OFFICE OF THE GOVERNOR
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MISSISSIPPI DIVISION OF MEDICAID

HOME AND COMMUNITY-BASED
ASSISTED LIVING WAIVER

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, Office of the Governor as the single state agency to administer the Medicaid program in Mississippi. Section 1915(c) of the Social Security Act authorizes 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. An 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 an individual is not Medicaid eligible at the time of HCBS application, Medicaid coverage for HCBS services may be possible for the individual if they meet the medical criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

A waiver provider's 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.
The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

All ICF/IID provider agreements are time-limited with the length of time primarily determined by the findings of the survey agency on visits to the facility.
The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification (HFLC) pursuant to federal law regulation, certifies ICF/IID's for participation in the Medicaid program. The duration of a facility's provider agreement will be for the same period of time, initially twelve (12) months or less, as certified or recertified for participation by the survey agency. An exception to this duration of the agreement may occur if the Division of Medicaid has adequate documentation showing proper cause, whereby it may refuse to execute an agreement or may cancel an existing agreement with a certified facility.

When the Division of Medicaid receives the properly executed certification notice from the state or federal survey agency certifying the facility for participation in the Medicaid program, the Division of Medicaid will implement the following:

1. A Mississippi Medicaid Provider Enrollment application and two (2) Provider Agreements will be sent to the facility.

2. The Medicaid Provider Enrollment application and a cover letter that directs all forms will be signed and returned to the fiscal agent along with:

a. a copy of the current license of the facility;

b. a copy of the Certificate of Need (not required for a participating provider with no changes); and

c. a certified copy of the minutes, or other legally sufficient documents, authorizing the person who signs the agreements to do so on behalf of the corporation.

3. When the above material is received, it will be reviewed for completeness, and, if complete, submitted to the Executive Director of the Division of Medicaid for approval or disapproval.

4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid record. The Medicaid Provider Enrollment form will be sent to the fiscal agent so that a Medicaid provider number may be assigned.

5. If the Executive Director disapproves, the facility will be notified in writing. The reasons or the disapproval will be clearly stated, and information will be given on how to appeal the decision. For further information on Provider Agreements, refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.2 and Part 200, Chapter 4.

Note: Applications and Provider Agreements are available on the website at www.medicaid.ms.gov

ELIGIBILITY

The Assisted Living Waiver provides services to individuals who, but for the provision of such services, would require placement in a nursing facility. Qualified beneficiaries are allowed to reside in a Personal Care Home-Assisted Living (PCH-AL) facility, and Medicaid reimburses for the services received in the facility. The facility must be licensed as a PCH-AL Facility by the Mississippi State Department of Health.

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool that encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm that will generate a numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

PROVIDER ENROLLMENT

Providers interested in becoming Personal Care Home-Assisted Living (PCH-AL) facility providers must complete a proposal package, undergo a facility inspection, and enter into a provider agreement with the Division of Medicaid. All PCH-AL facilities must be certified by the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

PROPOSAL PACKET

A proposal packet may be obtained through the Division of Medicaid. The completed proposal packet and a copy of the MSDH facility license/certification must be mailed back to the Division of Medicaid. DOM staff will review the proposal. If the proposal is accepted, a facility inspection will be scheduled.

FACILITY INSPECTION

Upon completion of the proposal packet, DOM staff will inspect the facility to ensure that the facility meets the quality assurance standards adopted by MSDH.

MISSISSIPPI MEDICAID PROVIDER APPLICATION

When all requirements noted above have been satisfied, DOM staff will forward a Mississippi Medicaid Provider Application. The completed application must be returned to the Division of Medicaid. DOM staff will review the application. If approved, the application will be forwarded to the Bureau of Provider/Beneficiary Relations for approval. When all approvals have been obtained, the application will be sent to the fiscal agent.

Upon notification that a provider number has been issued, a welcome letter will be sent to the new provider and the provider will be added to the referral list.

FREEDOMOFCHOICE

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."

Assisted Living Waiver services will not restrict an individual's free choice of providers. Each individual found eligible for the waiver will be given free choice of all qualified providers.

PRIORAPPROVAL/PHYSICIANCERTIFICATION

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 approval, the following forms must be submitted:

- Pre-Admission Screening (PAS) Tool
- Plan of Care Form
- Admitted and Discharged Form

PRE-ADMISSION SCREENING (PAS) TOOL- ASSISTED LIVING WAIVER PROGRAM

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. The PAS will generate a Summary and Physician Certification page that must be signed by the physician.

Scores less than the set numerical threshold may be approved based on a secondary review by the DOM HCBS staff if all of the following criteria are met:

- Beneficiary has a diagnosis of schizophrenia/other psychoses, major depression, or bipolar disorder
- Beneficiary takes one (1) or more psychotropic medications
- Beneficiary needs or receives medication administration and/or regulation
- Beneficiary PAS score is at least twenty-five (25) and less than forty-five (45)

In addition to the above criteria, the beneficiary may have a history of, or may currently exhibit other behaviors which include, but are not limited to: verbal aggression, physical aggression, resistive behavior, wandering/elopement, inappropriate/unsafe behaviors, self-injury, delusions, hallucinations, manic symptoms and mood swings.

After the applicant has made an informed choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically to the Division of Medicaid, Bureau of LTC.

PLAN OF CARE

The Plan of Care form is completed by the case manager. This form, in conjunction with the Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services.

ADMITTED AND DISCHARGED FORM

The Admitted and Discharged 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.

DOM staff will review/process all 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. The original of all three (3) forms will be retained by the case manager as part of the original case record.

A beneficiary may be locked into only one waiver program at a time.

COVERED SERVICES

CASE MANAGEMENT SERVICES

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.
Currently, all case management services are provided through the Division of Medicaid, HCBS section of the Bureau of Long Term Care.

ASSISTED LIVING SERVICES

Assisted Living Services may include the following:

- **PERSONAL CARE SERVICES**

Services rendered by personnel of the licensed facility to assist beneficiary in performing one or more of the activities of daily living, including but not limited to: bathing, walking, excretory functions, feeding, personal grooming, and dressing.

- **HOMEMAKER SERVICES**

Services consisting of general household activities including routine household care of beneficiary's residential unit.

- **CHORE SERVICES**

Services needed to maintain the beneficiary's residential unit in a clean, sanitary and safe mode.

- **ATTENDANT CARE SERVICES**

Hands-on care, both of a supportive and health-related nature, specific to the needs of a medically stable, physically disabled beneficiary.

- **MEDICATION OVERSIGHT/MEDICATION ADMINISTRATION**

Services consisting of personnel providing reminders or cues to beneficiaries to take medication, open preset medication containers, and handle/administer medication to the extent permitted under state law. Personnel must operate within the scope of applicable licenses and/or certifications.

- **THERAPEUTIC, SOCIAL, AND RECREATIONAL PROGRAMMING**

Recreation and leisure experiences to help elderly and/or disabled beneficiaries to increase their physical, mental, emotional and social skills.

- **INTERMITTENT SKILLED NURSING SERVICES**

Nursing care and interventions rendered to the beneficiary as ordered by the physician.

- **TRANSPORTATION**

Services specified in the Plan of Care for transporting beneficiaries to medical appointments. Transportation services may be provided by the PCH-AL or through the DOM Non-Emergency Transportation (NET) program. Services through NET are available only when the beneficiary has not reached the maximum services limits provided under the State Plan.

- **ATTENDANT CALL SYSTEM**

Emergency response systems for beneficiaries who are at risk of falling, becoming disoriented, or experiencing some disorder that puts them in physical, mental or emotional jeopardy.
Other individuals or agencies may also furnish care directly, or under agreement with the PCH- AL facility. Care provided by these other entities may supplement services provided by the PCH- AL facility, but they may not be provided in lieu of those provided by the PCH-AL facility.

DOCUMENTATION/RECORD MAINTENANCE

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth in the waiver Quality Assurance Standards for each service. In addition, PCH-AL facility providers are required to submit copies of all service logs/documentation of visits, along with a copy of their billing for each waiver beneficiary served, to the individual's case manager no later than the 15th of the following month in which the service was rendered. The case manager may make an initial verbal request for missing documentation and billing verification from the waiver provider, allowing ten (10) working days for the information to be received. If the information is not provided within the allotted time, the case manager or case management supervisor may make a second verbal request allowing an additional ten (10) working days for the information to be received. If the information is still not received, the third request must be made by the case management supervisor in writing and copied to the HCBS Division Director. The written request should reference the dates that the first and second requests were made and the name of the person to whom the request was made. An additional ten (10) days must be allowed for the provider to submit the required missing documentation. The letter should indicate that no further referrals will be made to the provider until all required documentation is received. If the information is still not received, the HCBS Division Director will determine appropriate action.

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.

HEARINGS AND APPEALS FOR DENIED/TERMINATED SERVICES

If the beneficiary/legal representative disagrees with the decision of the local case management team, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the case management team 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 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 case manager will be notified by the Division of Medicaid to either initiate/continue or terminate 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, sexual harassment of the service providers. The case manager is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.

Assisted Living Services
General Description

Please fill in all blanks and attach required documents.

Type or print in black ink.

1. **Proposed Services: ___Assisted Living Services_____**

2. **County(s) in which the services are to be provided: _____**
   _____

3. **Target Population to be served: _Medicaid Assisted Living Waiver Clients (21 & over)_**

4. **Do you currently provide any other home or community-based service?**
   _____

5. **Number of beds available for Assisted Living Waiver recipients: _____**

6. **Attach a copy of the facility's Personal Care Home_Assisted Living License.**
   (To keep a Medicaid provider number current, a copy of your yearly renewal license must be forwarded to the Division of Medicaid)

7. **Attach a copy of the applicant agency's organization chart.**

8. **Attach a list of applicant's actual proposed staff/ waiver participant ratio.**

9. **Attach a descriptive copy of the facility's breakdown of actual cost the client will be assessed for room and board charges as well as any other mandatory charges not included in the "bundle" of services covered under the waiver.**

10. **Attach a copy of your facility's admission agreement reflecting the actual cost per month that waiver clients will be assessed, excluding the "bundle" of services covered under the waiver.**

Assisted Living Services
Applicant Information

Please type or print in black ink

Facility Name: _____

_____

Mailing Address: _____

_____

*Street: _____

_____

City/Zip: _____

County: _____

Year Established: _____

Signatory Authority: _____

_____

Contact Person: _____

Title of Contact Person: _____

_____

Telephone: _____ Fax: _____

Name of Owner: _____

Business Telephone: _____

Legal Status (Check one)

[ ] Public (State of Local Government)

[ ] Non-Profit

[ ] Private for Profit

[ ] Other (Specify):_____

Clients receiving these services must be eligible for Medicaid, as stipulated in the federally approved waiver and require the level of care that is provided in a nursing facility. Eligibility for these services is determined by a case management team at the Division of Medicaid where the service will be provided in a nursing facility. Participants must be enrolled in the Assisted Living Waiver for Medicaid reimbursement.

* Actual physical address of the Assisted Living Facility

Assisted Living Facility Service
Provider Certification Checklist

Please read and answer all questions.

1. Does applicant agree to develop and comply with DOM approved policies, procedures, and Quality Assurance Standards? (Required for administrative authority) [ ] YES [ ] NO

2. Is applicant current on criminal background check on all employees? [ ] YES [ ] NO
(Submit copy of form to be used)

3. Is applicant financially stable? [ ] YES [ ] NO

a. Is applicant free from tax liens? [ ] YES [ ] NO
b. Has applicant filed a tax return for the current year? [ ] YES [ ] NO

NOTE: If yes, complete the attached Current Annual Operating Budget form as well as a Narrative.

I understand that incomplete or incorrect information provided will disqualify the application from consideration.

As the duly authorized representative, I declare under penalty or perjury that all statements made herein and on any attached documents are true and complete to the best of my knowledge. **I further understand that any omission, misrepresentation or falsification of any information contained in this proposal application or contained in any communication supplying information to Medicaid to complete or clarify this proposal application may be punishable by criminal, civil or other administrative actions.**

_____ _____
Print Name (must be legible) Date

_____
Signature

_____ _____
Title Organization

Assisted Living Facility Service
Current Annual Operating Budget

CURRENT FUNDING SOURCES: Provide in detail all applicant funding sources relative to the provision of the services.

Expenses:

Salaries (Identify the number of positions and each position by title and yearly salary). If more space is needed, please attach to this form.

Job Title	Yearly Salary
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Fringe Benefits $_____

Supplies (office & program) $ _____

Equipment (office & program) $ _____

Travel $ _____

Training $ _____

Facility:

Land/Building Purchase $ _____

Utilities/ Telephone $ _____

Renovations $ _____

Other (specify): $ _____

_____ $ _____

_____ $ _____

Other:

Loan (s) $ _____

Insurance $ _____

Bond $ _____

Membership $ _____

Other (specify):

_____ $ _____

_____ $ _____

_____ $ _____

Total Annual Income $ _____

Less Total Annual Expenses $ _____

Balance (Net Annual Operating Income) $ _____

Quality Assurance

The Assisted Living Facility must develop, implement and maintain an internal quality assurance program that monitors, at a minimum, the following items:

- Assurance of knowledgeable, trained, competent and experienced staff
- Service delivery in accordance with the plan of care
- Assurance that waiver participants are informed of their rights and responsibilities
- Proper reporting of fraud, abuse, neglect, and exploitation of waiver participants
- Development of an active discharge plan at the time of admission