a method for completing participant quality surveys;
2. Specify monthly OIG and Nurse Aide Abuse Registry checks;
3. Specify background checks every 2 years; and
4. Update covered categories of eligibility to reflect updated category titles (no change in coverage).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
[X] Waiver Application	I. Public Input
[X] Appendix A Waiver Administration and Operation	A-2-b; QIS PM4 Data Source

Component of the Approved Waiver	Subsection(s)
☒ Appendix B Participant Access and Eligibility	B-4-b
☒ Appendix C Participant Services	C-2-a;C-2-b; C-1/C-3 Provider Qualifications, Frequency for Case Management, PCA, Transition Assistance
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	G-2-a; G-2-b; G-2-c; G QIS PM3 Data Source
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

The State is amending this waiver to make the following changes:

1. Add the option for telephone interviews to supplement home visits as a method for completing participant quality surveys;
2. Specify monthly OIG and Nurse Aide Abuse Registry checks;
3. Specify background checks every 2 years; and
~~1.~~4. Update covered categories of eligibility to reflect updated category titles (no change in coverage).

A. The **State** of **Mississippi** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Independent Living Waiver

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MS.0255
Draft ID: MS.002.05.01

D. Type of Waiver *(select only one)*:

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/17
Approved Effective Date of Waiver being Amended: 07/01/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

The participant must:
1) 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.
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care.
3) 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.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Naik

First Name: Anita

Title: Office Director

Agency: Mississippi Department of Rehabilitation Services

Address: 1281 Highway 51 North

Address 2:

City: Madison

State: **Mississippi**

Zip: 39110

Phone: (601) 853-5230 **Ext:** ☐ **TTY**

Fax: (601) 853-5301

E-mail: anaik@mdrs.ms.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

DOM and MDRS have implemented a personal care curriculum which is required for all non- licensed personal care attendants prior to providing services to person on the waiver. Changes to the PCA training curriculum must be approved by DOM. Documentation of completion of this course work must be maintained at the operating agency, and be made available to DOM upon request. A personal care attendant must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The training, to be conducted by the person and the case manager/registered nurse, or an agency permitted by law to train nurse aides, shall include the purpose and philosophy of self-directed services by persons with disabilities, disability awareness, employee-employer relationships and the need for respect for the person's s privacy and property. Upon hire and annually thereafter, training must also include the Vulnerable Person's Act, caregiver boundaries, and managing challenging situations. Instructions and training will cover the basic elements of body functions, infection control procedures, universal precautions, maintaining a clean and safe environment, 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. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet. The educational program will be personalized with participation of the person to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants will not be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the person and the case manager/registered nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care attendant must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the person and case manager/registered nurse to be adequate in fulfilling the responsibilities of personal care.

There must be adequate justification for the relative to function as the PCA attendant, e.g., lack of other qualified PCAs attendants in remote areas. PCA 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 they must be certified competent to perform the required tasks by the person and the case manager/registered nurse.

Minimum Requirements:

- Must be at least 18 years of age;

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

- Must be able to follow verbal and written instructions;

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

- Must be certified as meeting the training and competence requirement by the person and the Case Manager/Registered Nurse;

- Must be able to communicate effectively and carry out directions.

- 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.

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

Verification of Provider Qualifications

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Specialized medical equipment and supplies include devices, controls, or appliances which enable the person to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or provide a direct medical or remedial benefit to the person. These items must be specified on the PSS.

Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payers (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Each request for specialized medical equipment is evaluated by the case manager or DOM staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation. The case manager will update the person and monitor the progress of each specialized medical equipment request on a monthly basis. If the case manager determines there is a need to make adjustments to the request, he/she will notify the appropriate personnel (i.e. Assistive Technology) as soon as possible. The case manager will discuss and document the person's choice of vendor on the PSS prior to authorizing for services.

If it is determined through the person-centered planning process that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

The services under the Independent Living Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialty Medical

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

For PM 1, DOM will (a) have MDRS remove individual immediately; and (b) require MDRS to review hiring practices and modify if necessary in thirty days.
For PM 2, DOM will require MDRS to immediately remove the non-licensed/non-certified provider from providing care to the person until the non-licensed/non-certified provider qualification standards are met.
For PM 3, DOM will (a) require MDRS to remove the provider from providing care to the person immediately; (b) ask MDRS to apply applicable measures to ensure the provider is trained prior to resuming care; and (c) require MDRS to apply applicable disciplinary action if warranted in accordance with their policies and procedures.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify: