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.

Eligibility requirements for the Assisted Living Waiver Program include following:

- Beneficiary must be twenty-one (21) years of age or older, **AND**
- Beneficiary must require nursing facility level of care, if assistance is not otherwise provided, **AND**

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. Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening (PAS) policy.

## Medicaid Beneficiary Eligibility

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

- SSI (COE – 001),
- **OR** an aged, blind, or disabled individual who meets all factors of eligibility can qualify 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. COE–062 denotes eligibility in the Assisted Living Waiver.

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.

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.

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, **AND**
- Beneficiary takes one (1) or more psychotropic medications, **AND**
- Beneficiary needs or receives medication administration and/or regulation, **AND**
- 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.

Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening (PAS) policy.

## 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.**

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. Case Managers may carry an average, active caseload, of no more than fifty (50) cases.

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. Refer to Provider Policy Manual Section 12.0 for Non-Emergency (NET) policies the PCH-AL facility or through NET program.

- **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, metal or emotion jeopardy.

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.

Waiver providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services. Providers are issued a copy of the CMS approved waiver requirements for their respective service(s) and providers are notified when revisions are made.

Providers are required to report changes in contact information, staffing, and licensure within ten (10) calendar 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.

The quality management strategy for the waiver includes the following:

- Level of care need determination consistent with the need for institutionalization
- Plan of care consistent with the beneficiary's needs
- Providers who meet the provider specifications of the CMS approved waiver, including licensure/certification requirements
- Critical event/incident reporting mechanism for beneficiaries and caregivers (for reporting concerns/incidents of abuse, neglect, and exploitation)
- State (DOM) retention of administrative authority over the waiver program
- State (DOM) financial accountability for the waiver program

**Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.**

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

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

If the beneficiary/legal representative disagrees with the decision of the local 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.