

Division of Medicaid	New: X	Date: 06/01/06
State of Mississippi	Revised:	Date:
Provider Policy Manual	Current:	
Section: HCBS/Assisted Living Waiver	Section: 68.01	
	Pages: 1	
Subject: Introduction	Cross Reference:	

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.

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Section: HCBS/Assisted Living Waiver	Section: 68.02	
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Subject: Eligibility	Cross Reference:	

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 and located in one of the following counties: Bolivar, Forrest, Harrison, Hinds, Lee, Newton or Sunflower.

Eligibility requirements for the Assisted Living Waiver Program include following:

- Beneficiary must be 21 years of age or older, **AND**
- Beneficiary must have a deficit in at least three (3) activities of daily living **or** a diagnosis of Alzheimer's or other dementia with a deficit in at least two (2) activities of daily living, **AND**
- Beneficiary must require nursing facility level of care, if assistance is not otherwise provided, **AND**
- Beneficiary must be aged, blind or disabled and currently qualify for Medicaid due to receipt of SSI cash assistance or qualify for Medicaid based on income that is under 300% of the SSI limit for an individual. Resources must be less than \$4,000.00.

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Section: HCBS/Assisted Living Waiver	Section: 68.03	
Subject: Provider Enrollment	Pages: 1	
	Cross Reference:	

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, HCBS section of the Bureau of Long Term Care. The completed proposal packet and a copy of the MSDH facility license/certification must be **mailed** back to the Division of Medicaid, HCBS section of the Bureau of Long Term Care. DOM HCBS 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 HCBS 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 HCBS staff will mail a Mississippi Medicaid Provider Application. The completed application must be **mailed** back to the Division of Medicaid, HCBS Section of the Bureau of Long Term Care. DOM HCBS 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, DOM HCBS staff will send a welcome letter to the new provider. The appropriate case manager will be notified to add the provider to the referral list.

Providers may not submit the proposal or the enrollment application for waiver services electronically.

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State of Mississippi	Revised:	Date:
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Section: HCBS/Assisted Living Waiver	Section: 68.04	
Subject: Freedom of Choice	Pages: 1	
	Cross Reference:	

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.

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State of Mississippi	Revised:	Date:
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Section: HCBS/Assisted Living Waiver	Section: 68.05	
Subject: Prior Approval/Physician Certification	Pages: 1	
	Cross Reference:	

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:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care

DOM 260 HCBS Physician Certification

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the beneficiary meets the medical criteria for nursing facility care.

HCBS 305 Assessment

The HCBS 305 Assessment form is completed by the case manager. The tool is used to determine eligibility for Case Management and Assisted Living services.

DOM 301 HCBS Plan of Care

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

DOM HCBS staff will review/process all three (3) 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 HCBS case manager as part of the original case record.

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

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Subject: Covered Services	Pages: 1 Cross Reference:	

The Assisted Living Waiver provides the following 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.

Under the Assisted Living Waiver, all case managers must be a social worker licensed to practice in the State of Mississippi with at least two (2) years of full time experience in direct services to elderly and disabled clients.

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
- Homemaker services
- Chore services
- Attendant care services
- Medication oversight/medication administration (to the extent permitted under state law)
- Therapeutic, social, and recreational programming
- Intermittent skilled nursing services
- Transportation
- Attendant call system

Services are provided in a home-like environment in a licensed PCH-AL facility. The service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides for supervision, safety and security.

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.

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Section: HCBS/Assisted Living Waiver	Section: 68.07	
Subject: Quality Assurance Standards	Pages: 1	
	Cross Reference:	

Waiver providers must meet the quality assurance standards adopted by the Mississippi State Department of Health for PCH-AL facilities. The standards are part of the waiver document approved by the Centers for Medicare and Medicaid Services.

DOM HCBS staff will send a copy of the Quality Assurance Standards to the prospective waiver provider upon receipt of the proposal packet/enrollment application. In addition, DOM HCBS staff will notify waiver providers when revisions are made to the standards.

Waiver providers are required to report changes in contact information, staffing, and licensure within ten (10) days to DOM HCBS staff. DOM HCBS staff will contact waiver providers annually to verify/update information and to ensure that all services are being provided.

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State of Mississippi	Revised:	Date:
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Section: HCBS/Assisted Living Waiver	Section: 68.08	
	Pages: 1	
Subject: Documentation/Record Maintenance	Cross Reference:	

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. **However, in accordance with the waiver document approved by the Centers for Medicare and Medicaid Services, providers of Assisted Living Waiver services must maintain records for a minimum of six (6) years.**

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.

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Section: HCBS/Assisted Living	Section: 68.09	
	Pages: 1	
Subject: Beneficiary Cost Sharing	Cross Reference:	
	Beneficiary Information 3.08	

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. Beneficiaries enrolled in waiver programs are exempt from co-pay for waiver services. Co-pay is required for services other than waiver services. Refer to Beneficiary Information, Section 3.08, in this manual.

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Subject: Reimbursement		

Reimbursement for PCH-AL facility 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.)

Assisted Living facility services must be billed as follows:

Service	Code	Modifier	Billing Unit
Personal Care-Assisted Living Facility Services	T1020	U4	Daily rate per eligible beneficiary

Reimbursement for PCH-AL facility services is only for those services provided within the facility. Mississippi Medicaid does not reimburse for room and board. Transportation is an integral part of PHC-AL services and is not reimbursed separately.