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Report to the Mississippi Legislature

Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Waiver Program

PEER: The Mississippi Legislature's Oversight Agency

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PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) www.peer.ms.gov

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review
PEER Committee

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RAY ROGERS
PERCY W. WATSON

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

Post Office Box 1204
Jackson, Mississippi 39215-1204

James A. Barber
Executive Director

www.peer.ms.gov

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

January 6, 2020

Honorable Tate Reeves, Governor
Honorable Delbert Hosemann, Lieutenant Governor
Honorable Philip Gunn, Speaker of the House
Members of the Mississippi State Legislature

On December 16, 2019, the PEER Committee authorized release of the report titled ***Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Waiver Program.***

A handwritten signature in black ink that reads "Becky Currie".

Representative Becky Currie, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Letter of Transmittal	i
Report Highlights	vii
Introduction	1
Authority	1
Scope and Purpose	1
Scope Limitation	2
Method	2
Background	3
What is the Direct Care Workforce and What Occupations are Included?	3
What are Personal Care Services and how do Home Care Providers Differ from Home Health Providers?	4
How are Direct Care Workers Trained?.....	5
How much do Direct Care Workers Earn?	6
How Personal Care Services are Provided through Medicaid in Mississippi	8
How are Personal Care Services Administered through Medicaid?	8
What Role do Personal Care Attendants have in Providing Services through Medicaid in Mississippi?.....	10
What is the Scope of the Medicaid Elderly and Disabled Waiver Program in Mississippi?..	12
What Concerns Have Been Raised Regarding Personal Care Services Funded through Medicaid’s Elderly and Disabled Waiver Program?	20
Concern: Medicaid Reimbursement Rates for Personal Care Services Have Decreased.....	21
Concern: The Division of Medicaid Did Not Notify Home Care Provider Agencies of Physical Office Requirements in a Timely Manner	24
Concern: Increased Administrative Requirements Have Increased Overhead Costs and Caused Home Care Provider Agencies to No Longer Be Profitable	26
Concern: Increased Operational Costs to Implement the MediKey Electronic Visit Verification System When It Does Not Increase the Identification of Fraud, Waste, and Abuse	29
Concern: Personal Care Attendant Training is Too Costly and Home Care Providers Need More Cost-Efficient Options and Flexibility in DOM Standards	33
Concern: Certified Nurse Aides Employed by Home Care Provider Agencies Are Not Able to Obtain Recertification Resulting in Increased Turnover Rates	39
Concern: There are Too Many Home Care Provider Agencies in the State and the Division of Medicaid Needs to Enact a Moratorium on the New Providers Similar to Moratoriums Enacted on Other Healthcare Entities	44
Concern: Some of the Planning and Development Districts that Provide Case Management Services Also Operate Home Care Agencies and Skew the Placement of Waiver Participants to their Agencies	47
Concern: The Planning and Development Districts and their Case Management Teams do not Notify the Home Care Provider Agencies in a Timely Manner when a Loss of Waiver Participant Eligibility Occurs.....	49

What Solutions Could be Considered to Address Concerns Regarding Personal Care Services?.....	50
The Division of Medicaid Should Periodically Review the Reimbursement Rates for Waiver Services, Including Personal Care Services.....	50
The Mississippi Department of Health and the Division of Medicaid Should Identify Potential Areas to Streamline the Fingerprint Requirement with the National Background Check Program.....	50
The Division of Medicaid Should Continue to Work with FEI Systems to Implement Improvements to the MediKey System.....	53
The Division of Medicaid Should Work with the Centers for Medicare and Medicaid Services to Amend the CPR Certification Requirement.....	54
The Division of Medicaid Should Ensure Consistent Personal Care Attendant Requirements for the Elderly and Disabled Waiver Program.....	54
The Home Care Provider Agency Representatives Should Identify and Develop a Training Program Option to Allow for Recertification of Certified Nurse Aides Working for Home Care Providers, with Consultation from the Mississippi State Department of Health on the Feasibility of Such Option.....	55
The Division of Medicaid Should Continue Monitoring the Number of Applicants and Approved Providers Since the Implementation of their Mandatory Orientation Process.....	57
 Recommendations	 60
 Appendix A: 2018 Standard Occupational Classification Manual Definitions	 62
 Appendix B: 2017 North American Industry Classification System (NAICS)	 64
 Appendix C: Personal Care Attendant Requirements	 65
 Appendix D: Elderly and Disabled Waiver Fact Sheet	 67
 Appendix E: Location of Medicaid-Approved Personal Care and In-Home Respite Providers in Mississippi	 69
 Appendix F: Medicaid Home Health Agency Rates (per visit), Effective October 1, 2018	 70
 Appendix G: Historical Medicaid Reimbursement Rates for Personal Care and Homemaker Services	 72
 Appendix H: Personal Care Services Quality Assurance Standards (revised January 2019).....	 73
 Appendix I: Nurse Aide Training Programs	 84
 Appendix J: Nurse Aide Skills	 87

Agency Responses 88

List of Exhibits

Exhibit 1: U.S. Direct Care Worker Median Hourly Wages Adjusted for Inflation, 2012-2018 7

Exhibit 2: Personal Care Aide’s Median Hourly Wages Adjusted for Inflation, 2012-2018 7

Exhibit 3: Division of Medicaid Waiver Programs that Utilize Personal Care Attendants..... 12

Exhibit 4: Number of Elderly and Disabled Waiver Slots Available to Beneficiaries within each of the Planning and Development Districts..... 18

Exhibit 5: Medicaid Beneficiaries served by the Elderly and Disabled Waiver, Fiscal Year 2012 through Fiscal Year 2019 19

Exhibit 6: Medicaid Reimbursement Rates for Homemaker Services and Personal Care Services Provided through the Elderly and Disabled Waiver Program, from October 1, 2003 to Present Day 21

Exhibit 7: Current Moratoriums in place for Healthcare Providers in Mississippi..... 46

Exhibit 8: Number of Home Care Providers who have Applied to the Service the Elderly and Disabled Waiver, State Fiscal Years 2012 through 2020 59

Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Waiver Program

CONCLUSION: Representatives of home care provider agencies raised multiple concerns regarding the provision of personal care services funded through the Medicaid Elderly and Disabled Waiver. PEER staff examined these concerns and sought to identify any potential solutions. Several of the providers' concerns were valid, such as a decrease in reimbursement rates and challenges in the recertification of Certified Nurse Aides. The Division of Medicaid should continue to evaluate provider reimbursement rates, streamline background checks, enhance the MediKey system, and align training requirements.

Background:

The direct care workforce includes the primary providers of paid hands-on, long-term care and personal assistance received by the elderly or persons living with disabilities or other chronic conditions in either an institutional or home and community-based setting. This workforce includes multiple occupations, such as personal care attendants or aides, home health aides, certified nurse aides, and others.

Personal care services are non-medical support services to assist the elderly and persons with disabilities or chronic illness in meeting their activities of daily living (e.g., bathing, dressing, eating, grocery shopping, etc.) in order to optimize functioning at home or in a community-based setting. The primary distinction between home care providers and home health providers is that home care providers do not provide clinical services whereas home health aides and nursing assistants do provide clinical services, typically under the direct supervision of licensed nursing staff.

Medicaid is the largest single payer of long-term services and supports (LTSS) in the United States. While all states are required to provide coverage for nursing facility services and home health services through Medicaid, states may also offer home and community-based services (HCBS) through section 1915(c) of the Social Security Act. This section allows states to waive regular Medicaid income and resource limits and provide HCBS to beneficiaries who would otherwise need institutional care. In Mississippi, Medicaid covers personal care services primarily through four waiver programs, with the Elderly and Disabled Waiver serving the most beneficiaries annually.

Providing personal care services through Medicaid is a more cost-efficient option for states, as it allows more individuals to remain in their homes and communities rather than in an institutional setting. According to the AARP, the median annual cost of a nursing facility was \$97,455 for a private room and \$87,600 for a shared room in comparison to a median annual cost of \$18,200 for adult day services in 2017.

What is the Elderly and Disabled Waiver?

The Medicaid Elderly and Disabled Waiver provides home and community-based services to individuals age 21 years old and older who would otherwise require the level of care provided in a nursing facility. Beneficiaries of this waiver must also meet certain financial and medical requirements. If eligible and approved for the waiver, the beneficiary may receive personal care (and other) services.

How much does it cost to administer the Elderly and Disabled Waiver in Mississippi?

Elderly and Disabled Waiver - FY 2017	
Total Number of Participants Served	19,181
Total Waiver Expenditures	\$217,933,521
Cost per Participant	\$14,933

According to Division of Medicaid staff, a maximum of 17,800 waiver participants can be served at any one single point in time. As of October 29, 2019, there are 19,795 personal care attendants available to serve participants in the Elderly and Disabled Waiver.

What concerns were raised about personal care services funded through Medicaid's Elderly and Disabled Waiver?

PEER staff attended several meetings between home care provider agency representatives, Division of Medicaid staff, and Mississippi Department of Health staff to discuss multiple concerns raised about the administration and delivery of personal care services funded through the Elderly and Disabled Waiver. Many of these concerns focused on the increased operational costs in providing personal care services, coupled with decreased Medicaid reimbursement rates and increased administrative requirements. These providers also raised concerns about the training requirements of personal care attendants, challenges in retaining higher skill level staff, and wanting to limit the growing number of home care providers.

What is the status of personal care service concerns raised by home care providers?

Concern	Status	Reason	Effect
Medicaid personal care services reimbursement rates have decreased.	Valid	Medicaid hired an actuarial firm, Milliman, Inc., to revise provider reimbursement rates for waiver services.	Rates decreased by approximately 28% in 2012, from \$5.56 per 15-minute unit to \$4.00 per 15-minute unit.
Medicaid did not notify home care providers of physical office requirements in a timely manner.	Not Valid	Medicaid notified providers on March 29, 2017, for requirements effective July 1, 2017.	Providers initially had until October 17, 2017, to comply, which was then extended until February 28, 2018.
Increased costs of physical office requirements.	Unknown	Effective July 1, 2017, providers must be no more than 60 minutes from counties served or a satellite office will be required.	Providers did not submit information to allow PEER to determine the extent of the costs associated with satellite offices established by providers.
Increased time to conduct national background checks.	Valid	Home care agencies are not licensed by the MSDH, so they cannot access the department's FingerPro system.	Background and fingerprint checks come from multiple sources, some taking up to three weeks to return the results.
The MediKey system does not increase the identification of fraud and abuse.	Not Valid	The federal 21st Century Cures Act mandates that states implement electronic visit verification for all Medicaid personal care services and home health services.	Referrals to the Office of Program Integrity about personal care service claims have increased since MediKey. Personal care services audits for FY 2017 have identified overpayments of \$858,164.
Personal care attendant training is too costly and providers need more cost-efficient options and flexibility given the high turnover rates in this field.	Valid	National literature notes direct care turnover rates range from 45% to 60%. Currently, there are three separate documents that providers must adhere to in providing personal care services.	Lack of a comprehensive set of personal care attendant requirements from a single source document can cause a perceived disconnect on whether or not certain requirements are still applicable.
Certified Nurse Aides employed by home care agencies are not able to obtain recertification.	Valid	Home care agencies are not an MSDH-approved clinical setting. CNAs must complete at least eight hours of clinical skills training from a paid clinical facility.	CNAs have two years to complete the eight hours of clinical training. Therefore, it is likely that the CNA would leave the home care agency to maintain certification.
Medicaid should enact a moratorium on new providers.	Not Valid	Only the Legislature or the federal CMS may enact a moratorium on new home care providers.	There are currently 207 active approved personal care services provider agencies.

What solutions could be considered to address personal care service concerns?

PEER sought to identify any potential solutions that could potentially be implemented to improve the delivery of personal care services based on the concerns raised by the home care provider agency representatives, where applicable, including:

- The Division of Medicaid (DOM) should continue to monitor the reimbursement rates and update the actuarially-sound rates upon any substantive program changes, as warranted.
- DOM and MSDH should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system.
- DOM should continue working on any operational improvements to MediKey, as necessary.
- DOM should review, update, and align the requirements specific to personal care attendants.
- MSDH should continue to work with the home care agencies to identify a feasible option in the development of a training program to allow for the recertification of their Certified Nurse Aide employees.
- DOM should periodically review the service provider selection and placement of waiver participants periodically by both planning and development district and provider agency.

In addition to the above recommendations regarding specific home care provider concerns, DOM should:

- consider the potential for implementing and measuring health-outcome quality metrics for their waiver programs; and,
- continue exploring the feasibility of potential options for improvements to providing long-term services and supports, such as value-based payments.

Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Waiver Program

Introduction

Authority

The PEER Committee reviewed the role of home care providers in providing personal care services in Mississippi, specifically focusing on the delivery of services provided by personal care attendants through the Division of Medicaid's Elderly and Disabled Waiver program. The Committee acted in accordance with MISS. CODE ANN. Section 5-3-51 et seq. (1972).

Scope and Purpose

On June 26, 2019, PEER staff attended an open forum meeting at the Mississippi State Capitol between representatives of the home care provider agencies and staff from the Mississippi Division of Medicaid. During the course of this meeting, some home care providers expressed concerns with their role in providing care through the state's Elderly and Disabled Waiver program. Their primary concerns focused on a historical decrease in Medicaid reimbursement rates that occurred in 2012, coupled with increasing administrative requirements implemented by the Division of Medicaid over the years (e.g., physical office requirements) that has caused their operational expenses to increase and inhibits their agencies from being profitable.

In addition to these concerns, the representatives of the home care provider agencies noted issues with the number of home care provider agencies rendering personal care services through the Elderly and Disabled Waiver program and requested a moratorium on such providers be enforced by the Division of Medicaid. These providers also stated that additional training and data sharing is needed to ensure the correct usage of the state's electronic visit verification system (MediKey) and questioned if the increased administrative burden was truly identifying and/or reducing instances of fraud, waste, and abuse.

Lastly, additional meetings were conducted with both Division of Medicaid staff and Mississippi State Department of Health staff to discuss the home care provider agencies' issue with not being able to obtain recertification for Certified Nurse Aides (CNAs) who work solely under the employ of a home care agency as a personal care attendant.

As a result of the initial open forum and subsequent meetings, PEER sought to review each of these concerns and determine their validity as well as identify any potential corrective actions or recommendations that could be implemented to address the home care provider agencies' concerns, where applicable.

Scope Limitation

As discussed later in the report beginning on page 3, the direct care workforce is broad and encompasses many different occupational classifications depending on the employment setting or the scope of services provided. For the purposes of this review, PEER limited its scope to those personal care services provided by personal care attendants through the Division of Medicaid's 1915(c) home and community-based services (HCBS) Elderly & Disabled Waiver program. Personal care attendants also provide services through other Medicaid HCBS waiver programs or may be directly employed and provide personal care services outside of Medicaid.

Method

In conducting fieldwork, PEER:

- conducted a literature review of the direct care workforce, specifically looking at the service delivery of personal care services;
- compared Mississippi's training requirements for personal care attendants with those of other states;
- compared Mississippi's certification requirements for Certified Nurse Aides with those of other states;
- reviewed applicable federal laws and guidance issued by the Centers for Medicare and Medicaid regarding long-term services and supports;
- reviewed the request for proposals and resulting contract between the Division of Medicaid and FEL.COM, INC. for implementation of the MediKey system;
- reviewed state laws and administrative code governing the Mississippi Division of Medicaid's 1915(c) home and community-based services Elderly & Disabled Waiver program;
- interviewed representatives and providers of multiple home care provider agencies in Mississippi; and,
- interviewed personnel of the Mississippi Division of Medicaid and the Mississippi Department of Health.

Background

This chapter addresses the following questions:

- What is the direct care workforce and what occupations are included?
- What are personal care services and how do home care providers differ from home health providers?
- How are direct care workers trained?
- How much do personal care workers earn?

What is the Direct Care Workforce and What Occupations are Included?

The direct care workforce includes the primary providers of paid hands-on, long-term care and personal assistance received by the elderly or persons living with disabilities or other chronic conditions in either an institutional or home and community-based setting. This workforce includes multiple occupations, such as personal care attendants or aides, home health aides, Certified Nurse Aides and others.

According to PHI,¹ the direct care workforce includes the primary providers of paid hands-on, long-term care and personal assistance received by persons who are elderly or living with disabilities or other chronic conditions. This workforce provides care commonly referred to as long-term services and supports (LTSS), which may include care provided in both an institutionalized setting (e.g., nursing home or facility) and care provided in the home and community-based setting (e.g., adult day services and personal care).

One challenge in trying to compare occupations within the direct care workforce is in the nomenclature of how each state defines them, either through statute or based on the scope of practice for each profession. The 2018 Standard Occupational Classification (SOC) Manual² was developed with the purpose of creating a system of classification that would allow all government agencies and private industry to produce comparable data. The 2018 SOC classifies most of the direct care workforce within the overarching categories of *31-0000 Healthcare Support Occupations (i.e., 31-1120*

¹ PHI is a national organization that works to transform eldercare and disability services and promote quality direct care jobs as one of the leading advocates for the direct care workforce. PHI has headquarters in Bronx, New York and reports that it has 25 years of experience in the direct care workforce setting. PHI collects and examines data about the direct care workforce in order to identify best practices and to support evidence-based policies advocating for quality direct care.

² The Executive Office of the President, Office of Management and Budget (OMB) created the Standard Occupational Classification Revision Policy Committee (SOCRPC) to revise the SOC. The SOCRPC used the Bureau of Labor Statistics Occupational Employment Statistics occupational classification system as the starting point for the new SOC framework. The 2018 SOC replaced the 2010 SOC.

Home Health and Personal Care Aides) and 31-1130 Nursing Assistants, Orderlies, and Psychiatric Aides.

The SOC describes the role and duties of a home health aide (e.g., home health attendant) as someone who monitors the health status of an individual and addresses their health-related needs. This work is typically done under the direction of licensed nursing staff. The SOC defines a personal care aide (e.g., personal care attendant) as someone who provides personal care and assists with the activities of daily living support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). The SOC defines a nursing assistant (e.g., Certified Nurse Aide) as someone who provides or assists with basic care or support under the direction of onsite licensed nursing staff.

For a full description of the roles and duties for each of these professions as defined by the 2018 SOC, see Appendix A on page 62.

What are Personal Care Services and how do Home Care Providers Differ from Home Health Providers?

Personal care services are non-medical support services to assist the elderly and persons with disabilities or chronic illness in meeting their activities of daily living in order to optimize functioning at home or in a community-based setting. The primary distinction between home care providers and home health providers is that home care providers do not provide clinical services whereas home health aides and nursing assistants do provide clinical services, typically under the direct supervision of licensed nursing staff.

Long-term services and supports (LTSS) encompass a variety of health, health-related, and social services, such as personal care services. Personal care services are non-medical support services to assist the elderly and persons with disabilities or chronic illness in meeting their daily living needs and optimize functioning at home or in a community-based setting rather than receiving care in an institution. Personal care services generally focus on the activities of daily living (ADL), which include assistance with bathing, dressing, eating, grocery shopping, personal hygiene, and other activities.

While states may use various titles for direct care workers, the primary distinction between home care providers and home health providers are based on the services provided in an approved work setting. Home care providers do not provide clinical services to clients. Home health providers may provide similar tasks as home care providers, but they also provide clinical services (e.g., administering medication and checking vital signs), typically under the direct supervision of licensed nursing staff.

This distinction is also noted within the 2017 North American Industry Classification System (NAICS), which defines the home health care industry as establishments primarily engaged in providing skilled nursing services in the home. The 2017 NAICS defines the home care industry as establishments primarily

engaged in providing nonresidential social assistance services to improve the quality of life for the elderly, persons diagnosed with intellectual and developmental disabilities, or persons with disabilities.

For a full description of the NAIC definitions of the home health care industry and the home care industry, see Appendix B on page 64.

How are Direct Care Workers Trained?

There is no real consistency in the minimum training requirements for personal care workers among the states. In contrast, the Nursing Home Reform Act, adopted by Congress as part of the Omnibus Budget Reconciliation Act of 1987, established a minimum of 75 hours of training, which includes 16 hours of clinical training, for both home health aides and certified nurse assistants.

The United States Department of Health and Human Services, Office of Inspector General (OIG), released a report in December of 2006 entitled, *States' Requirements for Medicaid-Funded Personal Care Service Attendants* (OEI-07-05-00250). This report identified 301 different sets of requirements for personal care workers in the Medicaid program. According to the OIG report, federal law requires that personal care services must be provided in a home and must follow a plan of care subject to approval and authorized by the state's Medicaid agency. States are required to develop qualifications or requirements for personal care attendants to ensure quality of care, but currently there are no federally-established minimum training standards for personal care attendants. This lack of a minimum set of standards has resulted in wide variation among the states regarding their respective training requirements for personal care attendants.

According to PHI, there are two different training requirements for personal care attendants in Mississippi. There is a 40-hour training requirement as well as a proof of competency demonstration for all personal care attendants that work for a home care agency approved by the Division of Medicaid to provide services through the state's 1915(c) home and community-based services (HCBS) Elderly & Disabled Waiver program. This requirement states 12 training topics that the training must cover, but the Division of Medicaid gives the home care provider agencies the discretion on who and how this training is provided. For a list of the training requirements for these personal care attendants, see Appendix C on page 65.

There is also a training requirement for personal care attendants who provide services through the Division of Medicaid's Independent Living Waiver program. According to PHI, the state provides a model curriculum for all personal care attendants under this waiver that includes training in 14 training topics (some of these topics overlap with those required under the Elderly and Disabled Waiver program). This training may be provided by the Mississippi Department of Rehabilitation Services (MDRS) or an alternative agency that is qualified to train nursing assistants.

Because the state does not license home care agencies, personal care attendants employed by private-pay home care agencies are not subject to any state-established training requirements. In addition, the state does not regulate training for personal care attendants who are employed or hired directly by an individual.

Unlike personal care attendants, home health aides and Certified Nurse Aides have federally established minimum training requirements. The Nursing Home Reform Act, adopted by Congress as part of the Omnibus Budget Reconciliation Act of 1987, was designed to improve the quality of care in long-term health care facilities and to define training standards for home health and nurse aides working in these settings. Federal legislation (42 CFR 484) requires that Medicare-certified home health agencies employ home health aides who are trained and evaluated through training programs approved by their state. Federal legislation (42 CFR 483) requires that each state establish state-approved nurse aide training programs. These federal regulations require that these training programs consist of at least 75 hours of training, including at least 16 hours of supervised practical or clinical training. States can also require additional training hours beyond the 75-hour minimum requirement. Mississippi currently only requires the 75-hour minimum training requirement.

How much do Direct Care Workers Earn?

Wages for direct care workers employed within the home care industry (e.g., personal care aides, personal care attendants) are outpaced by wages for direct care workers employed by both the nursing home (e.g., nursing assistants) and residential care industries home (e.g., home health aides). Personal care aides in Mississippi made, on average, \$9.96 per hour. While this average hourly wage is below the 2018 national home care worker average of \$11.52 per hour, personal care aides in Mississippi made more in comparison to its contiguous states from 2016 through 2018.

According to the American Association of Retired Persons (AARP), nearly two million home health and personal care aides provided care in 2015, at just slightly more than \$11 per hour on average. These workers would have earned roughly \$22,000 each in 2015 if they worked full time.

PHI compiles various data on the direct care workforce in its online workforce data center, including the average wages for direct care workers. Exhibit 1, on page 7, lists the average wages (adjusted for inflation) for all direct care workers within the home care, nursing home, and residential care home industries from 2012 through 2018.

Exhibit 1: U.S. Direct Care Worker Median Hourly Wages Adjusted for Inflation, 2012-2018

Industry	2012	2013	2014	2015	2016	2017	2018
Home Care	\$10.52	\$10.45	\$10.46	\$10.72	\$10.98	\$11.30	\$11.52
Nursing Homes	\$12.45	\$12.44	\$12.30	\$12.58	\$12.91	\$13.15	\$13.38
Residential Care Homes	\$11.43	\$11.38	\$11.26	\$11.49	\$11.71	\$11.89	\$12.07

SOURCE: PHI Workforce Data Center (last modified August 30, 2019). Wage and employment trends were sourced from the Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) program using May 2008 to May 2018 State Occupational Employment and Wage Estimates.

Wages for direct care workers employed within the home care industry (e.g., personal care aides, personal care attendants) are outpaced by wages for direct care workers employed by both the nursing home (e.g., nursing assistants) and residential care home (e.g., home health aides) industries.

According to the PHI workforce data center, personal care aides in Mississippi earned, on average, \$9.96 per hour in 2018. This average hourly wage is below the 2018 national home care worker average of \$11.52 per hour.

Exhibit 2, below, lists the average personal care aide wages, from both public and private payment sources, for Mississippi and its four contiguous states (Alabama, Arkansas, Louisiana, and Tennessee) from 2012 through 2018.

Exhibit 2: Personal Care Aide’s Median Hourly Wages Adjusted for Inflation, 2012-2018

	2012	2013	2014	2015	2016	2017	2018
Alabama	\$9.30	\$9.16	\$9.02	\$9.11	\$9.09	\$8.99	\$8.98
Arkansas	\$9.33	\$9.26	\$9.09	\$9.21	\$9.50	\$9.75	\$9.83
Louisiana	\$9.31	\$9.18	\$9.03	\$9.10	\$9.17	\$9.08	\$8.96
Mississippi	\$9.31	\$9.04	\$8.91	\$9.03	\$10.00	\$9.84	\$9.96
Tennessee	\$9.51	\$9.52	\$9.38	\$9.48	\$9.54	\$9.65	\$9.84

SOURCE: PHI Workforce Data Center (last modified August 30, 2019). Wage and employment trends were sourced from the Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) program using May 2008 to May 2018 State Occupational Employment and Wage Estimates.

Looking just at the averages provided by PHI for these selected five states, personal care aides in Mississippi made more in comparison to its contiguous states from 2016 through 2018. However, prior to 2016 the average hourly personal care aide wages in Mississippi were either comparable to or less than the contiguous states.

How Personal Care Services are Provided through Medicaid in Mississippi

Because of the concerns raised by the home care agency representatives regarding personal care services funded through the Division of Medicaid's 1915(c) home and community-based services (HCBS) Elderly & Disabled Waiver program, PEER limited its scope to those personal care services provided by personal care attendants through Medicaid. Personal care attendants also provide services through other Medicaid HCBS waiver programs, may be directly employed by an individual, or work for a private for-profit home care agency that provides personal care services outside of Medicaid.

In order to better understand how personal care attendants provide personal care services through Medicaid, PEER sought to address the following questions in this chapter:

- How are personal care services administered through Medicaid?
- What role do personal care attendants have in providing services through Medicaid in Mississippi?
- What is the scope of the Medicaid Elderly and Disabled Waiver program in Mississippi?

How are Personal Care Services Administered through Medicaid?

Medicaid covers personal care services for eligible individuals through two primary methods, through the Medicaid State Plan or through Medicaid waivers. Medicaid is the largest single payer of long-term services and supports (LTSS) in the United States, accounting for 30.6% of total Medicaid expenditures in 2016. In Mississippi, long-term supports and services expenditures totaled approximately \$1.42 billion (state and federal funds combined) in Fiscal Year 2017. Of these total LTSS expenditures in Fiscal Year 2017, roughly 71% were attributed to institutional care and 29% were attributed to home and community-based services.

As noted previously, long-term services and supports (LTSS) refers to a broad range of health and health-related services, and other types of assistance (e.g., personal care services) that are needed by individuals over an extended period of time. Given the growing elderly population who will need LTSS in conjunction with increased Medicaid spending on LTSS, there has been a shift to expand the number of services provided through home and community-based settings over the years. One primary example of a home and community-based service (HCBS) that allows the elderly and disabled to remain in their home before needing to be placed in a nursing home or other institutional setting is through the provision of personal care services.

How Does Medicaid Provide Personal Care Services?

Medicaid provides personal care services for eligible individuals through two primary methods, through the Medicaid State Plan or through Medicaid waiver and demonstration programs approved by the Centers for Medicare and Medicaid Services (CMS).

Medicaid covers personal care services for eligible individuals through two primary methods, through the Medicaid State Plan or through Medicaid waiver and demonstration programs approved by the Centers for Medicare and Medicaid Services (CMS). States that provide personal care services through Medicaid State Plan programs must comply with the general Medicaid program requirements in section 1902 of the Social Security Act. For a waiver or demonstration program, CMS can waive certain Medicaid program requirements at a state's request under certain conditions to increase flexibility, expand coverage to certain populations or geographic areas, or cover services not otherwise covered as a state plan benefit.

What are the Goals of Providing Personal Care Services through Medicaid?

The two primary goals of providing personal care services through Medicaid are to allow more individuals to remain in their homes and communities rather than being placed in an institutional setting, while also allowing states to better control costs.

One primary goal in the shift to HCBS has been to allow more individuals to be served at home or in the community before needing institutional care. According to the U.S. Department of Health and Human Services, Office of Inspector General, one key factor in this shift to more home and community-based services was the United States Supreme Court decision in *Olmstead v. L.C.* 527 U.S. 581 (1999), which held that unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.

The other goal in expanding home and community-based services is to allow states to control costs by providing more efficient spending of available Medicaid dollars. For example, the AARP *Across the States: Profiles of Long-Term Services and Supports* (August 2018) notes the median annual cost of a nursing facility was \$97,455 for a private room and \$87,600 for a shared room in comparison to a median annual cost of \$18,200 for adult day services in 2017.

How Much Does Medicaid Spend on Personal Care Services?

Medicaid is the largest single payer of long-term services and supports (LTSS) in the United States, accounting for 30.6% (\$154.4 billion) of total Medicaid expenditures in 2016. In Mississippi, long-term supports and services expenditures totaled approximately \$1.42 billion (state and federal funds combined) in Fiscal Year 2017.

According to the Congressional Research Service factsheet entitled, *Who Pays for Long-Term Services and Supports?* (August 22, 2018), Medicaid is the largest single payer of LTSS in the United States. This fact sheet stated that the total Medicaid LTSS spending (combined federal and state) was \$154.4 billion in 2016, which comprised 42.2% of all LTSS expenditures. Furthermore, the factsheet noted that Medicaid LTSS spending accounted for 30.6% of all Medicaid spending in 2016.

The Mississippi Division of Medicaid noted that in Fiscal Year 2017 long-term supports and services expenditures totaled approximately \$1.42 billion (state and federal funds combined) in order to provide services to 49,180 beneficiaries. Of these total LTSS expenditures in Fiscal Year 2017, roughly 71% were attributed to institutional care (e.g., nursing homes and intermediate care facilities) in order to serve 46% (22,539) of the beneficiaries. The remaining 29% of total LTSS expenditures were attributed to various home and community-based services provided through the Division of Medicaid's waiver programs, which served 54% (26,641) of the beneficiaries.

What Role do Personal Care Attendants have in Providing Services through Medicaid in Mississippi?

The Mississippi Division of Medicaid utilizes personal care attendants to provide personal care services primarily through four 1915(c) waiver programs: the Elderly and Disabled Waiver, the Independent Living Waiver, the Intellectual Disabilities/Developmentally Disabled Waiver, and the Traumatic Brain Injury/Spinal Cord Injury Waiver. In Fiscal Year 2017, the Elderly and Disabled Waiver program served the most beneficiaries (76.7%) and accounted for over half (53.9%) of total expenditures among these waivers.

In Mississippi, the Division of Medicaid primarily utilizes waivers authorized through section 1915(c) of the Social Security Act (commonly known as Medicaid HCBS waivers) to provide HCBS to beneficiaries. Four waiver programs in particular, the Elderly and Disabled Waiver, the Independent Living Waiver, the Intellectual Disabilities/Developmentally Disabled Waiver, and the Traumatic Brain Injury/Spinal Cord Injury Waiver, utilize personal care attendants who work for personal care agencies, which must be approved by the Division of Medicaid and bill for services on the attendants' behalf.

While all states are required to provide coverage for nursing facility services and home health services through Medicaid, states may offer home and community-based services (HCBS) through section 1915(c) of the Social Security Act. Section 1915(c) of the Social Security Act allows states to waive regular Medicaid program income and resource limits and provide HCBS to beneficiaries who would otherwise need institutional care. Under this waiver authority, states must demonstrate cost neutrality (i.e., not cost the federal government more than providing care in an institutional setting). States can use these waivers to offer a variety of services, including personal care services. States set the eligibility standards for these waiver programs, which include the level of care required and the target group of beneficiaries. States also may include other

eligibility standards relating to age, condition, cap enrollment, and use waiting lists.

According to the Mississippi Division of Medicaid, they have the following 1915(c) waivers that utilize personal care attendants:

- Independent Living (IL) Waiver - provides case management, personal care attendant, environmental accessibility adaptations, specialized medical equipment and supplies, transition assistance services for aged individuals who have severe orthopedic and/or neurological impairments. Individuals must also be medically stable and be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care.
- Intellectual Disabilities/Developmentally Disabled (ID/DD) Waiver - provides day services to adults, in-home respite, prevocational services, supervised living, support coordination, supported employment, supported living, specialized medical supplies, therapy services, behavior support services, community respite, crisis intervention, crisis support, home and community supports, host home, in-home nursing respite, job discovery, shared supported living, transition assistance for individuals for those with autism, intellectual or developmental disabilities.
- Elderly and Disabled (E&D) Waiver - provides adult day care, case management, in-home respite, personal care services, extended home health services, community transition services, home delivered meals, institutional respite care, physical therapy services, speech therapy services for aged individuals who require nursing facility level of care if assistance is not provided.
- Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver - provides case management, personal care attendant, respite, environmental accessibility adaptations, specialized medical equipment and supplies, transition assistance services for individuals with a diagnosis of traumatic brain or spinal cord injury and be medically stable.

How Do the Division of Medicaid's Waiver Programs Compare?

In Fiscal Year 2017, the Elderly and Disabled Waiver program served the most beneficiaries (76.7%) and accounted for over half (53.9%) of total expenditures in comparison to the other three waivers who utilize personal care attendants (PCAs). As of October 29, 2019, there are 23,082 PCAs providing services to Medicaid beneficiaries through these waivers in which 19,795 (85.7%) are employed by a home care agency able to provide personal care services through the Elderly and Disabled Waiver program.

Exhibit 3, below, provides some details on each of the four waiver programs provided through Medicaid, including: the number of beneficiaries served, the total waiver expenditures, the cost per beneficiary, and the number of personal care attendants who provide personal care services to these beneficiaries.

Exhibit 3: Division of Medicaid Waiver Programs that Utilize Personal Care Attendants

Waiver Program	Number of Beneficiaries ¹	Waiver Expenditures ¹	Cost per Beneficiary ¹	Number of Personal Care Attendants ²
Independent Living Waiver	2,340	\$58,470,277	\$26,798	3,287
Traumatic Brain Injury/Spinal Cord Injury Waiver	829	\$23,723,716	\$35,189	
Intellectual Disabilities/Developmentally Disabled Waiver	2,649	\$104,323,692	\$43,905	19,795
Elderly and Disabled Waiver	19,181	\$217,933,521	\$14,933	

¹Number of beneficiaries, waiver expenditures, and cost per beneficiary are for Fiscal Year 2017.

²Number of personal care attendants working for a personal care agency approved by Medicaid is as of October 29, 2019.

SOURCE: Division of Medicaid’s Long-Term Supports and Services fact sheet presented to the Medical Care Advisory Committee on May 10, 2019. Number of personal care attendants provided by both MediKey and the Mississippi Department of Rehabilitation Services on October 29, 2019.

These four waivers served 24,999 beneficiaries in Fiscal Year 2017, totaling \$404,451,206 in expenditures. In comparison of these four waivers, the Elderly and Disabled Waiver program served 19,181 beneficiaries (76.7% of total beneficiaries) and accounted for \$217,933,521 (53.9%) of total expenditures.

In total, there are 23,082 PCAs providing services to Medicaid-eligible beneficiaries. Of these PCAs, 19,795 (85.7%) are employed by a home care agency able to provide personal care services through the Elderly and Disabled Waiver program. This number only includes those PCAs working for home care agencies approved by the Division of Medicaid to provide services. This does not include any PCAs that are directly employed by an individual or working for a private agency not participating in Medicaid.

What is the Scope of the Medicaid Elderly and Disabled Waiver Program in Mississippi?

The Mississippi Division of Medicaid’s Elderly and Disabled Waiver program provides all participants with case management to develop an individualized service plan. Should the participant need personal care services or in-home respite services, they will be provided such services by personal care attendants working for a home care agency. Currently there are 207 Medicaid-approved personal care service providers and 175 in-home respite providers. Working for these two provider agencies, there are 19,795 registered personal care attendants that could serve participants in one of the 17,800 waiver slots.

The Elderly and Disabled Waiver program is administered and operated by the Office of Long-Term Care within the Mississippi Division of Medicaid. This waiver program is authorized in §1915(c) of the Social Security Act and permits the state to provide home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The approved effective date of the most recent Elderly and Disabled Waiver program was July 1, 2017 for a five-year period. In addition, this waiver program was recently amended (e.g., updated training requirements for personal care attendants) with a proposed effective date of October 1, 2019.

The Mississippi Division of Medicaid *Administrative Code, Title 23: Medicaid Part 208, Chapter 1: Home and Community-Based Services (HCBS) Elderly and Disabled Waiver* establishes the administrative rules and requirements in administering the waiver program.

What Services Does the Medicaid Elderly and Disabled Waiver Provide?

All participants within the Elderly and Disabled Waiver program receive case management. Based on the individual's needs, the waiver may provide any of or a combination of adult day services, community transition services, extended home health services, home-delivered meals, in-home respite services, institutional respite services, and personal care services.

The Elderly and Disabled Waiver program provides home and community-based services to individuals age 21 years old and older who would otherwise require the level of care provided in a nursing facility. Beneficiaries of this waiver must also meet certain financial and medical requirements. If a beneficiary is eligible and approved for the Elderly and Disabled Waiver program, the beneficiary may receive the following services:

- adult day services;
- case management;
- community transition services;
- extended home health services;
- home-delivered meals;
- in-home respite services;
- institutional respite services; and,
- personal care services.

Qualified individuals may also receive physical therapy and speech therapy services. See Appendix D, on page 67, for a description of the services provided by the Elderly and Disabled Waiver.

Which Waiver Services Utilize Personal Care Attendants?

Both the personal care services and in-home respite services utilize personal care attendants. As of October 7, 2019, there were 207 home care provider agencies to provide personal care services and 175 agencies to provide in-home respite care to waiver participants.

There are two primary waiver services offered through the Elderly and Disabled Waiver program that utilize home care provider

agencies and personal care attendants: personal care services and in-home respite services. According to the Division of Medicaid's Elderly and Disabled Waiver program, personal care services:

...are non-medical support services to assist the person in meeting daily living needs and ensure optimal functioning at home and/or in the community...Personal Care Services include: assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Meal preparation may be provided; however, the cost of meals is not covered. Housekeeping chores may be provided if the care is essential to the health and welfare of the individual, rather than the individual's family. Personal Care Service may also involve hands-on assistance or cuing/prompting the person to perform a task; accompanying and assisting the person in accessing community resources and participating in community activities; supervision and monitoring in the person's home, during transportation, and in the community setting. If the person's transportation is being provided by the Medicaid NET provider, the PCS provider may only accompany the person when medically justified. However, they may accompany the participant in the community without justification by any other means of transportation, provided that they are not driving the vehicle in which the participant is being transported.

In-home respite service is non-medical care or supervision provided to a person, unable to care for themselves, in the absence of the person's primary caregiver. Typically, in-home respite service is provided on a short-term basis, either due to the unexpected absence of or as scheduled relief for the primary caregiver.

As of October 7, 2019, 207 home care provider agencies were approved by Medicaid to provide personal care services through the Elderly and Disabled Waiver program. There are also 175 home care provider agencies that are approved by Medicaid to utilize personal care attendants to provide in-home respite care to beneficiaries through the Elderly and Disabled Waiver program, as of October 7, 2019. Some of these home care provider agencies may provide both personal care and in-home respite services. However, for Medicaid purposes these home care provider agencies will have a different Medicaid identification number for each type of service provided and counted separately even if it is the same agency. These total number of home care provider agencies also reflect any active provider approved by the Division of Medicaid, but do not take into account any agency that may be under a temporary payment suspension. For a map of these provider locations, see Appendix E on page 69. As noted previously on page 12, there are 19,795 total personal care attendants that may provide either personal care services or in-home respite services to waiver participants.

How are Elderly and Disabled Waiver Services Provided?

The state's ten planning and development districts are responsible for providing case management services to each participant in the Elderly and Disabled Waiver program. The case management team develops an individualized service plan for each participant electing to receive home and community-based services in lieu of institutional care. The waiver participant selects from a list of available Medicaid-approved providers to perform the necessary services, such as a home care agency to provide personal care services. Currently there are 207 Medicaid-approved home care provider agencies for personal care services, and 19,795 personal care attendants that could serve waiver participants.

Case management agencies serve as the primary point of entry into the Elderly and Disabled Waiver program. Under a provider agreement with the Division of Medicaid (DOM), case management services are provided by the ten planning and development districts³ (PDDs) in the state for all persons in this waiver program. The main objective of case management is to ensure continuity of care.

How is the Waiver Applicant Assessed to Receive Waiver Services?

The case management team performs a comprehensive assessment with the waiver applicant to identify the participant's needs, preferences, and goals for services. Should the case management team determine that the waiver applicant requires at least two of the services offered through the waiver, the applicant then is given the choice to select to participate in the waiver and receive services.

The case management team is composed of a registered nurse and a licensed social worker who are responsible for performing a comprehensive assessment by which a waiver person's needs, preferences and goals for services are determined. Each case management team has a maximum caseload of 100 waiver participants. During the assessment process, if the person is determined to require the level of care through this waiver program, then the person must be informed of any feasible alternatives under the waiver and then given the choice of institutional care funded through traditional fee-for-service Medicaid, or home and community-based services funded through the waiver, and indicate his or her service choice with a signature.

Level of care for the Elderly and Disabled Waiver is determined through the application of the Division of Medicaid's comprehensive long-term services & supports assessment instrument. This instrument encompasses activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors, and medical conditions/services in order to generate a numerical score. Those applicants at or above the level of care threshold are deemed clinically eligible. Currently, the

³ Each PDD is a not-for-profit corporation governed by a Board of Directors appointed by local boards of supervisors. Each PDD represents a distinctly different region of the state, but have common functions (e.g., economic development, community development, human resource development, job training, social services and transportation). The state Area Agencies on Aging are also housed within the PDDs. The PDDs provide case management services, transition assistance, adult day care, and home delivered meals.

minimum level of care requirement for the applicant to meet is to need at least two of the services provided through the Elderly and Disabled Waiver program.

How Does the Waiver Participant Select a Provider?

The case management team develops an individualized service plan that describes the waiver services to be furnished to the participant. The participant is given a list of qualified providers to choose from in their service area and selects the one that best meets their needs, preferences, and goals.

If the person selects the HCBS option through this waiver program, the case management team then develops an individualized service plan and arranges for those services to be provided through a person-centered approach. All waiver services are furnished pursuant to the service plan. The service plan describes the waiver services to be furnished to the participant, their projected frequency, and the type of provider that furnishes each service. The service plan also notes any other services (regardless of funding source) and informal supports that complement waiver services in meeting the needs of the participant. Case managers are also required to visit the person on a monthly basis. The PDDs are responsible for periodic monitoring and reevaluation of the individualized plan of services, at least on an annual basis.

Once the service plan is developed, the person and/or their representative is given a list of qualified providers to choose from in their service area. The person and/or their representative reviews the list of qualified providers to determine which provider best meets the needs, preferences, and goals of the person. The person and/or their representative may be given an opportunity, in some instances, to meet the provider prior to the selection in order to make a more informed choice. Once all options are taken into consideration, the person and/or representative selects the provider they feel best meets their needs. For example, if a waiver participant is determined to need personal care services, then the person and/or their representative will be provided with a list of home care provider agencies that are approved by the Division of Medicaid to provide personal care services within their respective PDD responsible for the waiver participant's case management.

How are Providers Paid by Medicaid for Waiver Services?

Waiver services are reimbursed by Medicaid through the traditional fee-for-service model based on a unit of service. A unit of service for case management is for a one-month period and is paid a flat rate of \$190.20 per waiver participant. A unit of service for personal care services and in-home respite services is paid at a rate of \$4.41 per 15-minutes based on the participant's individual service plan.

Services provided through the Elderly and Disabled Waiver program are paid via the traditional fee-for-service model. Through this model, a provider is reimbursed after services have been rendered to the waiver participant based on an established rate per each unit of service provided. These providers bill their claim

directly to MediKey. MediKey then submits those claims to DOM's payment system, which is housed and managed by the state's fiscal agent, currently Conduent Inc.⁴

A unit of service for case management equals all activities provided over a one-month period to the waiver participant by the PDDs and the case management team. The PDDs are currently reimbursed a flat rate of \$190.20 per month for case management for each beneficiary they provide services to that month. The rate for case management is updated each year based on the maximum per unit rate in the CMS-approved waiver application.

A unit of service for both personal care services and in-home respite services are for all services provided to waiver participants in increments of 15-minutes. Currently, both of these services are reimbursed by Medicaid at a rate of \$4.41 per 15-minutes.

For extended home health services covered under the waiver, a unit of service for home health aides and skilled nursing services is per visit and may vary by the individual provider agencies. Effective October 1, 2018, home health aide services are reimbursed at rates ranging from \$34.81 to \$46.46 per visit. Skilled nursing services are reimbursed at rates ranging from \$60.42 to \$122.81 per visit. For a list of each of the reimbursement rates for these home health services, see Appendix F, on page 70.

How Many Participants are Served through the Elderly and Disabled Waiver?

There are currently 17,800 waiver slots allocated among the ten planning and development districts to provide services to participants in the Elderly and Disabled Waiver program. Division of Medicaid staff estimate that approximately 19,705 unduplicated individuals were served through this waiver in Fiscal Year 2019.

Waiver capacity is managed by the Division of Medicaid and is allocated on a statewide basis by providing slots to each of the ten PDDs. A waiver slot represents an available funded position that is able to serve a participant. DOM's annual budget request includes estimated waiver expenditures based on the average cost per participant and estimated enrollment (i.e., funded slots). The total funded slots are based on the total available funding as designated annually by the Legislature and DOM draws down allowable federal match funds for waiver expenditures (approximately a 75% federal and 25% state match rate).

According to Division of Medicaid staff, there are currently 17,800 total waiver slots allocated among the ten PDDs. This means that a maximum of 17,800 waiver participants can be served at any one single point in time. Exhibit 4, page 18, shows the number of waiver slots by PPD, as of October 18, 2019.

⁴ Conduent Inc. is responsible for providing technical infrastructure for certain DOM business operations not performed in-house, such as processing provider claims, claims reimbursement, and provider enrollment.

Exhibit 4: Number of Elderly and Disabled Waiver Slots Available to Beneficiaries within each of the Planning and Development Districts

PDD	Allocated E&D Waiver Slots
Central Mississippi	2,400
East Central	1,400
Golden Triangle	1,480
North Central	1,100
North Delta	1,700
Northeast Mississippi	1,320
South Delta	1,600
Southern Mississippi	3,200
Southwest Mississippi	1,900
Three Rivers	1,700
Total	17,800

SOURCE: Division of Medicaid staff, as of October 18, 2019.

The Division of Medicaid distributed funded slots amongst the PDDs following discussions with, and recommendations from, the PDD directors. According to DOM staff, these recommendations were based on the capacity and need in each area. In FY 2020, DOM received additional authorization from the Legislature to implement a five percent increase in funded slots (approximately 890 slots). Upon implementation of these additional slots, DOM is in the process of determining whether some reallocation of slots should occur going forward based on waiting lists and population.

Division of Medicaid staff stated that 19,627 total participants were served through the Elderly and Disabled Waiver in FY 2017. This total reflects an unduplicated count of waiver participants who have been enrolled in the waiver at any point within the state fiscal year (July 1 through June 30). The actual number of participants served is higher than the total funded number of slots because an individual may be enrolled in the waiver and then discharged (e.g., loss of eligibility, death, transition to an institution). Therefore, once a waiver slot opens it will then be filled with another applicant from the waiting list to ensure appropriate utilization of that funded slot throughout the state fiscal year.

DOM staff also noted that this waiver program served an estimated 19,286 participants in FY 2018 and 19,705 participants in FY 2019. Exhibit 5, page 19, lists the number of waiver participants served from Fiscal Years 2012 through 2019.

Exhibit 5: Medicaid Beneficiaries served by the Elderly and Disabled Waiver, Fiscal Year 2012 through Fiscal Year 2019

Elderly and Disabled Waiver Participants	
FY 2012	16,060
FY 2013	17,584
FY 2014	18,758
FY 2015	17,707
FY 2016	19,186
FY 2017	19,627
FY 2018 ¹	19,286
FY 2019 ²	19,705

¹The FY 2018 number is an estimate. The official count for FY 2018 will be issued in December 2019.

²The FY 2019 number is an estimate. The official count for FY 2019 will be issued in December 2020.

SOURCE: Division of Medicaid staff, as of October 18, 2019.

What Concerns Have Been Raised Regarding Personal Care Services Funded through Medicaid's Elderly and Disabled Waiver Program?

PEER staff attended several meetings between representatives of home care provider agencies, Division of Medicaid staff, and Mississippi Department of Health staff to discuss multiple concerns raised regarding the administration of and delivery of personal care services funded through the Elderly and Disabled Waiver program. Many of these concerns focused on the increased operational costs in providing personal care services, coupled with decreased Medicaid reimbursement rates and increased administrative requirements. These home care providers also voiced concerns regarding the training requirements of personal care attendants, challenges in retaining higher skill level staff because of recertification limitations, and wanting to limit the growing number of home care provider agencies.

PEER sought to determine the validity of the following home care providers' concerns:

- decreases in Medicaid reimbursement rates for personal care services;
- untimely notification by the Division of Medicaid in implementation of physical office requirements for home care provider agencies;
- increased administrative requirements have caused overhead costs to increase to an extent that home care provider agencies are no longer profitable;
- implementation of the MediKey electronic visit verification system on home care provider agency operations;
- need for more cost-efficient options and flexibility in training and hiring personal care attendants;
- inability for Certified Nurse Aides employed under home care provider agencies to obtain recertification;
- there are too many home care provider agencies in the state and the Division of Medicaid needs to enact a moratorium on new providers similar to those enacted on other healthcare entities;
- some of the planning and development districts that provide case management services also operate home care agencies and skew the placement of waiver participants to their agencies; and,
- the planning and development districts and their case management teams do not notify the home care provider agencies in a timely manner when a loss of waiver participant eligibility occurs.

Concern: Medicaid Reimbursement Rates for Personal Care Services Have Decreased

Medicaid rates decreased by approximately 28% in 2012, from \$5.56 per 15-minute unit to \$4.00 per 15-minute unit. Division of Medicaid staff noted two changes occurred in correlation to this decrease: homemaker services were replaced by personal care services, and Medicaid engaged an actuarial firm, Milliman, Inc., to revise reimbursement rates for their HCBS waivers.

One of the primary concerns raised by the home care provider agency representatives was the decrease in Medicaid reimbursement rates for personal care services, noting a significant decrease in 2012. According to rate tables provided by Division of Medicaid staff, homemaker services (some including tasks similar to personal care services) were reimbursed at a rate of \$5.56 per 15-minute unit, effective March 1, 2011. Effective July 1, 2012, the Medicaid reimbursement rate for personal care services decreased to \$4.00 per 15-minute unit, reflecting an approximate 28% decrease in comparison to the previous rate.

According to Division of Medicaid staff, two primary changes to the Elderly and Disabled Waiver program occurred that could have contributed to this decline in reimbursement rates. The first change was the shift from the use of homemakers to personal care attendants to provide personal care services. The second was a formal evaluation of the Medicaid reimbursement rates for each of the HCBS waiver programs by an actuarial firm. Exhibit 6, below, shows the Medicaid reimbursement rates for homemaker services from October 1, 2003 until the transition to personal care attendants to provide personal care services, effective July 1, 2012 to the present day.

Exhibit 6: Medicaid Reimbursement Rates for Homemaker Services and Personal Care Services Provided through the Elderly and Disabled Waiver Program, from October 1, 2003 to Present Day

Waiver Service	Begin Date	End Date	Rate per 15-Minute Unit
Personal Care Services	07/01/2017	Current	\$4.41
	07/01/2015	06/30/2017	\$4.24
	01/01/2015	06/30/2015	\$4.16
	07/01/2012	12/31/2014	\$4.00
Homemaker Services	03/01/2011	06/30/2013	\$5.56
	10/01/2010	02/28/2011	\$4.86
	07/01/2006	09/30/2010	\$4.15
	10/01/2003	06/30/2006	\$3.42

SOURCE: Division of Medicaid staff, as of October 18, 2019.

For a historical list of homemaker services reimbursement rates, see Appendix G on page 72.

Why Did Personal Care Services Replace Homemaker Services?

Division of Medicaid staff noted that homemaker services through the Elderly and Disabled Waiver were replaced by personal care services in order to be more aligned with the other HCBS waivers. DOM staff added that personal care attendants could provide waiver participants with more continuity of and comprehensive care because they could provide services outside of the home. Any active homemaker providers during this transition were allowed to be issued personal care service provider numbers without reapplying.

Effective July 1, 2012, the Elderly and Disabled Waiver program was amended to provide personal care services using personal care attendants in lieu of homemaker services provided by homemakers. According to the Elderly and Disabled Waiver program from July 1, 2007, homemaker services are defined as:

...supportive services provided or accomplished primarily in the home by trained homemakers that involves education and/or provision of home management tasks to assist in strengthening family life, promoting self-sufficiency, and enhancing quality of life.

The purpose of these services was noted to assist functionally impaired persons to allow them to remain in their home. The waiver stated that services included assistance in the activities of daily living, housekeeping, laundry, food preparation, and other types of home management tasks. While many of these tasks may be similar to or include certain tasks also included in personal care services, the primary distinction between a homemaker and a personal care attendant is that the homemaker was limited to providing services strictly within and pertaining to the home. In contrast, a personal care attendant can cover many of the same tasks in the home, but also provide services outside of the home within the community.

According to Division of Medicaid staff, homemaker services within the Elderly and Disabled Waiver program were replaced by personal care services in order to be more aligned with both the Independent Living Waiver and the Traumatic Brain Injury/Spinal Cord Injury Waiver that were recently approved at that time by CMS to utilize personal care attendants and provide beneficiaries with more continuity of and comprehensive care. DOM staff also noted that anyone previously approved to provide homemaker services through one of Medicaid's HCBS waivers and still active were given the option to be grandfathered in as an approved home care provider. Therefore, those providers would not have to re-apply as an approved home care provider and only had to apply for an updated provider number. DOM staff stated that most of these homemaker service agencies who employed homemakers did elect to transition over to be recognized as an approved home care provider agency to provide personal care services through the Elderly and Disabled Waiver program.

How Did the Rates Change as a Result of Milliman's Rate-Setting?

Milliman's rate-setting recommended a revised reimbursement rate of \$3.61 per 15-minute service unit for personal care services. Effective July 1, 2012, the Division of Medicaid established the reimbursement rate for personal care at \$4.00 per 15-minutes.

Division of Medicaid staff stated that they were unaware of the exact method for establishing the reimbursement rates for homemaker services. Given that multiple home and community-based services waivers were being amended and approved by CMS at that time, the Division of Medicaid engaged an actuarial firm, Milliman, Inc.,⁵ to assist in revising and establish a formal method in setting the Medicaid provider reimbursement rates for waiver services. Milliman provided DOM with a report on their recommended rate revisions on February 24, 2012.

According to this report, Milliman either compared waiver rates at that time to the same non-waiver Medicaid service rates to develop the rate revisions, or crafted new provider rates based on several rate variables. Regarding attendant care, personal care services, and in-home respite services, Milliman crafted rates using the following four variables:

- direct service provider salaries and benefits;
- direct service-related expenses and overhead costs;
- annual number of hours practitioners are at work; and,
- percentage of time an at-work practitioner is able to convert to billable units (productivity).

Milliman noted that assumptions for these rating variables were developed using data from the Bureau of Labor Statistics, a proprietary Milliman medical provider compensation survey, Mississippi planning and development district surveys, and both DOM and Milliman experience. For example, Milliman assumed an average annual salary of \$15,905 in 2012 for any attendant care provider and \$25,928 for an attendant care supervisor. In conclusion of Milliman's analysis of the HCBS waiver services, a revised reimbursement rate of \$3.61 per 15-minute service unit was recommended for both personal care services and in-home respite services. This revised rate of \$3.61 per unit was a 35.1% decrease from the rate of \$5.56 per unit at that time.

Because most of the agencies providing homemaker services transitioned to be able to continue serving Elderly and Disabled Waiver program participants by providing personal care services, they were accustomed to being reimbursed at the previous homemaker services rate of \$5.56 and then were being reimbursed at the revised rate of \$4.00 per service unit.

⁵ Milliman, Inc., is an independent actuarial and consulting firm with consulting practices in employee benefits, healthcare, investment, life insurance and financial services, and property and casualty insurance.

Concern: The Division of Medicaid Did Not Notify Home Care Provider Agencies of Physical Office Requirements in a Timely Manner

The Division of Medicaid established physical office requirements for home care provider agencies that went into effect on July 1, 2017. However, the Division of Medicaid provided PEER with documentation both informing the existing providers of the requirement, and multiple letters requesting from each of the providers a copy of their building privilege license to verify compliance with the requirement.

Another area noted by the home care provider agency representatives involved the notification by and implementation of changes to administrative requirements imposed by the Division of Medicaid. In particular, these representatives alleged that the Division of Medicaid added the physical office requirements without notifying the providers in a timely manner. They also noted that some were notified after the requirement went into effect, and noted that some providers were not informed at all.

Physical Office Requirements

The Division of Medicaid established physical office requirements for home care provider agencies that went into effect on July 1, 2017. These physical requirements for a primary office location and satellite office locations, as applicable, can be located in the DOM Administrative Code and the Personal Care Services Quality Assurance Standards.

Two primary sources stating the various requirements for home care provider agencies to participate in the Elderly and Disabled Waiver are the Division of Medicaid's *Administrative Code, Title 23: Part 208, Chapter 1* and the Division of Medicaid's *Personal Care Services Quality Assurance Standards*. See Appendix H, on page 73, for the complete list of the Personal Care Services Quality Assurance Standards.

Administrative Code Physical Office Requirements

The DOM Administrative Code was revised to add physical office requirements to correspond with the Elderly and Disabled Waiver renewal by CMS, effective July 1, 2017.

Title 23, Part 208 of the DOM Administrative Code, Rule 1.3, lists the provider enrollment requirements to participate in the Elderly and Disabled Waiver program. The physical office requirements state that the provider must:

- *establish an office in the state of Mississippi with a physical address prior to enrollment and maintain the office's physical address until the provider agreement is terminated; and,*
- *serve counties no more than sixty (60) minutes from the physical office or if greater than sixty (60) minutes the provider must maintain a satellite office.*

According to the DOM Administrative Code, Rule 1.3 was revised to correspond with the Elderly and Disabled Waiver renewal submitted to CMS with an effective date of July 1, 2017.

Personal Care Services Quality Assurance Standards Requirements

The Personal Care Services Quality Assurance Standards were revised to add physical office requirements that elaborated on the requirements established within the DOM Administrative Code, with an effective date of July 1, 2017. For example, these standards also required any office be located in a business zone with a working landline phone.

The Division of Medicaid Quality Assurance Standards define a required set of standards of practice for each provider to follow while providing personal care services through one of the HCBS waivers.

In addition to the physical office requirements established through the Administrative Code, the Personal Care Services Quality Assurance Standards elaborate on these requirements, stating that a physical office must:

- be located in Mississippi;
- be accessible to participants, caregivers, and employees;
- be no more than sixty (60) minutes from counties served or a satellite office will be required;
- be located in a non-residential building zoned for business;
- be maintained until the provider agreement is terminated;
- have signage matching the business name on the proposal;
- have a working landline phone;
- be open daily, from 8AM until 5PM on Monday through Friday; and,
- secure Health Insurance Portability and Accountability Act (HIPAA) compliant storage for participant records.

According to Division of Medicaid staff, these physical office requirements also went into effect on July 1, 2017. The most recent Personal Care Services Quality Assurance Standards were revised in January 2019.

Notification of Physical Office Requirements to Providers

Division of Medicaid staff provided PEER with documentation both informing the existing providers of the requirement, and multiple letters requesting from each of the providers a copy of their building privilege license to verify compliance with the requirement.

The home care provider agency representatives alleged that the Division of Medicaid added the physical office requirements without notifying the providers in a timely manner. They also noted

that some were notified after the requirement went into effect, and noted that some providers were not informed at all. However, these representatives did not provide any documentation or a list of providers who were involved in the allegation.

According to DOM staff, in order to ensure compliance with the requirement, DOM required all existing provider agencies submit a copy of their building privilege license. Furthermore, DOM noted that should a privilege license not be received by October 17, 2017, then the provider agency would have their personal care services Medicaid provider number suspended until it achieved compliance. PEER requested documentation from DOM staff during interviews to verify these allegations.

DOM staff provided PEER with a spreadsheet tracking each of the active providers at the time that contained the provider identification number, name, physical address, dates of letters requesting the provider building privilege licenses, and the status of and date the privilege license was received, when applicable. For each of the providers that were listed, DOM sent out an initial request letter and a final notice letter. The spreadsheet noted that the first request letter was sent out on March 29, 2017. The final notice letter provided to PEER by DOM staff was dated on September 17, 2017, noting provider suspension should the license not be received by October 17, 2017. Furthermore, DOM staff submitted a second round of letters, which also included an initial request letter dated September 17, 2017, and a final notice letter dated February 16, 2018. The final notice letter essentially extended the compliance deadline for the provider building privilege license to February 28, 2018.

DOM staff concluded by stating that the only way a home care provider agency would not be notified of the physical office requirements is if the agency did not maintain or update their physical mailing address with the Division of Medicaid.

Concern: Increased Administrative Requirements Have Increased Overhead Costs and Caused Home Care Provider Agencies to No Longer Be Profitable

PEER was not provided samples of costs associated with either the physical office requirements nor the costs of obtaining fingerprints as part of the national background check program. Division of Medicaid staff stated that these requirements are consistent with other approved provider types. Furthermore, home care agencies cannot utilize the MSDH FingerPro system because they are not licensed by MSDH.

The home care provider agency representatives also raised concerns with increased overhead costs associated with increasing administrative requirements in providing waiver services. One requirement these representatives noted specifically were the costs in complying with the physical office requirements. These representatives also questioned its need when the actual provision of services takes place in either the home and/or the community. The other concern they raised was the increased time and costs in having to conduct a fingerprint check to comply with the national criminal background check program.

Costs to Implement Physical Office Requirements

PEER was not provided any samples of home care provider operational expenditures to analyze by the representatives raising concerns on increased overhead costs. However, Division of Medicaid staff stated that these requirements are consistent with other approved provider types.

Home care provider agency representatives voiced concerns on how the physical office requirements increased the overhead costs of operating their businesses, especially when they would have to open up a satellite office to serve some of their existing clients. PEER was not provided any samples of home care provider operational expenditures to analyze by the representatives raising concerns on increased overhead costs. While it certainly would be more costly to the provider should a physical office not already be in place, this an inherent cost in conducting business in order to participate in the Medicaid program. Given that 207 providers are currently approved by Medicaid to provide personal care services to waiver participants, there is likely wide variation in each agency's operational costs and therefore up to each agency on whether or not it is profitable to continue serving waiver participants.

However, PEER did interview DOM staff regarding the necessity behind the physical office requirements based on the concerns presented. According to DOM staff, these requirements are consistent with other Medicaid-approved provider types. In particular, DOM staff noted that these requirements are essential in ensuring quality and safety aspects of the program, such as providing a central location for family members or other beneficiary representatives to contact. They also noted that having a physical office is necessary in performing compliance audits, validating providers, verifying enrollment, and ensuring that any personally identifiable information or health records are securely stored. PEER also inquired whether or not a home care provider could cease serving a beneficiary at any time due to operational or other limitations and DOM staff stated that they could if they so choose.

Cost to Conduct a National Background Check Requirement

The DOM Administrative Code requires home care providers to conduct a national criminal background check with fingerprints on all employees and volunteers prior to employment and every two years thereafter. PEER received no documentation from the home care providers to document how including a fingerprint check increases the cost of background checks. However, PEER did verify with MSDH staff that home care provider agencies cannot utilize their FingerPro system because those providers aren't licensed by the department.

According to the Centers for Medicare and Medicaid Services (CMS), since Congress enacted the federal Omnibus Budget Reconciliation Act (OBRA) in 1987, patient abuse and neglect have been identified as widespread problems for many receiving long-term care services and supports. The Affordable Care Act of 2010 (P.L. 111-148) established the framework for a nationwide program to conduct background checks on a statewide basis on all prospective direct patient access employees of long-term care facilities and providers.

According to CMS, the facilities and providers subject to this requirement include skilled nursing and nursing facilities, home health agencies, hospice and personal care providers, long-term care hospitals, residential care providers arranging for or providing long-term care services, and intermediate care facilities for individuals with intellectual disabilities.

Title 23, Part 208 of the DOM Administrative Code, Rule 1.3, lists the provider enrollment requirements to participate in the Elderly and Disabled Waiver program. One requirement states that the provider must:

conduct a national criminal background check with fingerprints on all employees and volunteers prior to employment and every two (2) years thereafter, and maintain the record in the employee's personnel file.

The Administrative Code also states that any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed to provide direct care to persons enrolled in the waiver. Furthermore, all home care provider agencies are responsible for verifying that all employees and volunteers are not on the Mississippi Nurse Aide Abuse Registry, which is housed at the Mississippi State Department of Health within the Professional Licensure Division.

The home care provider agency representatives voiced concerns with the cost for obtaining a fingerprint check to comply with the requirements of the national criminal background check for each employee and volunteer. While the Elderly and Disabled Waiver program states that providers must submit to DOM documentation regarding the manner in which the national criminal background check was performed, the home care provider agency representatives did not submit to PEER any samples of such documentation or applicable costs in obtaining fingerprints for conducting such checks.

These representatives noted that a local background check should be sufficient and are also much more time and cost-efficient in comparison to a national check, especially with the number of checks that have to be performed for a position that is subject to a high turnover rate. For example, the representatives asserted that a background check at the local sheriff's office in the area of service would provide more accurate results than having to rely on other law enforcement agencies to upload their information into the Federal Bureau of Investigation's National Crime Information Center (NCIC).

According to DOM staff, at this time, most providers are meeting the national background check requirements by requesting two separate checks: a state check through the Department of Public Safety (\$32.00) and a federal check through the FBI (\$18.00). DOM staff added that there is additional time in checks submitted directly to the FBI and can take two to three weeks for the results to come back to the requesting provider.

Lack of Access to the Mississippi State Department of Health's Fingerprint Check System

Home care provider agencies cannot utilize the Mississippi State Department of Health's FingerPro system because they are not licensed by the department.

The home care provider agency representatives also stated that they are not able to utilize the Mississippi Department of Health's (MSDH) fingerprint scan system, FingerPro. This centralized system allows for any entity licensed by MSDH to obtain a background check for \$50.00, including fingerprints. This system also checks local law enforcement records and the FBI NCIC.

PEER interviewed staff at the Mississippi State Department of Health about the background check and fingerprint concerns raised by the home care provider agency representatives. MSDH staff did verify that home care provider agencies cannot utilize the current MSDH system because they are not licensed by the department.

Currently, the MSDH Professional Licensure Division licenses the following: art therapists, athletic trainers, audiologists, audiology aides, body piercing operators, dieticians, eye enucleators, hemodialysis technicians, hair braiders, hearing aid dealers, medical radiation technicians, occupational therapists, respiratory care therapists, speech-language pathologists, speech-language pathology aides, and tattoo operators and facilities. In addition, other divisions within MSDH license emergency medical technicians and paramedics, feeding assistants, nursing aides, tanning booth operators, and radioactive materials.

Concern: Increased Operational Costs to Implement the MediKey Electronic Visit Verification System When It Does Not Increase the Identification of Fraud, Waste, and Abuse

PEER was not provided any examples of increased home care provider costs associated with hiring additional staff nor examples of increased workloads as a result of using MediKey. However, DOM staff did acknowledge that additional MediKey training sessions for these providers during its implementation would have been helpful. Referrals to the Office of Program Integrity have increased post-implementation of MediKey, and ongoing personal care services audits for FY 2016 and FY 2017 have resulted in identified overpayments of \$813,982.14 and \$858,164.78, respectively.

Personal care service fraud is of concern in Medicaid due to the high rate of utilization of the service, and that the need for such services is likely to continue to rise. CMS noted that Medicaid costs for personal care services increased 35% from 2005 to 2011, totaling \$12.7 billion. According to CMS, the number of personal care attendant and home health aide jobs is expected to grow by nearly 50 percent by 2022. Because of this growing profession and utilization, personal care fraud can be difficult to detect and may involve collusion among multiple people. Examples of personal care service fraud includes billing for services that were never rendered or billing for services supposedly rendered when a beneficiary was instead in institutional care. According to an Office of the Inspector General report issued in 2011, improperly

qualified personal care attendants providing services cost approximately \$724 million in a sample of 10 states.

Section 12006(a) of the 21st Century Cures Act, 114th Congress, mandates that states implement electronic visit verification (EVV) for all Medicaid personal care services and home health services that require an in-home visit by a provider. CMS notes that states must require EVV use for all Medicaid-funded personal care services by January 1, 2020, and home health services by January 1, 2023. Otherwise, the state is subject to incremental Federal Medical Assistance Percentages (FMAP) reductions up to one percent unless the state has both made a “good faith effort” to comply and has encountered “unavoidable delays.” Implementation of an EVV system was to combat some of the potential causes for fraud, waste, and abuse in providing personal care services.

On September 29, 2017, the Division of Medicaid entered into a software turnkey agreement with FEI.COM, INC. d/b/a FEI Systems using the Mississippi Department of Information Technology Services as the contracting agent. This contract was awarded through a competitive request for proposals for providing and implementing the state’s EVV system MediKey. FEI Systems agreed to provide the Division of Medicaid with the system consisting of software, installation and conversion services, technical support training, and hosting. The contract runs until November 1, 2022, with a cost not to exceed \$15,242,759.40.

MediKey is an electronic visit verification system designed to automate the manual processes associated with provider agency submission of claims to the Division of Medicaid. According to DOM staff, as of November 1, 2017, MediKey is currently utilized by providers of personal care and in-home respite services on the Elderly and Disabled Waiver program, and by providers of home and community-based services and in-home respite services on the Intellectual Disabilities/ Developmental Disabilities Waiver.

Cost to Implement and Utilize MediKey

PEER was not provided any examples of increased home care provider costs associated with hiring additional staff nor examples of increased workloads as a result of using MediKey. However, DOM staff did acknowledge that additional training sessions for these providers earlier in the process would have been helpful since this is the state’s first attempt at EVV compliance.

Home care provider agency representatives voiced multiple concerns on the implementation of the MediKey system, including increased operational costs to comply with the EVV from having to hire additional staff to address the additional workload generated from utilizing MediKey. They also alleged a lack of training and feedback to provider agencies on how to ensure correct use of the system.

PEER was not provided any examples of home care provider operational expenditures associated with additional staff nor examples of increased workloads as a result of implementation of MediKey by the home care provider agency representatives.

However, DOM staff did acknowledge that this is a first attempt at implementing and complying with the CMS EVV requirements, therefore additional training sessions for providers earlier in the process would have been helpful.

According to DOM staff, a MediKey kickoff training meeting was held with Elderly and Disabled Waiver program providers on June, 13, 2017. According to the timeline provided within this initial meeting, training occurred on both the administrator and staff levels beginning on June 27, 2017 and continuing through August 30, 2017 at sites across the state. During this time, DOM staff noted that varying case manager trainings (e.g., utilization of one-time password devices) occurred from June 27, 2017 through at least August 30, 2017. Provider and direct care staff training began on July 17, 2017 and continued through August 18, 2017. DOM staff also stated that the attached training resources were initially, and still are, posted on MediKey site for continued access by providers.

Identification and Reduction of Fraud, Waste, and Abuse

The DOM Administrative Code prohibits personal care and in-home respite provider employees from removing the one-time password (OTP) devices from the home of waiver participants. The allegation of not reducing or identifying fraud, waste, and abuse is not valid as audits of personal care service claims have increased since MediKey, and ongoing personal care services audits for FY 2016 and FY 2017 have resulted in identified overpayments of \$813,982.14 and \$858,164.78, respectively.

Home care provider agency representatives also raised concerns on whether or not the MediKey system is either reducing the potential for fraud or identifying any additional cases of fraud, waste, and abuse.

One-Time Password Devices Impact on Reducing Fraud, Waste, and Abuse

The DOM Administrative Code prohibits personal care and in-home respite provider employees from removing the one-time password (OTP) devices from the home of waiver participants. Management of these OTP devices is the responsibility of the planning and development districts through their case management teams.

Home care provider agency staff must clock in and out by calling into the MediKey electronic visit verification system via the waiver participant's landline telephone. Should the beneficiary not have a reliable landline or refuse to allow the personal care attendant to utilize their landline phone, they are assigned a one-time password (OTP) device to clock in and out. When the personal care attendant calls the visit verification line, it will recognize if an OTP device has been assigned to the waiver participant and prompt the caller with instructions.

The home care providers alleged that the use of these OTP devices does not lessen the potential of fraud, waste, and abuse by certain personal care attendants because they are small and can easily be removed from the home. For example, one representative

anecdotally stated an example at the open forum meeting of a personal care attendant being fired from an agency for filing personal care services for a waiver participant while actually being at a shopping center.

While the home care provider agency representatives did not provide PEER with any documentation supporting such cases of fraud, waste, and abuse, the Division of Medicaid does have requirements in place prohibiting such actions. According to the Division of Medicaid Administrative Code, requirements for use of the EVV include:

- *personal care and in-home respite provider employees are prohibited from removing the one-time password (OTP) device from the home of the person if an OTP is being utilized; and,*
- *the provider's employee must obtain and document the OTP codes designating service start and end times while in the home of the person, if not utilizing the person's telephone land line to substantiate services billed including the units of service.*

These home care provider agency representatives also alleged that certain providers often discard the OTP device in the trash when a participant is no longer being served through the waiver instead of recycling the device. According to DOM staff, these OTP devices are managed by the planning and development districts through their case management teams, not by DOM.

Identification of Fraud, Waste, and Abuse for Personal Care Services

According to DOM staff, referrals to the Office of Program Integrity to investigate personal care service claims have increased post-implementation of MediKey. Ongoing personal care services audits for FY 2016 and FY 2017 have resulted in identified overpayments of \$813,982.14 and \$858,164.78, respectively.

Home care provider agency representatives alleged that the MediKey EVV system has increased their workload, but has not yielded any additional identification of cases of fraud, waste, and abuse in providing personal care services to waiver participants.

Due to the amount of time providers have to submit claims for Medicaid reimbursement (up to 12 months from the date of service), DOM staff noted that final audits of personal care services for State Fiscal Years 2018 and 2019 (i.e., post-MediKey implementation) have not yet been completed. However, according to DOM staff, referrals to the Division of Medicaid's Office of Program Integrity for claims investigation have increased post-implementation. Furthermore, ongoing personal care services audits for FY 2016 and FY 2017 have resulted in identified overpayments of \$813,982.14 and \$858,164.78, respectively. DOM staff added that the implementation of MediKey has allowed DOM increased opportunities to identify areas where additional provider education is needed to prevent fraud due to non-compliance with EVV regulations, such as instances where personal care attendants are removing OTP devices from participant homes.

Concern: Personal Care Attendant Training is Too Costly and Home Care Providers Need More Cost-Efficient Options and Flexibility in DOM Standards

Personal care attendant training costs are borne solely by the providers. National literature states the turnover rate for direct care workers ranges from 45% to 60%. The cost of providing training was likely exacerbated when available federal grant funding expired on September 30, 2017. DOM staff asserted CPR certification from an online vendor is acceptable, but the Elderly and Disabled Waiver explicitly states otherwise. There is a perceived disconnect on the actual personal care attendant requirements in comparison to the Personal Care Services Quality Assurance Standards.

The home care provider agency representatives expressed several challenges in providing training based on the multiple requirements set forth in the CMS-approved Elderly and Disabled Waiver Program, the requirements set forth in Title 23 DOM Administrative Code, and the DOM Quality Assurance Standards. Their primary concern was on the cost of meeting all of these requirements given the higher turnover rates in the personal care workforce. These home care providers also expressed concerns on the delivery options in providing certain training requirements, as well as other cost concerns for the delivery characteristics of how certain personal care services should be provided.

As noted previously, home care provider agencies are subject to the rules and regulations established within the Division of Medicaid Administrative Code. Regarding personal care training requirements, the DOM Administrative Code states that the providers must:

ensure all employees and volunteers are trained upon hire, and annually thereafter, as designated by the Division of Medicaid.

Both the DOM Administrative Code and the Elderly and Disabled Waiver program list out specific minimum requirements for both personal care attendants and personal care attendant supervisors (e.g., be a high school graduate, be at least 18 years old). While DOM does not directly approve each individual personal care attendant, it is the responsibility of each home care provider agency to ensure that each of their 19,795 PCAs that may provide personal care services to beneficiaries through the Elderly and Disabled Waiver meet the minimum requirements.

In addition to the minimum requirements, all personal care attendants, including supervisors, unless otherwise excluded in the approved Elderly and Disabled Waiver, must successfully complete a 40-hour curriculum training course upon hire prior to rendering services. DOM also requires annual training for certain topics and certifications, such as CPR and First Aid. Lastly, the Division of Medicaid Quality Assurance Standards define required standards of practice for each provider to follow while providing Medicaid home and community-based personal care services. See Appendix H, on page 73, for a list of the personal care attendant minimum requirements and training curriculum requirements.

Cost of Providing Personal Care Attendant Training

National literature notes that direct care workers are subject to higher turnover rates, which ranges from 45% to 60%. According to DOM staff, cost concerns could be exacerbated by some providers who had their personal care training costs covered through a federal grant that expired on September 30, 2017. DOM staff stated that home care providers should be able to obtain CPR certification for their employees and volunteers from an online vendor. However, the most recent Elderly and Disabled Waiver states that CPR certifications from on-line services are not acceptable.

While the home care provider agency representatives only had a few isolated issues with the actual content of the training requirements (as noted in Appendix H on page 77), they did note that the cost of providing the initial 40-hour training curriculum and subsequent annual training requirements are too costly to their operations when coupled with the high turnover rates of these employees.

Personal Care Attendant Turnover Rates

National literature states the turnover rate for direct care workers is high, ranging from 45% to 60%. PHI estimates that the national average cost for replacing a direct care worker is \$2,200.

According to a recent publication by the National Conference of State Legislatures entitled, *Shoring Up the Long-Term Care Workforce* (August 2019):

Direct care jobs are often characterized as having low pay, poor benefits, and minimal training and advancement opportunities. Such factors can be associated with a high turnover rate for direct care workers, which ranges from 45% to 60%.

In addition to the high turnover in the direct care workforce, PHI estimates that the national average cost for replacing a direct care worker is \$2,200. While the actual turnover rate for personal care attendants varies and was not readily available from the home care provider agencies, if a 45% turnover rate was applied to the current number of personal care attendants in the Elderly and Disabled Waiver program, home care agencies would have to replace approximately 8,908 workers. Using the PHI replacement estimate, this would cost home care provider agencies approximately \$19.6 million.

Cost Increases of Personal Care Attendant Training

A federal grant was able to be utilized to provide some funding for personal care attendant training from July 1, 2012 through September 30, 2017. Currently, personal care attendant training costs are borne solely by the providers. In contrast, federal requirements allow DOM to cover nurse aide training at a 50:50 state and federal match rate.

The home care provider agency representatives raised concern over the cost of providing the initial 40-hour training curriculum and that it has continuously increased over the years. While these representatives did not provide PEER with any documentation or examples of such training costs, DOM staff did provide some historical context on why this concern may have been raised.

As noted previously, many of these home care providers have been providing personal care services since they were first transitioned over from homemaker services in 2012. According to DOM staff, some of these providers had their training costs covered by federal grants from July 1, 2012 through September 30, 2017.

CMS awarded Mississippi a grant in the amount of \$68.5 million through the State Balancing Incentive Payment Program under Section 10202 of the Affordable Care Act. The amount of the original award was based upon projected expenditures and was dependent on the actual amount spent on non-institutional long-term services and supports, and provided a strong financial incentive (an enhanced match rate of 5% for non-institutional LTSS) to stimulate greater access to these services. The original grant period of performance was from July 1, 2012 through September 30, 2015. The grant also provided the state with an additional amount of time to utilize the funding, which ended September 30, 2017. Some of this funding was utilized to provide for the training of personal care attendants.

Since the grant period ended in September 2017, the cost of providing personal care attendant training is solely the responsibility of the home care provider agencies.

In contrast, DOM is able to support nurse aide training through a 50:50 state and federal match rate through an interagency agreement with the MSDH. This is primarily attributed to the fact that there are federally-established standards for both nurse aides and home health aides. The DOM Administrative Code, Part 207, Chapter 2, Rule 2.12 states that DOM uses the direct reimbursement for nurse aide training and testing expenses incurred by nursing facilities. According to DOM staff, the cost of this training is based on the nursing facility's Medicaid utilization cost report.

Need for More Cost-Efficient Training Options

DOM staff stated that home care providers should be able to obtain CPR certification for their employees and volunteers from an online vendor. However, the most recent Elderly and Disabled Waiver program states that CPR certifications from on-line services are not acceptable. Regarding the annual physical requirement, DOM noted that personal care attendants must be physically able to perform the job tasks required.

The home care provider agency representatives raised concerns regarding the need for more cost-efficient options in providing some of the training requirements for personal care attendants. Specifically, these representatives stated they used to have the

option to provide CPR certification from an online vendor, but it has since been restricted to in-person supervised training only.

Because CPR certification is required upon hire and must be maintained annually thereafter, it represents an annual cost to the providers. According to these home care provider agency representatives, the cost of providing CPR certification through an online vendor is significantly more cost-effective in comparison to in-person training. For example, one of the providers noted that they can cover online CPR certification for approximately \$18 per employee versus \$50 per employee in-person. These representatives also noted it is much more time intensive to have to schedule in-person training, especially with higher turnover rates for this workforce.

According to the DOM training requirements, providers may use any training resources deemed appropriate, including in-service trainings completed by supervisory staff or online training by a vendor of their choice. This applies to both the initial 40-hour curriculum training course upon hire, the annual curriculum training, and both CPR certification and First Aid training.

However, the Elderly and Disabled Waiver amendment submitted for approval by CMS with a proposed effective date of October 1, 2019, states that personal care service providers:

Must maintain current and active first aid and CPR certification; CPR certifications from on-line services are not acceptable.⁶

PEER inquired with DOM staff regarding this concern and whether or not this would be a viable option to offer online. According to DOM staff, these providers should already be able to obtain CPR certification for their employees and volunteers from an online vendor. When presented with the specific language within the most recent Elderly and Disabled Waiver amendment submitted to CMS, DOM staff noted they would be amenable to working with CMS to update this particular training requirement to allow for online CPR certification.

The home care agency representatives also noted that it is costly to require an annual physical for all employees and volunteers. According to the DOM Admin Code, providers must:

ensure all employees and volunteers who have direct person contact receive an annual physical examination and have a negative Mantoux tuberculin skin test.

DOM staff noted that the requirements set forth in the CMS approved Elderly and Disabled Waiver explicitly states that personal care service providers or personal care attendants:

Must be physically able to perform the job tasks required and assurance that communicable diseases of major public health concern are not present, as verified by a physician.

⁶ The Division of Medicaid amended its Elderly and Disabled Waiver program submission to the Centers for Medicare and Medicaid Services on November 15, 2019, to allow CPR certification be obtained from an on-line vendor.

Flexibility for Delivery Characteristics in Quality Assurance Standards

The lack of a comprehensive set of personal care attendant requirements stated from a single source document can cause a perceived disconnect on whether or not certain requirements are still applicable. For example, while DOM staff noted that designated uniforms and badges are not explicit requirements for personal care attendants, the Personal Care Services Quality Assurance Standards still include these as part of the minimum instructions in providing personal care services.

The home care provider agency representatives raised concerns on the need for flexibility in the delivery characteristics of how certain personal care services should be provided. Specifically, these representatives stated the high costs in having to supply a designated uniform (e.g., scrub suits in a designated color) and providing identification badges for each of their employees.

PEER determined that, from these home care provider agency representatives' perspectives, it can be unclear on what requirements they must adhere to regarding their personal care attendants because of the lack of a comprehensive source for these requirements. Currently, there are three separate documents that home care providers must adhere to in providing personal care services, which include the CMS-approved Elderly and Disabled Waiver application, the DOM Administrative Code Title 23, and the Personal Care Services Quality Assurance Standards. Looking at the waiver program as a whole historically, some of the personal care attendant requirements explicitly stated within previous waiver applications submitted to CMS are now listed in the Quality Assurance Standards. One example of such was noted by these agency representatives regarding designated uniforms and identification badges.

These uniform and badge requirements were explicitly noted within the Elderly and Disabled Waiver program application when homemaker services were provided prior to implementing personal care services in 2012. According to the Elderly and Disabled Waiver, effective July 1, 2007, homemakers shall:

...wear uniforms that may consist of a smock top, a hospital scrub suit, lab jacket, apron, or whatever has been designated by the provider as a uniform. The uniform must be the same in color, style, and design for all homemakers in a particular agency. It is left to the discretion of the service provider to supply the uniform or require the homemakers to purchase one. A homemaker in a proper uniform has a professional appearance that makes the client feel more secure and enables the client to distinguish them from other paraprofessionals entering the client's home; and,

...shall wear an identification (ID) badge or picture ID that contains the provider's name and the homemaker's name and title. It is left to the discretion of the provider to decide how the badge is designed or obtained.

These two requirements were not explicitly stated within the most recent Elderly and Disabled Waiver program submitted to CMS, with a proposed effective date of October 1, 2019. Furthermore, when

PEER inquired with DOM staff regarding these specific requirements, DOM staff stated that these are not current personal care attendant requirements.

However, these two requirements have since been relocated from the Elderly and Disabled Waiver program application to the Division of Medicaid's Personal Care Services Quality Assurance Standards (revised January 2019). One component of these quality assurance standards includes minimum instructions to be followed when providing personal care attendant services. Two of these minimum instructions specifically mention the uniform and badge requirements that the home care provider agency representative had issues with, specifically stating:

- *PCA staff must wear uniforms that may consist of a smock top, a hospital scrub suit, lab jacket, apron, or other designated uniform. The uniform must be the same in color, style, and design for all PCA Staff/supervisors in a particular agency. It is left to the discretion of the service provider to supply the uniform or require the staff to purchase them.*
- *PCA staff must wear in plain view an identification (ID) badge or picture ID that contains the provider agency's name and the PCA staff member's name and title. It is left to the discretion of the provider to decide how the badge is designed or obtained.*

After removal of some of the previous personal care attendant requirements, the current Elderly and Disabled Waiver now states:

Personal Care Service providers must meet the Quality Assurance Standards, as defined by the Division of Medicaid...

While it is ultimately the responsibility of the provider agencies to remain current on applicable requirements from each of the three sources, the lack of a single comprehensive source for these requirements can create a perceived disconnect on whether or not certain requirements are still in place or not.

Regarding the cost of such requirements, both the previous homemaker language and the current quality assurance standards does leave the discretion in how uniforms and badges will be purchased with the provider agencies.

Concern: Certified Nurse Aides Employed by Home Care Provider Agencies Are Not Able to Obtain Recertification Resulting in Increased Turnover Rates

Certified Nurse Aides are not able to obtain recertification while working solely as a personal care attendant under the employ of a home care agency. A CNA has two-years to be recertified in a clinical setting otherwise they will lose their certification. It is possible that Pearson VUE had incorrectly recertified some CNAs without checking MSDH's list of approved providers. Lastly, while the home care providers say they need CNAs to administer better care to waiver participants, the waiver explicitly defines personal care services as non-medical.

One primary concern raised by the home care provider agency representatives was the inability for any Certified Nurse Aide (CNA) working strictly under the employ of a home care agency as a personal care attendant to obtain recertification. According to these home care providers, they would like to be able to retain the higher skill level staff attributed to obtaining this certification, but are unable to do so because of certain recertification requirements which also result in increased turnover rates. These representatives also asserted that their waiver participants' medical needs are greater and therefore they need staff that is able to provide greater levels of care.

Certified Nurse Aide Certification and Recertification Requirements

All CNAs are subject to federally-established training requirements. Once the training is completed, the candidate is able to take a written exam and skills evaluation as administered by Pearson VUE at a cost of \$101. A CNA must complete at least eight hours of clinical skills training, with pay, from an approved clinical setting (e.g., nursing home, home health agency, or hospital) every two years. CNAs are unable to get recertified while working solely for a home care agency because these provider types are not an MSDH-approved setting in Mississippi. It is possible that Pearson VUE had incorrectly recertified some CNAs without checking MSDH's approved setting list.

There are federally-established Nurse Aide Training and Competency Evaluation (NATCEP) requirements for both nurse aides (e.g., CNAs) and home health aides. These federal regulations require that these training programs consist of at least 75 hours of training, including at least 16 hours of supervised practical or clinical training. States can also require additional training hours beyond the 75-hour minimum requirement. Mississippi currently only requires the 75-hour minimum training requirement.

The Mississippi Department of Health, Health Facilities Licensure and Certification Division, is responsible for approving each NATCEP program in the state and must audit each program at least once every two years. According to MSDH staff, there are currently 89 approved programs in the state being offered by either community colleges, junior colleges, career and vocational centers, or proprietary training schools. While Mississippi only requires the 75-hour minimum, the total training hours provided by these approved programs range from 75 hours all the way up to 980 hours at the Meridian Community College as a component within their licensed professional nurse (LPN) training program. For a list of each of the 89 approved programs that provide NATCEP training and total hours provided, see Appendix I on page 84.

Once the candidate has completed the training course, they must then arrange to complete the National Nurse Aide Assessment Program (NNAAP®) examination program. This exam is provided through an agreement between the Mississippi State Department of Health and a third-party service provider as the authorized NNAAP

administrator in Mississippi, Pearson VUE.⁷ The NNAAP exam is an evaluation of nurse aide-related knowledge, skills, and abilities and is made up of both a written (or oral) component and a skills evaluation component.

Under the current arrangement between MSDH and Pearson VUE, the MSDH provides Pearson VUE with a list of approved training programs in the state that exam candidates must complete prior to obtaining CNA certification or recertification. Pearson VUE then administers the NNAAP exam to the candidates on behalf of MSDH. Pearson VUE retains all of the fees for both the initial certification exam and recertification. According to the Pearson VUE Mississippi Nurse Aide Candidate Handbook, the cost for both the written exam and skills evaluation combined is \$101. The cost for recertification is \$26. According to MSDH staff, state and federal regulations allow a candidate three attempts to pass both components of the NNAAP exam. The written component is made up of 70 multiple choice questions. The skills evaluation component consists of five of 23 nurse aide skills, randomly selected, where the candidate has 30 minutes to demonstrate competency in the selected skills. For a list of the 23 nurse aide skills, see Appendix J on page 87.

Upon passing the NNAAP exam, the original Certified Nurse Aide certification from the Mississippi State Department of Health is valid for twenty-four (24) months from the date of issue and the person is added to the Mississippi Nurse Aide Registry. According to MSDH staff, there are 19,267 CNAs in this registry, as of September 30, 2019.

Certified Nurse Aide Recertification

CNAs are unable to get recertified while working solely for a home care agency because they must complete at least eight hours of clinical skills training from a paid clinical facility (e.g., nursing home or hospital) every two years.

The home care provider agency representatives noted that they can hire CNAs upon initial certification, but will typically lose the employee within two years so that he or she will not lose their CNA certification due to the current recertification process. While no direct turnover rate was provided to PEER by these representatives, both DOM staff and MSDH staff did note that this is very likely since home care provider agencies are not an approved clinical setting for CNA recertification.

According to MSDH staff, CNAs are unable to get recertified while working solely for a home care agency because they must complete at least eight hours of clinical skills training from a paid clinical facility (e.g., nursing home or hospital) every two years from the date obtaining the initial certification.

⁷ Pearson VUE is headquartered in Philadelphia, Pennsylvania. According to MSDH staff, they have utilized a third-party service provider to certify and recertify Certified Nurse Aides as far back as 1997 with a company called Promissor. Over the years, the company was sold out and is currently operating under the name Pearson VUE.

The home care providers also raised concerns about needing CNA recertification for their employees and asserted that their personal care attendants can perform at least 13 of the 23 skills noted within the NNAAP administered by Pearson VUE (see Appendix J on page 87). MSDH staff stated that to be recertified the CNA should be able to perform all 23 nurse aide skills, and that the skills they are not able to perform are clinical skills. DOM staff reiterated that personal care services are defined as non-medical services.

Prior Recertification of Certified Nurse Aides by Pearson VUE

Should a CNA not work for one of the approved entities, then they should not be able to obtain recertification through Pearson VUE. However, MSDH staff acknowledged that the management team at Pearson VUE had recently changed and under previous management it is possible that some CNA recertification could have been approved without checking MSDH's approved setting list.

Representatives from the home care provider agencies also stated that Pearson VUE used to recertify CNAs who worked for home care agencies, but now they do not allow it. These providers alleged that many of their CNAs serving as personal care attendants who were recertified in 2018 and 2019 were receiving subsequent letters from Pearson VUE revoking their certification. These representatives did not provide PEER with any letters verifying such occurrences.

MSDH staff stated that Pearson VUE is only supposed to administer both CNA certification exams and recertification to those persons working for an agency on the list provided by MSDH of the approved home health agencies and other approved settings through NATCEP. MSDH staff again noted that home care agencies are not an approved setting that meets the federal NATCEP requirements for CNA recertification. Should a CNA not work for one of the approved entities, then they should not be able to obtain recertification through Pearson VUE.

MSDH staff did acknowledge that the management team at Pearson VUE had recently changed and prior to this change it is possible that some applications could have been approved without checking to verify if the CNA worked for a home health agency rather than a home care provider agency using MSDH's approved setting list. For example, some of the agencies currently approved by the Division of Medicaid to provide personal care services have "healthcare" or "home health" explicitly in the title. Regardless of the name used, if such agency is not listed on the MSDH-approved list, then Pearson VUE should not have issued recertification to a CNA working for such an agency.

Again, no documentation was provided to PEER to substantiate either position.

Need for Certified Nurse Aides as Personal Care Attendants

Personal care attendants should not be providing medical or clinical care through the waiver when personal care services are defined as non-medical. While using CNAs as personal care assistants may result in greater quality of care, personal care services are reimbursed at a flat rate regardless of the skill level of the attendant.

The home care provider agency representatives noted that waiver participants' medical needs are greater than in the past and that they need more experienced personal care attendants with higher skill levels, such as a CNA, in order to provide such services. These providers also stated that this would provide a greater quality of care to waiver participants by giving them access to more experienced providers with clinical experience.

Increased Medical Needs of Waiver Participants

Personal care services are explicitly defined as non-medical services through the Elderly and Disabled Waiver program. Personal care attendants should not be providing medical or clinical care through the waiver.

The home care provider agency representatives noted that waiver participants' medical needs have increased over time and therefore they need more experienced personal care attendants with higher skill levels, such as a CNA, in order to provide such services. There is a scope of practice conflict present for any personal care attendant providing medical or clinical care to a waiver participant as personal care services are defined by the waiver explicitly as non-medical services.

According to the most recent Elderly and Disabled Waiver submitted to CMS:

Personal Care Services (PCS) are non-medical support services to assist the person in meeting daily living needs and ensure optimal functioning at home and/or in the community.

Therefore, these personal care attendants should not be providing clinical or medical services to waiver participants. MSDH staff added that when CNAs note they are not able to be recertified despite providing clinical or medical services under a home care agency, MSDH reminds them that they are prohibited from providing such services to waiver participants because home care agencies are not an approved setting that meets the federal NATCEP requirements.

DOM staff added that prohibiting personal care attendants from providing medical services is also to ensure the safety of the waiver participants. Home health aides or nursing aides are typically providing skilled nursing care under direct supervision by a registered nurse. Furthermore, this care is typically based on a physician's plan of care, usually updated every 60 days at the

longest. In the waiver program, the individualized service plan is developed by the participant and the case management team, at least annually. While some of these home care agencies employ or are managed by registered nurses, there is no formal chain of command to document their clinical oversight and report clinical or medical conditions in comparison to how care is provided and documented through a home health agency or within a nursing home or other institutional facility.

Access to Greater Quality of Care

The overall quality of care should improve with a greater skilled workforce. While using CNAs as personal care assistants may result in greater quality of care, personal care services are reimbursed at a flat rate regardless of the skill level of the attendant. However, home care providers can save on training costs because CNAs are exempt from the 40-hour curriculum training course upon hire.

According to DOM staff, anyone with CNA certification has the ability to serve as a personal care attendant through the Elderly and Disabled Waiver program, and agreed that the overall quality of care should improve with a greater skilled workforce. DOM staff added that personal care services are reimbursed by Medicaid at a flat rate per 15-minute unit, regardless of the skill level of the personal care attendant.

Both DOM and MSDH staff acknowledged that hiring and retaining CNAs is advantageous to the home care provider agency from a cost-efficiency perspective because the CNA certification allows the personal care attendant to be exempted from the 40-hour curriculum training course upon hire. The DOM personal care attendant training requirements state:

All personal care attendants must successfully complete a 40-hour curriculum training course upon hire prior to rendering services. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three years as a nurse aide, orderly, nursing assistant, or an equivalent position by one of the above medical facilities shall be deemed to meet these initial training requirements.

Concern: There are Too Many Home Care Provider Agencies in the State and the Division of Medicaid Needs to Enact a Moratorium on New Providers Similar to Moratoriums Enacted on Other Healthcare Entities

Only the Legislature or CMS can enact a moratorium on new home care providers. However, national literature projects that both the number of personal care attendants and people needing their services, Medicaid or otherwise, will continue to increase in the coming years. In Mississippi, there are currently three moratoriums enacted through statute for home health agencies, hospice facilities, and skilled nursing facilities.

Home care provider agency representatives raised the concern that a moratorium is needed on new home care provider agencies in the

state. They noted that there are currently too many providers for the number of Elderly and Disabled Waiver program, participants served and that this decreases the quality of services provided. These representatives also alleged that the current number of provider agencies also increases unethical actions by providers, employees, and clients. Therefore, these representatives noted that home care provider agencies need the same kind of protections that other healthcare providers receive by having a moratorium on new providers.

Need for a Moratorium on New Home Care Providers

The Division of Medicaid cannot enact a moratorium on new home care providers. Only the Legislature or CMS can enact a moratorium. National literature projects that both the number of personal care attendants and people needing their services, Medicaid or otherwise, will continue to increase in the coming years.

The home care provider agency representatives requested at the open forum meeting on June 26, 2019, whether or not the Division of Medicaid could enact a moratorium on new home care providers. They noted that there are currently too many providers for the number of Elderly and Disabled Waiver program participants served.

Can the Division of Medicaid Enact a Moratorium on New Providers?

No. The Division of Medicaid cannot enact a moratorium on new home care providers. Such a moratorium would either need to be approved by or enacted by CMS, or enacted by the Mississippi Legislature through statute in the MISS. CODE. ANN. (1972).

When the home care provider agencies directly inquired with the Division of Medicaid if they had the authority to enact at least a short-term duration moratorium on new home care providers, DOM staff noted that they could not impose such a moratorium. DOM staff stated that only the Legislature could enact such a moratorium at the state level through statute.

In addition to a state enacted moratorium, CMS has the authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers if it determines a moratorium is necessary to prevent fraud, waste, or abuse.

For example, CMS first issued a temporary Enrollment Moratorium for home health agencies in 2013 covering certain counties around Miami, Florida and Chicago, Illinois. By August 2016, the Enrollment Moratorium covered all counties in Florida, Illinois, Michigan and Texas. CMS cited high incidents of fraud in these geographic areas and the saturation of home health agencies in these markets, which mitigates concerns of beneficiary access. As of January 30, 2019, CMS lifted its temporary provider enrollment moratoria for home health agencies in Florida, Illinois, Michigan and Texas. However, CMS also noted that many states will still

impose their own mandated moratoriums or require regulation through a certificate of need process for certain provider types.

Are There Too Many Home Care Providers?

While DOM staff noted there are currently 19,795 personal care attendants available to serve 17,800 waiver slots, the number of slots available in the future could potentially increase. National literature projects that both the number of personal care attendants and people needing their services, Medicaid or otherwise, will continue to increase.

DOM staff noted there are currently 19,795 personal care attendants available to serve 17,800 waiver slots. DOM staff added that the number of slots available in future years could potentially increase based on the amount of funding appropriated by the Legislature. Furthermore, this number only reflects both those personal care attendants and participants in the waiver program and does not factor in other waiver programs or directly hired personal care attendants through private-pay agreements.

Furthermore, national literature projects that both the number of personal care attendants and people needing their services, Medicaid or otherwise, will continue to increase. For example, the *AARP Across the States: Profiles of Long-Term Services and Supports* (August 2018) notes that the ages 85+ population is projected to more than triple between 2015 and 2050. Because members of this age group are most likely to need help with activities of daily living, the demand for direct care workers will also increase. According to PHI, the home care industry will need to fill approximately 4.2 million home care worker job openings (including one million new jobs) within the next decade, from 2016 to 2026 to meet this rising demand. PHI noted two primary trends for this employment growth, the expansion of the older adult population, paired with an ongoing shift in the provision of long-term services and supports from institutional care to home and community-based services.

Existing Moratoriums on Providers in Mississippi

Mississippi currently has three moratoriums enacted by the Legislature for the following institutional settings: home health agencies, hospice, and skilled nursing facilities. There are also additional institutional settings regulated through a certificate of need process.

The home care provider agency representatives noted that existing home care providers need the same kind of protections that other healthcare providers receive by having a moratorium on new providers. Currently, the home care providers operate under a free market system, only having to meet and adhere to DOM requirements if they want to provide personal care services through the waiver. While the representatives are correct in saying that there are currently moratoriums in place for healthcare

providers in the state, so far each of these provider types are institutional settings providing clinical or medical care.

Mississippi currently has three moratoriums enacted by the Legislature; each one is for an institutional setting. Exhibit 7, below, lists the three provider types with moratoriums in Mississippi.

Exhibit 7: Current Moratoriums in place for Healthcare Providers in Mississippi

Provider Type	Description	Source	Citation	Year Enacted
Skilled Nursing Facilities	Moratorium	Legislation	MISS. CODE ANN. § 41-7-191	1981
Home Health Agencies	Moratorium	Legislation	MISS. CODE ANN. § 41-7-191	1983
Hospice	Moratorium	Legislation	MISS. CODE ANN. § 41-85-7(3)	1995

SOURCE: PEER staff analysis of MISS. CODE ANN. §§ 41-7-191 and 41-85-7 et seq., interviews with Mississippi Department of Health staff, and interview with MSDH Board of Health legal counsel.

According to MISS. CODE ANN. § 41-7-191 (8) (1972), presently, the Mississippi Department of Health is prohibited from granting approval for or issuing Certificates of Need (CON) to any person proposing the new construction of, addition to, or expansion of any health care facility defined in subparagraphs (iv) (skilled nursing facility), (vi) (intermediate care facility), and (viii) (intermediate care facility for the mentally retarded) of Section 41-7-173 (h) or the conversion of vacant hospital beds to provide skilled or intermediate nursing home care, except as specifically authorized by statute.

MSDH, likewise, is prohibited from granting approval for or issuing a CON to any person proposing the establishment or expansion of the currently approved territory of, or the contracting to establish a home office, subunit, or branch office within the space operated as a health care facility as defined in Section 41-7-173 (h) (i) through (viii) by a health care facility as defined in subparagraph (ix) (home health agency) of Section 41-7-173 (h). MSDH, however, is authorized to issue a license to an existing home health agency (HHA) for the transfer of a county from that agency to another existing HHA, and to charge a fee for reviewing and making a determination on the application for such transfer not to exceed one-half of the authorized fee assessed for the original application for the HHA.

In addition to the moratoriums enacted through statute, the following health care facilities are regulated through a certificate of need (CON) process. These facilities include:

- hospitals;
- long-term care hospitals;
- psychiatric hospitals;
- chemical dependency hospitals;
- comprehensive medical rehabilitation facilities;
- skilled nursing facilities;
- intermediate care facilities;
- intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
- psychiatric residential treatment facilities;
- pediatric skilled nursing facilities;
- end-stage renal disease facilities (including freestanding hemodialysis units);
- ambulatory surgical facilities; and,
- home health agencies (moratorium in place as well).

Regarding the CON on home health agencies, according to MSDH staff, the state health plan does not currently show a need for additional home health agencies within the state. There are currently 48 total home health agencies licensed in the state, with 110 total branches.

Concern: Some of the Planning and Development Districts that Provide Case Management Services Also Operate Home Care Agencies and Skew the Placement of Waiver Participants to their Agencies

According to DOM staff, there are administrative firewalls in place to limit when such occurrences can occur. While PEER was not provided any direct evidence to determine the validity of this concern, DOM does have the potential to periodically review the placement distribution of waiver participants by case management agencies.

The home care provider agency representatives raised concerns on the selection of personal care services by waiver participants in certain planning and development districts. Specifically, these providers alleged that some of the planning and development districts who are responsible for providing case management to participants also own and operate their own personal care provider agencies. However, no direct evidence to determine the validity of this concern was provided to PEER by the representatives.

As noted earlier in the report, the Elderly and Disabled Waiver program uses a person-centered case management approach to identify a person's desired outcomes based on their personal needs and goals. As part of this person-centered process, the waiver participant selects the provider of his or her choice and must verify the selection with a signature. According to DOM staff, there are some rural areas where case management agencies also provide direct services. Therefore, an administrative firewall was added to

the waiver in 2014 to ensure that there is separation between case management and other services provided, such as personal care services.

According to Division of Medicaid Administrative Code, the person-centered process helps determine the services and supports the person requires and must:

Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process which ensures the individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

In addition, the Elderly and Disabled Waiver noted that as part of the DOM Continuous Quality Improvement process, DOM has the ability to monitor service provision and referrals to service providers by reports generated from the LTSS system to identify case management agencies that have disproportionately referred to services within their own agency.

When PEER inquired with DOM staff, they noted that they do regularly review a waiver participant's attestation form showing signature and selection of a service provider, but do not necessarily look at participant placement and provider selection on a statewide basis. DOM staff also acknowledged that they do have the ability to conduct such a review, if necessary.

Concern: The Planning and Development Districts and their Case Management Teams do not Notify the Home Care Provider Agencies in a Timely Manner when a Loss of Waiver Participant Eligibility Occurs

According to Division of Medicaid staff, these complaints are rare and there are multiple processes in place that both case managers and home care providers can use to verify eligibility.

The home care provider agency representatives expressed concerns regarding the untimely notification by some of the case management teams when a waiver participant becomes ineligible for waiver services, resulting in the home care provider agencies continuing to provide services to participants that they cannot be reimbursed for through Medicaid. While these providers did not provide PEER with any specific case managers or other examples, PEER inquired with DOM staff on how often this occurs to see if it is a widespread issue in the waiver program. DOM staff stated that these complaints are rare.

According to DOM staff, there is nothing in the DOM Administrative Code to state how quickly a case manager or provider must be notified when a beneficiary loses eligibility. However, there are processes and resources in place to ensure that any applicable provider or case manager has access to such information, which includes:

- *All Medicaid providers have immediate access to check eligibility via the Envision web portal and are expected to do so prior to the provision of services in accordance with DOM Administrative Code, Part 200 General Provider Information, Rule 3.5: Verification of Eligibility. This rule states that it is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. Evidence of eligibility is demonstrated by the Medicaid identification card issued to each Medicaid eligible member in a family. A beneficiary is expected to present his/her Medicaid identification card when services are rendered.*
- *Should they choose not to check eligibility in advance, personal care providers who are addressing shift validation errors in MediKey daily as they occur would immediately be made aware of an eligibility loss; thus, resulting in the loss of reimbursement for only one shift.*
- *Beneficiaries themselves are notified of the eligibility loss in accordance with Part 101, Chapter 10 of the Administrative Code. Since personal care attendants are in the home more frequently than the case managers, they are often made aware of eligibility losses before the case manager is notified via monthly eligibility reports.*

What Solutions Could be Considered to Address Concerns Regarding Personal Care Services?

PEER sought to identify any potential solutions that could potentially be implemented to improve the delivery of personal care services based on the concerns raised by the home care provider agency representatives, where applicable.

The Division of Medicaid Should Periodically Review the Reimbursement Rates for Waiver Services, Including Personal Care Services

The Division of Medicaid should continue to monitor the reimbursement rates and update the actuarially-sound rates upon any substantive program changes, as warranted. At a minimum, the rates for waiver services should be reviewed every five years in conjunction with the waiver renewal by CMS.

During the development of the current Elderly and Disabled Waiver program, the Division of Medicaid projected the average reimbursement rates per unit for each waiver service in year one of the waiver. The Division of Medicaid then adjusted the costs incrementally over the following four waiver years based on a 2.6% average projected Consumer Price Index increase.

According to DOM staff, the waiver service rates are reviewed annually and if increases are determined to be necessary and are feasible within budgetary appropriations, they may be increased appropriately to an amount no greater than the maximum authorized by CMS in the approved waiver. DOM staff added that a new actuarial rate study would most likely be completed prior to the 2022 renewal of the Elderly and Disabled Waiver program.

The Mississippi Department of Health and the Division of Medicaid Should Identify Potential Areas to Streamline the Fingerprint Requirement with the National Background Check Program

Upon implementation of the enhancements to the state's national background check system, which integrates the current FingerPro system with the RapBack system, the Mississippi State Department of Health should work with the Division of Medicaid to inform home care provider agencies of the counties and locations of the background check kiosks that will perform fingerprint scans as an option for them to conduct national criminal background checks on their employees and volunteers.

The Division of Medicaid and the Mississippi State Department of Health should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system in conducting fingerprint checks. When this agreement is finalized, the DOM should inform all of the existing Medicaid-approved providers of personal care services and in-home respite services about the access to this system.

Currently there are two separate but concurrent efforts happening that should continue to be developed for future implementation that could lessen the administrative burdens of conducting national criminal background checks, including fingerprint checks,

for home care providers. The first effort is a CMS grant awarded to the MSDH in order to enhance the state's current national background check system. The second effort is the development of an interagency agreement between the DOM and the MSDH to allow home care providers access to the MSDH FingerPro fingerprint system.

CMS Grant Funds to Enhance the State's National Criminal Background Check System

The MSDH received a \$3 million grant award through CMS for upgrading and enhancing the state's national criminal background check program efforts. MSDH staff noted that some of these grant funds will be used to purchase 25 fingerprint scan devices that will be placed at county health departments and serve as a potentially more time and cost-efficient option for home care providers to access. Once these kiosks are implemented, the MSDH should periodically examine the utilization of these fingerprint devices to ensure optimal placement.

According to MSDH staff, they have been in the process of working on a memorandum of understanding with the Mississippi Department of Public Safety to both enhance the state's current background check system and expand their fingerprint scan system to entities beyond just those that they license, which could potentially alleviate some of the concerns raised by the home care provider agencies. MSDH staff stated that they are able to carry out this effort through the authority within the MISS. CODE ANN. § 43-47-1 et seq., the Mississippi Vulnerable Adults Act of 1986.

MSDH staff provided a pre-grant application letter reviewed on April 10, 2017, to apply for a National Background Check Program grant of up to three million dollars through CMS. The application also noted letters of support were required from the Mississippi Department of Public Safety and the Mississippi Division of Medicaid.

The pre-grant application letter stated that the National Background Check Program aligns with the MSDH State Health Improvement Plan in that its goal is to provide an improved way of screening applicants seeking employment with long-term care facilities and providers. It also noted that the improved background check system would aid in protecting long-term care residents and their families from employees with disqualifying criminal convictions.

Regarding enhancements to the current national background check system, MSDH staff noted that it planned on integrating the RapBack system with the current FingerPro system. The current FingerPro system conducts background and fingerprint checks at a single point in time. However, the RapBack system enhancement will allow more continuous real-time monitoring. Should a provider request a check on an employee that comes back clean but then later commits a crime, FingerPro alone would require an additional check to detect the crime. Whereas, RapBack would notify the MSDH of the more recent crime on the employee who was previously checked as soon as the crime or incident was entered

into the system by law enforcement. MSDH could then inform the provider regarding the flag by RapBack on their employee.

On June 4, 2018, the MSDH received its award letter notifying approval of the state's award of a National Program for National and State Background Checks for Direct Patient Access Employees of Long-Term Care Facilities and Providers Grant under section 6201 of the Affordable Care Act. The award is for \$3,000,000 with a state match of \$1,164,556 and has a financial report requirement beginning on June 1, 2018 and ending on August 29, 2021.

According to MSDH staff, some of the grant funds will be utilized to purchase and acquire 25 machines that can perform fingerprint scans through fingerprint kiosks that integrate both the current FingerPro system and the RapBack system. The tentative plan is to place these machines in county health departments. MSDH staff noted that these will be dispersed equally on a geographic basis, but that they plan to monitor usage of the devices to see if they need to be relocated to other counties after implementation. While MSDH did not have a definitive launch date on when these will go live, staff did note that these will be able to be accessed by home care provider agencies. In addition, once FingerPro and RapBack are integrated then this should lessen the burden of the DOM waiver requirement of having to recheck each employee and volunteer every two years.

Interagency Agreement between DOM and MSDH for FingerPro Access

The Division of Medicaid and the Mississippi State Department of Health should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system in conducting fingerprint checks. When this agreement is finalized, the DOM should inform all of the existing Medicaid-approved providers of personal care services and in-home respite services about the access to this system.

As noted earlier, home care providers currently cannot access the MSDH FingerPro background check and fingerprint system because they are not licensed by the MSDH. Therefore, these providers have to request multiple checks from multiple sources. In addition, having to directly submit a check request to the FBI can take several weeks to get the results back.

Currently, the DOM and the MSDH are working on the development of an interagency agreement that would allow home care providers access to the FingerPro system in conducting fingerprint checks even though they are not licensed by MSDH. This should allow for these providers to have access to a centralized system that will streamline the background check and fingerprint check process.

According to MSDH staff, allowing these providers access to the FingerPro system should allow for overall faster processing as it serves as a central system that checks both local law enforcement and FBI databases instead of relying on multiple checks with various entities. In addition, MSDH staff noted their charge for the checks is \$50 and that they usually get the results from the check

back in 24 to 48 hours. Therefore, the cost in conducting these checks with fingerprinting would be consistent to current costs while providing much faster turnaround times on these checks.

When this agreement is finalized, the DOM should inform all of the existing Medicaid-approved providers of personal care services and in-home respite services about the access to this system.

The Division of Medicaid Should Continue to Work with FEI Systems to Implement Improvements to the MediKey System

The Division of Medicaid should continue to obtain feedback from the Medicaid-approved home care provider agencies regarding the user interface of the state's electronic visit verification system, MediKey, to identify potential areas for improvement and when opportunities for technical assistance and training may be needed. The Division of Medicaid should also continue working with FEI Systems on any business and operational improvements to MediKey, as necessary.

According to DOM staff, they are actively working with both the fiscal agent and FEI Systems to work on issues with the MediKey system and implement several operational improvements to lessen some of the administrative concerns raised by the home care provider agency representatives.

DOM staff stated that they are in the process of reviewing a proposal to upgrade the MediKey system to CareVisit technology. DOM staff noted that this upgrade would include new functionality that would:

- allow providers to clock-in/clock-out via a mobile phone application that ensures additional accountability by utilizing a GPS signal to ensure that provider staff are at the appropriate service location;
- allow provider administrators to be able to schedule and review visits in the administrator portal; and,
- allow beneficiaries to be able to access their records through a mobile beneficiary portal.

DOM staff also noted that if the upgrade to CareVisit is implemented, there should be a reduced reliance on paper timesheets because the mobile application allows both completed tasks and beneficiary signatures to be captured at clock-out electronically. DOM staff also noted that the upgrade would also include additional reporting capabilities that would allow providers more access to monitoring data and address some of their concerns on sharing EVV data and compliance to help the home care providers identify deficiencies and make the necessary improvements in service.

The Division of Medicaid Should Work with the Centers for Medicare and Medicaid Services to Amend the CPR Certification Requirement

The Division of Medicaid should work with the Centers for Medicare and Medicaid Services to amend the requirements within the most recent Elderly and Disabled Waiver program submission to allow home care providers to obtain CPR certification from an online vendor in addition to in-person training.

According to DOM staff, home care providers should already be able to obtain CPR certification for their employees and volunteers from an online vendor. Therefore, DOM should work with CMS to update and amend this particular training requirement within the most recent Elderly and Disabled Waiver to allow for online CPR certification.

According to DOM staff, the Division of Medicaid amended its Elderly and Disabled Waiver submission to the Centers for Medicare and Medicaid Services on November 15, 2019, to allow CPR certification to be obtained from an on-line vendor.

The Division of Medicaid Should Ensure Consistent Personal Care Attendant Requirements for the Elderly and Disabled Waiver Program

The Division of Medicaid should review, update, and align the personal care attendant requirements within the CMS-approved Elderly and Disabled Waiver program, the requirements set forth in Administrative Code Title 23, and the Personal Care Services Quality Assurance Standards. The Division of Medicaid should then clearly communicate to all active and future Medicaid-approved home care provider agencies on the existing requirements, as well as clarify any newly-created or previously-eliminated requirements.

As noted previously, the lack of a comprehensive set of personal care attendant requirements from a single source can create a perceived disconnect on what the actual requirements are for personal care attendants and the provision of personal care services. For example, the home care providers raised concerns on the costs of providing designated uniforms and badges to employees. Both DOM staff and the most recent Elderly and Disabled Waiver requirements did not specify such requirements. However, the Division of Medicaid's Personal Care Services Quality Assurance Standards (revised January 2019) still explicitly states that designated uniforms and badges for employees are minimum instructions to be followed when providing personal care attendant services.

Therefore, the Division of Medicaid should review, update, and align the personal care attendant requirements within the CMS-approved Elderly & Disabled Waiver, the requirements set forth in Administrative Code Title 23, and the Personal Care Services Quality Assurance Standards. The Division of Medicaid should then clearly communicate to all active and future Medicaid-approved home care provider agencies on the existing requirements, as well as clarify any newly-created or previously-eliminated requirements, when applicable.

The Home Care Provider Agency Representatives Should Identify and Develop a Training Program Option to Allow for Recertification of Certified Nurse Aides Working for Home Care Providers, with Consultation from the Mississippi State Department of Health on the Feasibility of Such Option

The Mississippi State Department of Health should continue to work with the home care provider agencies to identify a feasible option in the development of a training program or mechanism to allow for the recertification of Certified Nurse Aides who are under the employ of home care providers.

In order to discuss the home care provider agency representatives' concerns about the need for recertification of CNAs working for home care agencies, a meeting was held between the home care provider agencies, DOM staff, and MSDH staff on October 3, 2019.

The home care providers also inquired on whether or not the MSDH or Pearson VUE could develop a recertification program option for home care provider agencies similar to other approved entities. MSDH staff noted that while they do have one FTE position whose responsibilities include reviewing and approving proposed CNA training programs, each of the home health agencies, nursing homes, and hospitals have developed their own programs and have submitted these to MSDH for review and approval. MSDH staff clarified that they ensure the program is compliant with federal regulations, and that Pearson VUE's role is strictly to administer the test to employees of approved entities. MSDH staff also added that some home care providers have entered into agreements with home health agencies or nursing homes in their respective areas to perform and complete the required eight hours of clinical training once every 24 months.

While Certified Nurse Aides currently are not able to obtain recertification while working solely as a personal care attendant under the employ of a home care agency, MSDH stated that there are potential partnership options available that could be used to develop a recertification process for these CNAs and would offer assistance in working with these home care provider agency representatives to see which options are most feasible.

MSDH staff identified three potential options for developing a recertification process for those Certified Nurse Aides employed as personal care attendants by home care agencies. These options include:

- Option One - development of a recertification program administered by each individual home care provider agency;
- Option Two - development of a single recertification program for use by all home care provider agencies administered through a formal home care provider association; and,
- Option Three - development of a single recertification program for use by all home care provider agencies administered through the state's current junior colleges who already perform the initial nurse aide certification.

The following discussion briefly highlights some cursory advantages and disadvantages for the feasibility of each of the three options.

Under option one, there would need to be a CNA recertification program established for each of the 207 Medicaid-approved providers for personal care services and the 175 in-home respite providers. While some of these providers may overlap, this could potentially be up to an additional 382 training programs that would have to be examined by a single FTE at the MSDH at least once every two years in addition to the programs already reviewed for each of the home health agencies, nursing homes, and hospitals. Currently, expenditures for the review and approval of these programs is covered solely by the MSDH budget. Given the large number of home care provider agencies in the state, and the concerns voiced from their own representatives regarding the need to limit new providers, this option would likely not be feasible from a cost perspective. In addition, each home care provider would be responsible for the administration and overhead costs of establishing such a program, and also comply with all applicable documentation and reporting requirements.

Under option two, there would need to be the development of a single recertification program for use by all applicable home care provider agencies in the state. Regarding the impact of the MSDH approval and review process, this would require only the review of one additional program every two years. This option could utilize and develop a more formalized home care provider association to administer such a program. Currently, the Mississippi Home Care Providers Association consists of multiple providers who represent their profession, without any requirement or participation by all of such agencies. Because there would be both administrative and overhead costs in the development of such a program, it would also be easier to implement and fund a single program in comparison to the potential 382 programs noted in option one above. MSDH staff noted that building a more formalized association could help strengthen the profession in the state. They also provided the example of having each agency pay annual dues to such an association, which could help fund the development of the CNA recertification program and allow for the association to hire a registered nurse or other applicable staff to provide the program to applicable CNAs working as personal care attendants. The primary limitations to this option would be the time and resources needed to bring all of these different entities together and establish the necessary infrastructure to both develop the association itself and the CNA recertification program.

Option three is very similar to option two, but instead of a single CNA recertification program administered by a formal home care provider association, the home care provider agencies could partner with the community and junior colleges in administering such a program. Again, this would essentially add only one additional program for MSDH to approve and review every two years. The primary advantage to this option is that these community and junior colleges are already established and provide the initial CNA certification

programs. Therefore, the home care providers could work with these entities, with the consult of MSDH staff, to identify a partnership program where the CNA recertification component for the clinical skills could be performed through these colleges, whether through a school-based clinic or other clinical setting.

The Division of Medicaid Should Continue Monitoring the Number of Applicants and Approved Providers Since the Implementation of their Mandatory Orientation Process

The Division of Medicaid should continue monitoring the number of home care provider agencies that apply and are approved to provide waiver services since the implementation of their mandatory orientation process. In addition, DOM should consider expanding the current orientation process to periodically require existing providers to attend as well, at least after any substantive requirement changes have occurred to the waiver.

While the Division of Medicaid cannot enact a moratorium on new providers itself, it does now require any applicant seeking to be approved as an active home care provider agency to undergo a mandatory orientation process. DOM staff noted that upon enacting this mandatory orientation process, the overall number of new prospective provider applicants decreased.

According to Division of Medicaid staff, mandatory orientation is now required for any applicant seeking to be approved as an active home care provider agency. This orientation process began in January 2019 following Administrative Code updates (effective December 1, 2018) and is provided by DOM staff quarterly. An application to become an active provider will not be reviewed until the orientation process has been completed.

The Division of Medicaid Administrative Code, Title 23: Part 208, Chapter 1, *Rule 1.3* states that the provider:

be approved by Division of Medicaid after attending mandatory orientation and submitting a completed proposal package to the Office of Long-Term Care.

This orientation process was designed to provide potential applicants with an overview of the five 1915(c) home and community-based waivers provided through Medicaid, as well as any applicable rules and requirements listed within either the Division of Medicaid Administrative Code and within the Quality Assurance Standards.

The orientation process also covers the steps that must be followed to complete the application process. It highlights how often and by whom an approved provider will be monitored and audited. For example, it states that “DOM audits all waiver providers annually.” The orientation process also goes into more details on the administrative and staffing requirements for providing adult day care services, personal care services, and in-home respite services. Lastly, it provides an overview of the Mississippi electronic visit verification system (MediKey).

Division of Medicaid staff noted that the primary goal of requiring potential provider applicants to undergo this orientation is to ensure a certain level of quality by the potential service provider by establishing the expectations and what is actually required prior to submitting a proposal. This way the applicant will clearly understand and be informed on what all is required to be an active home care provider once approved. Any already approved and active home care providers do not have to attend the orientation process.

While it is not a moratorium, DOM staff did state that upon enacting the mandatory orientation the overall number of prospective provider applicants decreased. Exhibit 8, on page 59, lists the number of prospective provider applicants who applied, the number that were approved by Medicaid as an active provider, and the percentage of applicants approved for both personal care services and in-home respite services from State Fiscal Years 2012 through 2020.

In State Fiscal Year 2019, only four out of 38 prospective applicants were approved to be personal care service providers. In State Fiscal Year, 2020, there have been no approved providers for personal care services, as of October 18, 2019.

Exhibit 8: Number of Home Care Providers who have Applied to the Service the Elderly and Disabled Waiver, State Fiscal Years 2012 through 2020

State Fiscal Year		Personal Care	In-Home Respite
2012	Proposals Received	0	30
	Proposals Approved	0	15
	Percentage Approved	0%	50%
2013	Proposals Received	45	42
	Proposals Approved	12	17
	Percentage Approved	27%	40%
2014	Proposals Received	74	38
	Proposals Approved	20	7
	Percentage Approved	27%	18%
2015	Proposals Received	94	60
	Proposals Approved	30	15
	Percentage Approved	32%	25%
2016	Proposals Received	93	75
	Proposals Approved	30	25
	Percentage Approved	32%	33%
2017	Proposals Received	67	50
	Proposals Approved	15	13
	Percentage Approved	22%	26%
2018	Proposals Received	86	78
	Proposals Approved	20	20
	Percentage Approved	23%	26%
2019	Proposals Received	38	40
	Proposals Approved	4	6
	Percentage Approved	11%	15%
2020	Proposals Received	6	6
	Proposals Approved	0	0
	Percentage Approved	0%	0%

SOURCE: DOM staff, as of October 18, 2019.

Recommendations

- 1) The Division of Medicaid should continue to monitor the reimbursement rates and update the actuarially-sound rates upon any substantive program changes, as warranted.
- 2) Upon implementation of the enhancements to the state's national background check system, which integrates the current FingerPro system with the RapBack system, the Mississippi State Department of Health should work with the Division of Medicaid to inform home care provider agencies of the counties and locations of the background check kiosks that will perform fingerprint scans as an option for them to conduct national criminal background checks on their employees and volunteers. Furthermore, the Mississippi State Department of Health should periodically examine the utilization of these fingerprint devices to ensure optimal placement.
- 3) The Division of Medicaid and the Mississippi State Department of Health should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system in conducting fingerprint checks. When this agreement is finalized, the DOM should inform all of the existing Medicaid-approved providers of personal care services and in-home respite services about the access to this system.
- 4) The Division of Medicaid should continue to obtain feedback from the Medicaid-approved home care provider agencies regarding the user interface of the state's electronic visit verification system, MediKey, to identify potential areas for improvement and when opportunities for technical assistance and training may be needed. The Division of Medicaid should also continue working with FEI Systems on any business and operational improvements to MediKey, as necessary.
- 5) The Division of Medicaid should review, update, and align the requirements within the CMS-approved Elderly and Disabled Waiver program application, the requirements set forth in Administrative Code Title 23, and the Personal Care Services Quality Assurance Standards specific to personal care attendants. The Division of Medicaid should then clearly communicate to all active and future Medicaid-approved home care provider agencies on the existing requirements, as well as clarify any newly-created or previously-eliminated requirements.
- 6) The Mississippi State Department of Health should continue to work with the home care provider agencies to identify a feasible option in the development of a training program or mechanism to allow for the recertification of Certified Nurse Aides who are under the employ of these home care providers.

- 7) The Division of Medicaid should continue monitoring the number of home care provider agencies that apply and are approved to provide waiver services since the implementation of their mandatory orientation process.
- 8) The Division of Medicaid should consider expanding the current orientation process for prospective personal care service applicants and in-home respite service applicants to require existing providers to attend as well. The Division of Medicaid could require this periodically or after any substantive requirement changes, as warranted. This could potentially provide clarification on the current requirements for providing services through the Elderly and Disabled Waiver program.
- 9) The Division of Medicaid should periodically review the service provider selection and placement of waiver participants periodically by both planning and development district and provider agency. This would allow for an additional method to monitor referrals to identify any case management agencies who may have disproportionately referred waiver participants to services within their own agency.
- 10) The Division of Medicaid should consider the potential for implementing and measuring health-outcome quality metrics for their home and community-based services waiver programs. For example, since the purpose of the Elderly and Disabled Waiver program is to allow participants to stay in their home and community instead of institutionalization, the Division of Medicaid could potentially measure how long the participant receives services before transitioning to an institutional setting, or how often the participant in the waiver is admitted to an emergency room department for care.
- 11) The Division of Medicaid should continue exploring the feasibility of potential options for improvements to providing long-term services and supports, such as value-based payments.

Appendix A: 2018 Standard Occupational Classification Manual Definitions

The 2018 SOC classifies most of the direct care workforce within the overarching category of *31-0000 Healthcare Support Occupations*. These can be broken down further into the sub-categories of *31-1120 Home Health and Personal Care Aides* and *31-1130 Nursing Assistants, Orderlies, and Psychiatric Aides*.

Within the sub-category of *31-1120 Home Health and Personal Care Aides*, the 2018 SOC provides the following details on what role and duties define these occupations:

- ***31-1121 Home Health Aides*** - Monitor the health status of an individual with disabilities or illness, and address their health-related needs, such as changing bandages, dressing wounds, or administering medication. Work is performed under the direction of offsite or intermittent onsite licensed nursing staff. Provide assistance with routine healthcare tasks or activities of daily living, such as feeding, bathing, toileting, or ambulation. May also help with tasks such as preparing meals, doing light housekeeping, and doing laundry depending on the patient's abilities.

Examples of employee titles for this occupational classification include: Home Health Aide, Home Health Attendant, and Home Hospice Aide.

- ***31-1122 Personal Care Aides*** - Provide personalized assistance to individuals with disabilities or illness who require help with personal care and activities of daily living support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). May also provide help with tasks such as preparing meals, doing light housekeeping, and doing laundry. Work is performed in various settings depending on the needs of the care recipient and may include locations such as their home, place of work, out in the community, or at a daytime nonresidential facility.

Examples of employee titles for this occupational classification vary widely and include: Blind Escort, Elderly Companion, Geriatric Personal Care Aide, Home Care Aide, and Personal Care Attendants.

Within the sub-category of *31-1130 Nursing Assistants, Orderlies, and Psychiatric Aides*, the 2018 SOC provides the following details on what role and duties define the nursing assistant occupation:

- ***31-1131 Nursing Assistants*** - Provide or assist with basic care or support under the direction of onsite licensed nursing staff. Perform duties such as monitoring of health status, feeding, bathing, dressing, grooming, toileting, or ambulation of patients in a health or nursing facility. May

include medication administration and other health-related tasks. Includes nursing care attendants, nursing aides, and nursing attendants. Excludes "Home Health Aides" (31-1121), "Personal Care Aides" (31-1122), "Orderlies" (31-1132), and "Psychiatric Aides" (31-1133).

Examples of employee titles for this occupational classification include: Certified Nurse Aide, Certified Nursing Assistant, and Nursing Care Attendant.

SOURCE: 2018 Standard Occupational Classification Manual.

Appendix B: 2017 North American Industry Classification System (NAICS)

The 2017 North American Industry Classification System (NAICS) developed by the Executive Office of the President, Office of Management and Budget (OMB), provides the following industry descriptions:

- **621610 Home Health Care Services** - *This industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.*

Examples of these industries include: Home Health Care Agencies, Home Infusion Therapy Services, In-Home Hospice Care Services, and Visiting Nurse Associations.

- **624120 Services for the Elderly and Persons with Disabilities** - *This industry comprises establishments primarily engaged in providing nonresidential social assistance services to improve the quality of life for the elderly, persons diagnosed with intellectual and developmental disabilities, or persons with disabilities. These establishments provide for the welfare of these individuals in such areas as day care, non-medical home care or homemaker services, social activities, group support, and companionship.*

Examples of these industries include: Non-Medical Home Care Providers, Homemaker Service Providers, Self-Help Organizations, Companion Service Providers, Adult Day Care Centers, and Activity Centers for Older Adults and People with Disabilities.

SOURCE: 2017 North American Industry Classification System (NAICS), Office of Management and Budget (OMB).

Appendix C: Personal Care Attendant Requirements

Each personal care attendant must meet the following minimum requirements:

- (a) Be a high school graduate, have a GED or must demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits;*
- (b) Successfully complete a curriculum training course covering topics as defined by the Division of Medicaid and pass a scored examination upon hire prior to rendering services, and annually thereafter. All new hire training must include a hands-on skills assessment to ensure the trainee's ability to provide the necessary care safely and appropriately;*
- (c) Demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity and exhibit basic qualities of compassion and maturity and be able to respond to waiver persons and situations in a responsible manner;*
- (d) Be at least eighteen (18) years of age;*
- (e) Possess a valid state issued identification, and have access to reliable transportation;*
- (f) Be able to function independently without constant observation and supervision;*
- (g) Be physically and mentally able to perform the job tasks required, including lifting and transferring, and provide assurance that communicable diseases of major public health concern are not present, as verified by a physician;*
- (h) Have interest in, and empathy for, persons who are ill, elderly, or disabled;*
- (i) Have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people;*
- (j) Maintain current and active first aid and CPR certification; and,*
- (k) Be able to carry out and follow verbal and written instructions.*

All personal care attendants must successfully complete a 40-hour curriculum training course upon hire prior to rendering services. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three years as a nurse aide, orderly, nursing assistant, or an equivalent position by one of the above medical facilities shall be deemed to meet these initial training requirements.

DOM allows the providers to develop their own 40-hour curriculum training course as long as it covers each of the following topics:

- *Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation*
- *Participant Rights and Dignity*
- *Crisis Prevention and Intervention*
- *Caring for Participants with Alzheimer's/Dementia*
- *Care of Participants with Mental Illness*
- *How to Deal with Difficult Participants*
- *Assisting with Activities of Daily Living*
- *Assisting with IADLs including Meal Preparation and Housekeeping*
- *HIPPA Compliance*
- *Recognition and Care of Individuals with Seizures*
- *Elopement Risks*
- *Safe Operation and Care of Individuals with Assistive Devices*
- *Caring for Individuals with Disabilities*
- *Safety including Preventing and Reporting of Accidents/Incidents*
- *Professional Documentation Practices*
- *Signs and Symptoms of Illness*
- *Emergency Preparedness*
- *Universal Precautions and Infection Control*
- *Person Centered Thinking*

DOM requires that each new hire also perform a skills demonstration for tasks associated with providing personal care services. New hires must also complete CPR certification and receive First Aid training.

DOM also requires that personal care attendants must successfully complete an annual curriculum training course covering at a minimum each of the following topics:

- *Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation*
- *Participant Rights and Dignity*
- *Crisis Prevention and Intervention*
- *How to Deal with Difficult Participants*
- *HIPPA Compliance*
- *Safety including Preventing and Reporting of Accidents/Incidents*
- *Professional Documentation Practices*
- *Emergency Preparedness*
- *Universal Precautions and Infection Control*
- *Person Centered Thinking*

In addition to the above, each personal care attendant must have both CPR certification and First Aid training and maintain these two requirements annually.

SOURCE: DOM Administrative Code and the Elderly and Disabled Waiver.

Appendix D: Elderly and Disabled Waiver Fact Sheet

Eligibility:

To qualify for the Elderly and Disabled Waiver, you must meet the following eligibility criteria:

- You must be age 21 or older.
- You may qualify by either Supplemental Security Income (SSI) or 300 percent of SSI. If income exceeds the 300 percent limit, you must pay the amount that is over the limit each month to the Division of Medicaid under an income trust, provided you are otherwise eligible.
- You must be determined clinically eligible through the use of a comprehensive Long-Term Services and Supports (LTSS) assessment tool.
- You must require nursing facility level of care if assistance is not provided.
- Your nursing facility level of care must be certified by a physician and re-certified every 12 months at a minimum.

Covered Services:

Upon approval of home and community based-services, the following services are offered through this waiver:

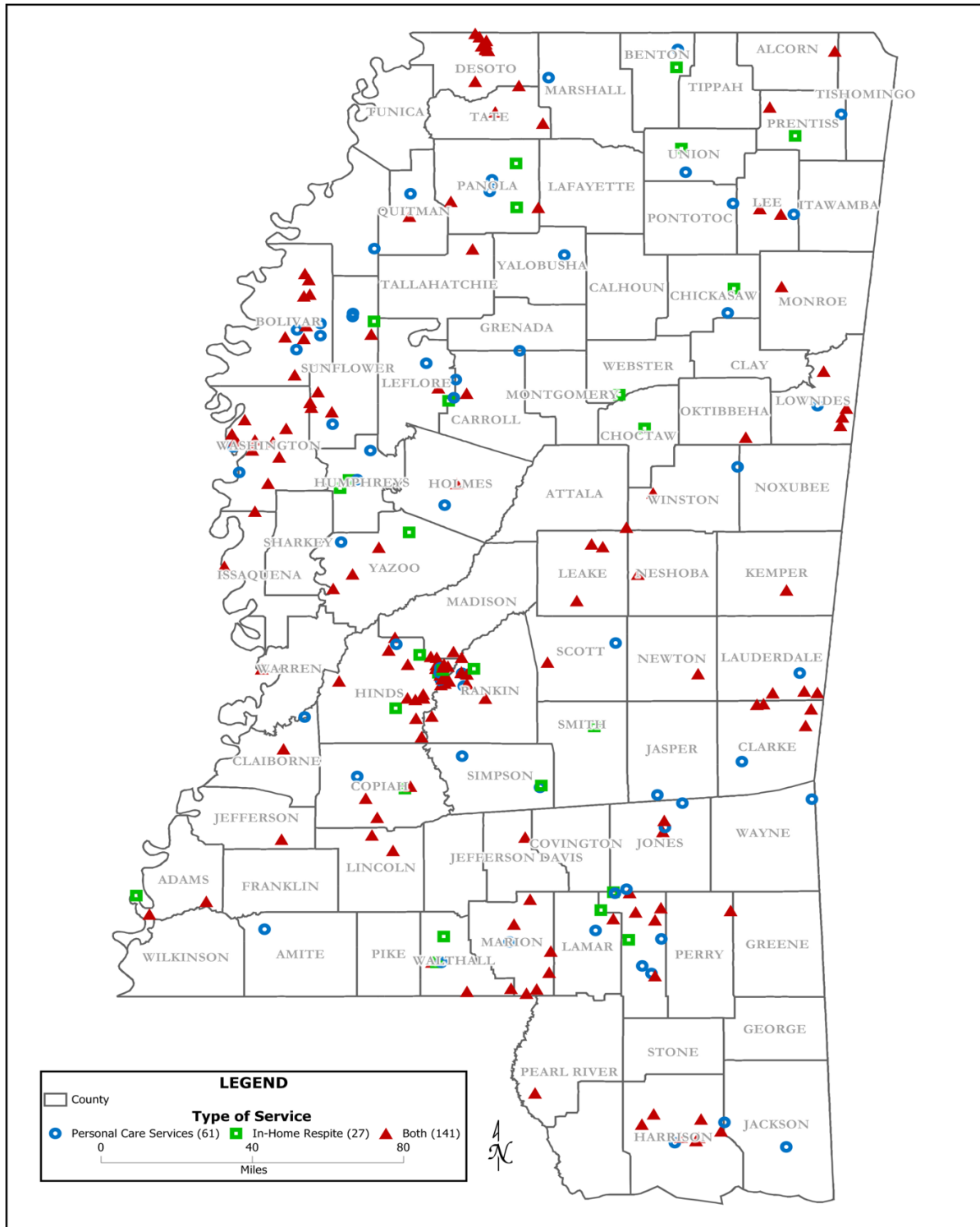
- **Case management** is a required service and you are assigned to a local case management team. The team consists of a registered nurse and licensed social worker. They are responsible for assessing your health, welfare, and social needs; developing a plan of services and supports; and managing and coordinating services on the plan of services and supports.
- **Adult day services** are for aged and disabled persons, and consist of the provision of services for part of a day at a day care program site. Adult day care is the arrangement of a structured, comprehensive program which provides a variety of health, social and related supportive services in a protective setting during the daytime and early evening. This community-based service is designed to meet the needs of aged and disabled people through an individualized care plan, including personal care and supervision, provision of meals, as long as meals do not constitute a full nutritional regimen, medical care, transportation to and from the site, social, health and recreational activities.
- **Extended home health services** are when home health benefits under the State Plan have been exhausted. People in the Elderly and Disabled Waiver program are eligible for extended home health services. These services include:

skilled nursing, nurse aide, physical therapy and speech therapy.

- **Home delivered meals** are well-balanced meals delivered to your home if you are unable to leave without assistance, unable to prepare your own meals, and/or have no responsible caregiver in the home.
- **In-home respite services** are provided if you cannot be left alone or unattended. It provides non-medical care and supervision/assistance if you are unable to care for yourself in the absence of your primary full-time, live-in caregiver(s) on a short-term basis. Services are rendered to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization.
- **Institutional respite services** are provided if you cannot be left alone or unattended. It provides non-medical care and supervision/assistance if you are unable to care for yourself in the absence of your primary full-time, live-in caregiver(s) on a short-term basis. Services are rendered to provide assistance to the caregiver(s) during a crisis situation and/ or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the participant. Institutional respite services are provided in a hospital, nursing facility, or licensed swing bed facility by the facility staff.
- **Community transition services** are provided if you currently reside in a nursing facility and wish to transition from the nursing facility to the Elderly and Disabled Waiver. This is a one-time assistance of initial expenses required for setting up a household.
- **Personal care services** are non-medical support services to assist you in meeting daily living needs and ensure optimal functioning at home and/or in the community. Services include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Meal preparation and housekeeping chores may be provided if the care is essential to your health and welfare rather than your family. These services may also involve accompanying and assisting you in accessing community resources and participating in community activities; supervision and monitoring in your home, during transportation, and in the community setting.

SOURCE: Division of Medicaid *ELDERLY AND DISABLED WAIVER: Home and Community-Based Services Fact Sheet*.

Appendix E: Location of Medicaid-Approved Personal Care and In-Home Respite Providers in Mississippi¹



¹ These locations represent only the providers' primary offices and do not reflect any satellite offices. SOURCE: PEER created from information provided by Division of Medicaid staff, as of October 7, 2019.

Appendix F: Medicaid Home Health Agency Rates (per visit), Effective October 1, 2018

Provider Name	Skilled Nursing Care	Physical Therapy	Speech Therapy	Home Health Aide
Alliance Home Care	\$119.24	\$65.00	\$65.00	\$42.89
Amedisys Home Health of Biloxi	119.24	65.00	65.00	39.05
Amedisys Home Health of Collins	110.39	65.00	65.00	38.76
Amedisys Home Health of Meridian	119.24	65.00	65.00	42.71
Amedisys Home Health of Vicksburg	119.24	65.00	65.00	38.20
Baptist Memorial Home Care	119.24	65.00	65.00	42.89
Comfort Care Home Health (South Central)	119.24	65.00	65.00	42.89
Continue Care Home Health - Cleveland	119.91	65.67	65.67	43.56
Continue Care Home Health - Hollandale	122.81	68.57	68.57	46.46
Delta Regional Medical Center Home Health	119.24	65.00	65.00	0
Forrest General Home Care	122.81	68.57	68.57	46.46
Forrest General Home Care of Marion	122.81	68.57	68.57	46.46
Gilbert's Home Health Agency	87.87	68.57	68.57	39.70
Gilbert's Home Health Agency of Calhoun City	85.44	68.57	68.57	38.71
Gilbert's Home Health Agency of Columbus	78.77	68.57	68.57	35.33
Gilbert's North MS Home Health	78.09	68.57	68.57	36.29
Home Health Care Systems, Inc.	117.06	67.29	67.29	45.18
Kare-In-Home Health Services, Inc.	113.89	65.93	65.93	43.82
Magna Home Health	85.75	66.24	66.24	36.38
Magnolia Regional Health Center Home Health	122.81	68.57	68.57	46.46
Medgar Evers Home Health Agency	60.42	65.00	65.00	42.89
Mid-Delta Home Health of Charleston	102.52	68.57	68.57	46.46
Mid-Delta Home Health, Inc.	103.85	68.57	68.57	45.40
Mississippi HomeCare of Eupora	86.83	65.00	65.00	42.89
Mississippi HomeCare of Jackson	109.25	65.00	65.00	42.89
Mississippi HomeCare of Picayune	106.38	65.00	65.00	42.89
Mississippi HomeCare of Richton	92.72	65.00	65.00	42.89
Mississippi HomeCare of Vicksburg	119.24	65.00	65.00	41.96

North MS Medical Center HHA	122.81	68.57	68.57	46.46
Pro-Care Home Health	119.24	65.00	65.00	42.89
Quality Home Health Care of the Gulf Coast, Inc.	119.40	65.16	65.16	43.05
SAAD Home Nursing Services of MS	116.45	65.00	65.00	42.89
South MS Home Health, Inc. - Region I	106.86	65.00	65.00	42.89
South MS Home Health, Inc. - Region II	113.42	65.00	65.00	42.89
Southern Home Care	122.81	68.57	68.57	46.46
St. Luke Home Health Care Services	122.81	68.57	68.57	45.75
Sta-Home Health Agency of Carthage	117.50	66.03	66.03	43.92
Sta-Home Health Agency of Greenwood	121.61	67.37	67.37	42.88
Sta-Home Health Agency of Jackson	122.81	68.57	68.57	38.64
Sunflower Home Health	118.69	65.00	65.00	35.28
Tender Loving Care	106.80	65.00	65.00	34.81
UMMC Grenada Home Health Agency	122.81	68.57	68.57	46.46
Van Winkle Home Health Care	101.16	65.00	65.00	42.69
Wayne General Hospital HHA	122.81	68.57	68.57	46.46

SOURCE: Division of Medicaid staff.

Appendix G: Historical Medicaid Reimbursement Rates for Personal Care and Homemaker Services

Personal Care Services:

Waiver Service	Begin Date	End Date	Rate (per 15-minute unit)
Personal Care Services	07/01/2017	Current	\$4.41
	07/01/2015	06/30/2017	\$4.24
	01/01/2015	06/30/2015	\$4.16
	07/01/2012	12/31/2014	\$4.00

Homemaker Services:

Waiver Service	Begin Date	End Date	Rate (per 15-minute unit)
Homemaker Services	03/01/2011	06/30/2013	\$5.56
	10/01/2010	02/28/2011	\$4.86
	07/01/2006	09/30/2010	\$4.15
	10/01/2003	06/30/2006	\$3.42

Waiver Service	Begin Date	End Date	Rate (per hour)
Homemaker Services	07/01/2000	09/30/2003	\$13.65
	07/01/1999	06/30/2000	\$11.39
	07/01/1998	06/30/1999	\$10.85
	09/01/1997	06/30/1998	\$10.34
	07/01/1996	08/31/1997	\$9.85
	07/01/1995	06/30/1996	\$9.38
	07/01/1994	06/30/1995	\$8.93
	10/01/1991	06/30/1994	\$8.50
	08/01/1991	09/30/1991	\$7.56
	10/01/1986	07/31/1991	\$7.20

SOURCE: Division of Medicaid staff.

Appendix H: Personal Care Services Quality Assurance Standards (revised January 2019)

The Division of Medicaid (DOM) Quality Assurance Standards set forth in this document defines required standards of practice for each provider to follow while providing Medicaid home and community-based personal care services (PCS). In addition to the Quality Assurance Standards, all providers of Elderly and Disabled Waiver services must satisfy all requirements set forth in Title 23 Miss. Administrative Code and the CMS-approved Elderly and Disabled Waiver application.

Personal Care Services are:

- Non-medical support services;
- Provided to assist participants in meeting daily living needs;
- Provided in the home and/or community of the waiver participant;
- Provided to ensure optimal functioning at home, during transportation, and/or in the community;
- Provided to assist the participant in accessing and participating in community resources; and,
- Intended to prevent, delay or avoid premature institutionalization of the participant.

Physical Office must be/have:

- Located in Mississippi,
- Accessible to participants, caregivers, and employees,
- No more than sixty (60) minutes from counties served or a satellite office will be required,
- Located in a non-residential building zoned for business,
- Maintained until the provider agreement is terminated,
- Signage matching the business name on the proposal,
- A working landline phone,
- Open daily, 8am-5pm, Monday-Friday,
- Secure Health Insurance Portability and Accountability Act (HIPAA) compliant storage for participant records.

Period of Approval:

The Medicaid Provider Agreement and the period of certification for the Home and Community-Based Services (HCBS) Waiver service providers will be open ended and will continue to be in force, subject to the provisions of the agreement.

Qualification of Approved PCS Provider Agencies Approval:

To be approved as a PCS provider, an agency must provide written documentation to the Division of Medicaid stating how it will meet the following standards:

1. There shall be a Medicaid Provider Agreement in which the provider agrees to the Home and Community-Based Waiver requirements.
2. There shall be a dually constituted authority and a governing structure for assuring responsibility and for requiring accountability for performance. (i.e. Board of Directors)
3. There shall be responsible fiscal management.
4. The unit rate for service that shall not exceed the amount stipulated in the Medicaid fee schedule.
5. There shall be responsible personnel management including:
 - a. Appropriate process used in the recruitment, selection, retention, and termination of Personal Care Attendant (PCA) staff, and;
 - b. Written personnel policies and job descriptions.
6. There shall be a roster of PCA Staff who are trained and available as back-up PCA staff for scheduled services.
7. There shall be written criteria for service provision, including procedures for dealing with emergency service requests.

PCS Agency Provider Standards:

PCS services must be provided by the PCS agency according to the approved Plan of Services and Supports (PSS) and by the following PCS agency provider standards. The PCS agency will:

1. Employ only (noncontract) persons qualified to perform PCS duties according to the Quality Assurance Standards as set by the Division of Medicaid (DOM);
2. Comply with all state and federal laws and regulations and labor laws;
3. Make appropriate PCA-participant assignments, considering both needs of the participant and the ability of the PCA staff, i.e.: physical dependencies and cultural preferences of the participant with the training and experience of the PCA Staff;
4. Provide only the units of service approved in the PSS authorized by the Case Manager;
5. Maintain regular channels of communication with the PCA staff in order that any change or requests for change is handled within at least one (1) business day, and in a manner that does not place the participant in jeopardy;
6. Assure that participant/care giver complaints and concerns regarding PCS are handled timely and documented, and that the documentation addresses the matter satisfactorily;
7. Evaluate new participants within three (3) business days of referral, unless specified by the Case Managers, and initiate PCS specified by the Case Managers; and,
8. Maintain written procedures regarding the reporting and recording of incidents when an unusual situation such as participant or worker injury, participant refusing services, thefts, etc., occurs during the delivery of services.

Staffing Requirements and Responsibilities:

- A. The PCS provider shall ensure the agency has an adequate number of full-time and part-time staff to cover the serviced counties.
- B. There shall be a Director/Compliance Officer responsible for ensuring overall program compliance.

The Director/Compliance Officer shall have the following qualifications:

- 1. A Bachelor's Degree in Social Work, or a related profession, with one year of direct experience working with aged and disabled participants, and two years of supervisory experience, or
- 2. A Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), with one year of direct experience working with aged and disabled participants, and two years of supervisory experience, or
- 3. A high school diploma with four years of direct experience working with the aged and disabled participants, and two years of supervisory experience.

Responsibilities include but are not limited to:

- 1. Ensuring continuing compliance with administrative code, provider agreement, all state and federal laws, quality assurance standards, and the waiver.
 - 2. Ensuring all mandatory training and certifications are completed timely.
 - 3. Ensuring all background checks are completed timely and maintained appropriately.
 - 4. Ensuring all OIG and Nursing Exclusion checks are completed timely and maintained appropriately.
 - 5. Ensuring all Corrective Action Plans are implemented appropriately if necessary.
 - 6. Ensuring immediate access to all participant and employee records as required for audit purposes.
- C. There shall be sufficient PCS supervisors employed to meet staffing ratios. Each one (1) supervisor may supervise a maximum of twenty (20) full-time equivalent PCA staff. If less than twenty PCA staff are working, only a pro rata share of a supervisor's time is needed. For example, if four full-time PCA staff are employed, then 20% of a supervisor's time would be required to meet this standard.

The PCA supervisor shall have the following qualifications:

- 1. At least two (2) years supervisory experience in programs dealing with elderly and disabled individuals and meet one (1) of the following requirements:
 - a. A Bachelor's Degree in Social Work, or a related profession, with one year of direct experience working with aged and disabled participants,
 - b. A Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), with one year of direct experience working with aged and disabled participants, and two years of supervisory experience, or
 - c. A high school diploma with four years of direct experience working with the aged and disabled participants, and two years of supervisory experience.

Responsibilities for the PCS supervisor include but are not limited to:

- 1. Supervising no more than twenty (20) full-time PCA staff;
- 2. Reviewing and approving service plans;

3. Receiving and processing requests for service;
 4. Observing and evaluating the PCA performing assigned tasks in the participants home;
 5. Performing supervised and unsupervised visits in the participant's home on a biweekly basis;
 6. Being accessible to PCA staff for emergencies, case reviews, conferences, and problem solving;
 7. Interpreting agency policies and procedures relating to the PCS program;
 8. Preparing, submitting, or maintaining appropriate records and reports;
 9. Planning, coordinating, and recording ongoing in-service training for the PCA staff;
 10. Reporting directly to the Agency's Director;
 11. Maintaining the regular, routine, activities of the PCS services program in the absence of the Director.
- D. There shall be sufficient PCA staff to ensure adequate provision of services to serviced counties.

The PCA staff shall have at a minimum:

1. Must be a high school graduate, have a GED, or demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits.

Additional requirements of the PCA staff are as follows:

1. Be at least 18 years of age;
2. Must demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity;
3. Possess a valid state issued ID, and have access to reliable transportation;
4. Must maintain current and active first aid and CPR certification;
5. Be physically able to perform the job tasks required and assurance that communicable diseases of major public health concern are not present, as verified by a physician;
6. Have interest in and empathy for, people who are ill, elderly, or disabled;
7. Be emotionally mature and able to respond to participants and situations in a responsible manner;
8. Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people;
9. Must not have been convicted of a crime substantially related to the dependent population or any violent crime;
10. Must be able to recognize the signs of abuse, neglect and/or exploitation and the procedures to follow as required in the Vulnerable Adult Act; and
11. Must have knowledge of how to prevent burns, falls, fires; and emergency numbers to contact emergency personnel if required.

Responsibilities of the PCA include, but are not limited to:

1. Provides the following personal care:
 - Mouth and denture care

- Shaving
 - Finger and toe nail care (no cutting)
 - Grooming hair - shampooing, combing, oiling
 - Bathing or bed bath - shower or tub (partial or complete)
 - Helps with dressing
 - Helps with toileting-bed pan, commode/chair, or urinal (emptying and cleaning)
 - Reminds waiver participant to take medication
 - Helps with eating
 - Transferring or changing the waiver participant's body position
 - Helps in ambulation
2. Providing the following housekeeping task:
- Assures that rooms are clean and in order
 - Prepares shopping lists
 - Purchases and stores groceries
 - Prepares and serves meals
 - Laundering, ironing, sweeping, mopping, and dusting
 - Run errands
 - Providing assistance/supervision during community outings
 - Cleans and operates equipment in the home such as the vacuum cleaner, stove, refrigerator, washer, dryer, and small appliances
 - Changes linen and makes the bed
 - Cleans the kitchen, including washing dishes, pots, and pans

Training:

- A. All direct care workers, including supervisors, unless otherwise excluded in the approved Elderly and Disabled Waiver, must successfully complete a 40-hour curriculum training course upon hire prior to rendering services covering each of the following topics:
- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation
 - Participant Rights and Dignity
 - Crisis Prevention and Intervention
 - Caring for Participants with Alzheimer's/Dementia
 - Care of Participants with Mental Illness
 - How to Deal with Difficult Participants
 - Assisting with Activities of Daily Living
 - Assisting with IADLs including Meal Preparation and Housekeeping

- HIPPA Compliance
- Recognition and Care of Individuals with Seizures
- Elopement Risks
- Safe Operation and Care of Individuals with Assistive Devices
- Caring for Individuals with Disabilities
- Safety including Preventing and Reporting of Accidents/Incidents
- Professional Documentation Practices
- Signs and Symptoms of Illness
- Emergency Preparedness
- Universal Precautions and Infection Control
- Person Centered Thinking

In addition to the above, providers must have the following training:

- CPR Certification
- First Aid

- B. Additionally, all direct care workers must successfully complete an annual curriculum training course covering at a minimum each of the following topics:
- Vulnerable Persons Act: Identifying, Preventing and Reporting of Abuse, Neglect and Exploitation
 - Participant Rights and Dignity
 - Crisis Prevention and Intervention
 - How to Deal with Difficult Participants
 - HIPPA Compliance
 - Safety including Preventing and Reporting of Accidents/Incidents
 - Professional Documentation Practices
 - Emergency Preparedness
 - Universal Precautions and Infection Control
 - Person Centered Thinking
- C. All training must include a scored examination to ensure retention of training information and materials by trainees.
- D. All new hire training must include a hands-on skills assessment to ensure the trainees ability to provide the necessary care safely and appropriately.
- E. All providers must maintain a current training plan as a component of their Policies/Procedures documenting their method of choice for the completion of required training. This training plan must be available to DOM upon request.

Documentation of completion of this training course must be maintained at the agency and be made available to the Division of Medicaid upon request. Failure of the Elderly and Disabled Waiver provider to comply with training requirements will require an acceptable plan of correction by the provider. Continued non-compliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.

Unit of Service:

One unit of service equals 15 minutes. Personal Care Service will be approved based upon needs. In some instances, Case Managers may allot a particular number of units for Community Assistance/Transportation (CAT) hours for the PCA to accompany the participant to medical appointments. In these instances, CAT hours are billed the same as regular PCS hours.

Minimum Program Requirements/Service Activities:

All providers of PCS under the Home and Community-Based Service Waiver program must adhere to the following minimum program requirements and service activities:

- A. The PCA staff must provide one or more of the following primary activities:
 1. Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. The provision of these services does not entail hands-on nursing care.
 2. Meal preparation may be provided only for the participant; however, the cost of meals is not covered.
 3. Housekeeping chores may be provided if the care is essential to the health and welfare of the individual, rather than the individual's family.
 4. May also involve hands-on assistance or cuing/prompting the person to perform a task;
 5. Accompanying and assisting the person in accessing community resources and participating in community activities; supervision and monitoring in the person's home, during transportation, and in the community setting. The Personal Care Attendant may accompany, when medically justified, persons during transport with transport provided by the Medicaid NET provider.
- B. Safety—The PCA staff should be aware of potential hazards in the participant's home environment and should do everything possible to ensure a safe environment for the participant, including but not limited to:
 1. Maintaining basic first aid and CPR certification;
 2. Ensuring use of proper sanitation/universal precautions;
 3. Following procedures to prevent burns, falls, and fires;
 4. Maintaining emergency numbers to contact emergency personnel if required; and,
 5. Recognizing signs of abuse, neglect, and/or exploitation and following the reporting procedures as required in the Vulnerable Adults Act.

Delivery Characteristics:

The following guidelines represent the basis by which PCA services must be provided. These guidelines serve as minimum instructions:

- A. Personal care services must be available as needed and flexible to meet the waiver participant's needs. At the least, must be available during the office hours Monday-Friday between 8:00 a.m. till 5:00 p.m.
- B. PCA staff must wear safety items such as gloves and partial facial masks when needed to prevent the spread of infections or diseases.

- C. PCA staff must wear uniforms that may consist of a smock top, a hospital scrub suit, lab jacket, apron, or other designated uniform. The uniform must be the same in color, style, and design for all PCA staff/supervisors in a particular agency. It is left to the discretion of the service provider to supply the uniform or require the staff to purchase them.
- D. PCA staff must maintain a clean, neat appearance at all times. Nails must be clean, neat, and short in length. PCA staff must wash their hands before and after coming in contact with participants.
- E. PCA staff must wear in plain view an identification (ID) badge or picture ID that contains the provider agency's name and the PCA staff member's name and title. It is left to the discretion of the provider to decide how the badge is designed or obtained.
- F. PCA staff must maintain HIPPA compliance and confidentiality of waiver participant information. (e.g., Do not discuss participant outside of the participant's home with anyone other than agency supervisory staff, do not photograph participant or their home for the purpose of sharing or posting on any social media site without prior written permission, etc.)
- G. In the absence of regularly scheduled staff, the participant should be offered immediate replacement staff. If the participant refuses a replacement, the Case Management Agency should be notified immediately.
- H. The PCS provider agency must purchase a generic cleaning supply kit for each PCA that can be carried to each home. However, these supplies will only be used if the waiver participant cannot provide supplies due to financial constraints.
- I. PCS may be furnished by family members if they are not legally responsible for the participant. Family members must be employed by a DOM-approved agency that provides PCS, must meet provider standards, and must be deemed competent to perform the required tasks.
- J. PCS services cannot be provided by anyone who resides in the home with the participant regardless of relationship.

Prohibited Service Activities:

The PCA staff may be faced with ethical issues while caring for a participant, and may be asked in the work place to perform tasks that are not part of the job description. The following activities are prohibited:

- A. Using the participant's car or transporting the participant;
- B. Consuming the participant's food, drink, or medications;
- C. Using the participant's telephone for any reason other than an emergency or for PCS related activities;
- D. Engaging in the discussion of personal problems, religious, or political beliefs with the participant/caregiver;
- E. Breaching the participant's confidentiality;
- F. Accepting any gifts or tips;
- G. Bringing friends, relatives, or other guests to the participant's home;
- H. Engaging in consumption of alcoholic beverages in the participant's home or consumption of alcoholic beverages before or during service delivery to the participant;
- I. Smoking in the participant's home;

- J. Soliciting money or goods from the participant/caregiver;
- K. Performing or engaging in yard maintenance;
- L. Performing or engaging in pet grooming;
- M. Performing or engaging in household repairs;
- N. Administering medication/injections or providing any other medical care;
- O. Using illegal drugs;
- P. Using abusive language in the participant's home;
- Q. Engaging in sexual misconduct with the participant or others residing in the home of the participant;
- R. Performing PCS for individuals in the home other than the participant;
- S. Engaging in heavy cleaning such as hanging or laundering curtains, waxing floors, or moving heavy furniture.

Communication with Case Management:

The Case Management Agency is the first line of contact with the participant and problem cases are reported to the Division of Medicaid. The PCS supervisor shall maintain regular and ongoing communication with the Case Management provider regarding case-managed PCS participants. Such communication will keep both the PCS provider and Case Manager informed of the participant's status, and will help in deciding whether to continue or terminate services.

- A. The Case Manager shall develop and direct the Plan of Services and Supports (PSS) for case-managed participants that are referred for personal care services.
- B. The PCS provider shall note on the record of contact all factual observation, contacts, or visits with the participant, and actions or behavior displayed by the participant. This documentation is essential in determining if changes should be made in the PSS. It is also essential to show that certain tasks were performed on certain dates and times. Furthermore, the case record documentation is a valuable source of information in case of legal action.
- C. PCA staff shall not allow or be subjected to sexual harassment or advances by participants. This kind of behavior should not be tolerated. The staff must firmly state to the participant and/or family member in the home that such behavior will be reported to the supervisor and Case Management staff. The participant and caregiver should be notified that the continuation of such behavior could jeopardize the service being received in the future.
- D. The PCS supervisor is to report immediately to the Case Management agency any participant situation that is, or may be harmful to the participant, and/or others, or any situation deemed potentially dangerous.
- E. A decision to terminate PCS is ultimately the responsibility of the Division of Medicaid. After the State has notified the Case Management agency that the PCS is being terminated, the Case Management agency provides to the participant written notification of the decision, the right to appeal, and the procedures for requesting an appeal. Participants receiving PCS may be terminated by DOM based on the following criteria:
 - 1. Death;
 - 2. Relocation out of state or services area;
 - 3. Increase of informal or formal support;

4. Improved health status or condition;
5. Participant and/or caregiver becomes abusive and belligerent, including sexual harassment;
6. Participant and/or caregiver refused services;
7. Caregiver/participant reports that he/she no longer needs the service;
8. Participant is placed in a long-term care facility;
9. Participant is not Medicaid eligible;
10. The participant's home environment is not safe for services to be rendered.

Any situation involving the above criteria must be reported to the PCS Supervisor and Waiver Case Manager, and documented in the participant's case record. In case of death or suspicions of abuse, neglect, or exploitation, the PCS Provider must report the incident to the Division of Medicaid Office of Long-Term Care and the Case Management Agency within 24 hours of the occurrence.

MediKey - Electronic Visit Verification (EVV) System:

MediKey is an electronic visit verification system designed to ensure the Division of Medicaid's mission of providing access to quality health care coverage for vulnerable Mississippians with accountability, consistency, and respect. The system automates the manual processes associated with provider agency submission of claims. The system is currently utilized by providers of PCS services on the Elderly and Disabled Waiver. Provider agency staff must clock-in/clock-out by calling into an automated visit verification system via the beneficiary's telephone land line. Beneficiaries without reliable land lines are assigned a one-time password (OTP) device that staff will use to clock in and out. The visit verification line will recognize if a device has been assigned and prompt the caller with instructions.

Requirements for the use of the MediKey system include, but are not limited to:

- A. PCS provider employees are prohibited from removing the one-time password (OTP) device from the home of the person if an OTP is being utilized.
 1. Removal of the OTP device from the person's home will result in the provider's inability to adequately substantiate the services billed, including the units of service; therefore, the provider will not be reimbursed for services billed during the time period that the OTP device was removed from the person's home.
 2. If it is discovered, post-payment, that the OTP device was being removed from the home, the provider will be required to refund the Division of Medicaid any money received from the Medicaid program for the time period that the OTP device was removed from the home [Refer to Miss. Admin. Code Part 305].
- B. The PCA must obtain and document the OTP codes designating service start and end times while in the home of the person, if not utilizing the person's telephone land line to substantiate services billed including the units of service.

To enroll please contact the LTSS helpdesk at 1-844-366-5877 or LTSSMississippiHelpDesk@feisystems.com.

Training materials for MediKey can be found at:

<https://evv-www-two.ltssmississippi.org/TrainingResource/TrainingResource/List/>

Compliance Monitoring, Evaluation, and Reporting:

The Division of Medicaid will monitor Personal Care Service providers at least annually.

- A. All professional, institutional, and contractual providers participating in the Medicaid program must:
 1. Maintain all records substantiating services rendered and/or billed under the program, and,
 2. Upon request, make such records available to representatives of the Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid (DOM), or the Mississippi Medicaid Fraud Control Unit (MFCU) in substantiation of any and all claims.
- B. All case records shall be retained for five years after the participant has been terminated from the program.
- C. If a participant has been terminated and re-enters the system within five years from the date of termination, the previous case record shall be retrieved and utilized.
- D. All case records shall be maintained in an area inside the office location that will protect confidentiality of information, and protection from damage, theft, and unauthorized inspection or use. The waiver participant's case record must consist of the following:
 - Copy of Referral form (copy form returned to Case Manager)
 - Plan of Services and Supports (PSS)
 - Record of Contact (used for documentation of visits and other pertinent information)
 - Activity Sheet
 - Emergency Preparedness Plan
 - Any other documentation relating to the participant's care

SOURCE: Personal Care Services Quality Assurance Standards (revised January 2019).

Appendix I: Nurse Aide Training Programs

MSDH-Approved Facility	County	Course Hours
Copiah-Lincoln Comm. College	Adams	100
Kosciusko Attala Co. Vo-Tech Center (Adult/Night Class)	Attala	80
Kosciusko Attala Co. Vo-Tech Center	Attala	720
Cleveland Career Development and Technology	Bolivar	100
Medical 2 Career College (Cleveland Career Development Tech Ctr.)	Bolivar	96
Calhoun Co. Career & Tech Center	Calhoun	80
J. Z. George High School	Carroll	275
J. Z. George High School (Adult/Night Class)	Carroll	100
Clarke County Vocational Center	Clarke	80
Coahoma Comm. College	Coahoma	90
MS Job Corps Center	Copiah	88
Copiah-Lincoln Comm. College	Copiah	100
Copiah-Lincoln Comm. College	Copiah	121
Blue Care Medical Academy	Desoto	76
Northwest MS Comm. College	Desoto	420
Pearl River Comm. College	Forrest	80
Simply the Best Kare	Forrest	80
MS Gulf Coast Comm. College (LPN/RN) (George County)	George	370
MS Gulf Coast Comm. College (NATP/noncredit) (George County)	George	80
MS Gulf Coast Comm. College (NATP/ for credit) (George County)	George	436
Holmes Comm. College	Grenada	80
Pearl River Community College	Hancock	96
MS Gulf Coast Comm. College (LPN/RN) (Jefferson Davis Campus/Primary Location)	Harrison	370
MS Gulf Coast Comm. College (NATP/noncredit) (Jefferson Davis Campus/Primary Location)	Harrison	80
Gulfport Job Corps Center	Harrison	110
Access Training Inc.	Hinds	115
Access Training Inc.	Hinds	80
Hinds Comm. College (LPN)	Hinds	312
Hinds Comm. College (Nurse Aide)	Hinds	100
Hinds Comm. College (Assoc. Degree Program)	Hinds	259
Hinds Comm. College (Nurse Aide)	Hinds	100
Hinds Comm. College	Hinds	100
Jackson Medical Mall HC Proprietary School	Hinds	130
Holmes Comm. College	Holmes	80

MS Gulf Coast Comm. College (LPN/RN)	Jackson	370
MS Gulf Coast Comm. College (NATP/noncredit)	Jackson	80
Jones County Junior College	Jasper	275
Jones County Junior College (Adult Night Class)	Jasper	120
Kaho Healthcare Training Facility	Jefferson	132
Dennis Fortenberry Career Center	Jefferson-Davis	120
Pearl River Comm. College (Adult Night Class) (Dennis Fortenberry Career Center)	Jefferson-Davis	120
Jones County Junior College (Health Care Assistant Curriculum)	Jones	275
Jones County Junior College (Adult/Night Class)	Jones	100
East MS Comm. College	Kemper	116
Northwest MS Comm. College	Lafayette	600
Meridian Comm. College (LPN)	Lauderdale	980
Meridian Comm. College (Nurse Aide)	Lauderdale	480
Leake Co. Vo-Tech Center	Leake	86
Itawamba Comm. College (Belden Campus)	Lee	96
Itawamba Comm. College (LPN)	Lee	412
Medical 2 Career College	Lee	96
MS Delta Comm. College (Summer) (Golden Age NH)	Leflore	80
MS Delta Comm. College (Golden Age NH)	Leflore	360
Kaho Healthcare Training Facility	Lincoln	124.5
McKellar Technology Center	Lowndes	80
East MS Comm. College (LPN)	Lowndes	320
East MS Comm. College (Nurse Aide)	Lowndes	320
Madison Career & Tech Center (Nurse Aide)	Madison	450
Holly Springs Career & Technology Center	Marshall	80
Itawamba Comm. College (Monroe Co. Votech Center)	Monroe	96
Winona Career & Tech Center	Montgomery	260
Winona Career & Tech Center (Adult/Night Class)	Montgomery	260
East Central Comm. College (Philadelphia-Neshoba Co. Vo-Tech Center)	Neshoba	80
East Central Comm. College	Newton	80
Millsaps Career & Technology Center (Night Class)	Oktibbeha	75
Millsaps Career & Technology Center (High School)	Oktibbeha	80
Finch-Henry Job Corps Center	Panola	103
Pearl River Comm. College (Poplarville Campus)	Pearl River	100
Southwest MS Comm. College	Pike	600
Northeast MS Comm. College	Prentiss	120

Northeast MS Comm. College (Alcorn Co. Vocational Center)	Prentiss	120
Hinds Comm. College (LPN)	Rankin	312
Hinds Comm. College (Nurse Aide)	Rankin	100
Hinds Comm. College (Assoc. Degree Program)	Rankin	259
Copiah -Lincoln Comm. College	Simpson	100
MS Gulf Coast Comm. College (LPN/RN) (Perkinston Campus)	Stone	370
MS Gulf Coast Comm. College (Nurse Aide) (Perkinston Campus)	Stone	80
Burns Healthcare Institute	Sunflower	75
Northwest MS Comm. College	Tate	253
Tippah Co. Career & Tech Center (Northeast MS Comm. College)	Tippah	120
Hinds Comm. College (NATP)	Warren	100
Hinds Comm. College (LPN)	Warren	312
Greenville Technical Center	Washington	75
MS Delta Comm. College (Summer Classes)	Washington	78
MS Delta Comm. College	Washington	360
Wayne County Vo-Tech Center	Wayne	928
Wayne County Center (Jones County Junior College)	Wayne	275
East Central Comm. College (Louisville Career Advancement Center)	Winston	80
Stepping Stones Career College	Winston	120

SOURCE: Mississippi State Department of Health staff, as of September 24, 2019.

Appendix J: Nurse Aide Skills

SKILL 1 — HAND HYGIENE (HAND WASHING)

SKILL 2 — APPLIES ONE KNEE-HIGH ELASTIC STOCKING

SKILL 3 — ASSISTS TO AMBULATE USING TRANSFER BELT

SKILL 4 — ASSISTS WITH USE OF BEDPAN

SKILL 5 — CLEANS UPPER OR LOWER DENTURE

SKILL 6 — COUNTS AND RECORDS RADIAL PULSE

SKILL 7 — COUNTS AND RECORDS RESPIRATIONS

SKILL 8 — DONNING AND REMOVING PERSONAL PROTECTIVE EQUIPMENT (GOWN AND GLOVES)

SKILL 9 — DRESSES CLIENT WITH AFFECTED (WEAK) RIGHT ARM

SKILL 10 — FEEDS CLIENT WHO CANNOT FEED SELF

SKILL 11 — GIVES MODIFIED BED BATH (FACE AND ONE ARM, HAND AND UNDERARM)

SKILL 12 — MEASURES AND RECORDS ELECTRONIC BLOOD PRESSURE

SKILL 13 — MEASURES AND RECORDS URINARY OUTPUT

SKILL 14 — MEASURES AND RECORDS WEIGHT OF AMBULATORY CLIENT

SKILL 15 — PERFORMS MODIFIED PASSIVE RANGE OF MOTION FOR ONE KNEE AND ONE ANKLE

SKILL 16 — PERFORMS MODIFIED PASSIVE RANGE OF MOTION FOR ONE SHOULDER

SKILL 17 — POSITIONS ON SIDE

SKILL 18 — PROVIDES CATHETER CARE FOR FEMALE

SKILL 19 — PROVIDES FOOT CARE ON ONE FOOT

SKILL 20 — PROVIDES MOUTH CARE

SKILL 21 — PROVIDES PERINEAL CARE (PERI-CARE) FOR FEMALE

SKILL 22 — TRANSFERS FROM BED TO WHEELCHAIR USING TRANSFER BELT

SKILL 23 — MEASURES AND RECORDS MANUAL BLOOD PRESSURE

SOURCE: Pearson VUE Mississippi Nurse Aide Candidate Handbook, September 2019.

Agency Responses



MISSISSIPPI STATE DEPARTMENT OF HEALTH

December 2, 2019

Mr. James A. Barber, Executive Director
Joint Legislative Committee on Performance Evaluation
and Expenditure Review
501 North West Street, Suite 301-A
Jackson, MS 39201

Dear Mr. Barber,

Our team has reviewed the draft report “Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Waiver Program.” We appreciate PEER’s thorough analysis of the Mississippi State Department of Health’s Certified Nurse Aid Program and Criminal History Record Check Unit.

We agree with the PEER recommendation that “The Division of Medicaid and the Mississippi State Department of Health should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system in conducting fingerprint checks.” The Mississippi Division of Medicaid (MDOM) approached MSDH about three months ago to revise the current interagency agreement. MDOM requested our agency expand the fingerprinting capabilities of the Criminal History Record Check Unit to cover entities that are Medicaid providers of personal home care services and in-home respite services. That agreement is complete, and MSDH will continue to work with these providers to make sure they have access to the FingerPro system. Using this system, both a state and federal background check is conducted simultaneously resulting in shorter turnaround time.

To lessen the burden on home care providers of conducting background checks on employees every two years as required by Medicaid, MSDH urges the legislature to consider Rapback legislation. This system will allow MSDH to alert providers of employees that commit potentially disqualifying crimes as soon as the information is entered into the system by law enforcement. More importantly, this system would prevent people that have disqualifying crimes from working with our most vulnerable adults and children.

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PEER
Page 2
December 2, 2019

Regarding the concern that certified nurse aides (CNAs) employed by home care providers are unable to recertify under the current healthcare settings approved by MSDH, we agree that the development of a single recertification program for use by all home care provider agencies administered through the state's community colleges that take part in the initial certification of CNAs would be the solution that would give the most benefit to all parties. Because MSDH has a relationship with the community colleges, we offer our help in initiating a discussion to aid home care providers that use CNAs.

MSDH appreciates the opportunity to discuss the important work we do and appreciates the opportunity to work with your staff to offer solutions to providers of home care services in Mississippi.

Sincerely,

A handwritten signature in blue ink that reads "Thomas Dobbs". The signature is fluid and cursive, with the first name being more prominent.

Thomas Dobbs, MD, MPH
State Health Officer



MISSISSIPPI DIVISION OF
MEDICAID

December 5, 2019

James A. Barber, Executive Director
Mississippi Joint Legislative PEER Committee
PO Box 1204
Jackson, MS 39215-1204

Dear Mr. Barber:

This letter is in response to the November 15, 2019 correspondence regarding the draft PEER report entitled *Role of Personal Care Attendants in the Delivery of Services through the Medicaid Elderly and Disabled Program*. Division of Medicaid (DOM) staff reviewed the draft PEER report and submits the following responses:

- 1. The Division of Medicaid should continue to monitor the reimbursement rates and update the actuarially-sound rates upon any substantive program changes, as warranted.**

DOM agrees with the PEER recommendation to continue to monitor the reimbursement rates and update the actuarially-sound rates upon any substantive program changes, as warranted.

- 2. Upon implementation of the enhancements to the state's national background check system, which integrates the current FingerPro system to the Rapback system, the Mississippi Department of Health should work with the Division of Medicaid to inform home care provider agencies of the counties and locations of the background check kiosks that will perform fingerprint scans as an option for them to conduct national criminal background checks on their employees and volunteers. Furthermore, the Mississippi State Department of Health should periodically examine the utilization of these fingerprint devices to ensure optimal placement.**

DOM agrees with the PEER recommendation and will work with the Mississippi State Department of Health to provide education and notification to providers once the enhancements to the national background check system are complete.

- 3. The Division of Medicaid and the Mississippi Department of Health should continue the development of the interagency agreement that would allow home care providers access to the FingerPro system in conducting background checks. When this agreement is finalized, the DOM should inform all of the existing Medicaid-approved providers of personal care services and in-home respite services about the access to the system.**

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The Interagency Agreement between DOM and the Mississippi State Department of Health (MSDH) was finalized on November 21, 2019, and directs the MSDH to conduct background checks as outlined by DOM on waiver service providers including personal care attendants. DOM and MSDH are in collaboration to discuss the implementation strategy for this new process, and will provide additional guidance to providers via list serv and the Medicaid Provider Bulletin once the plan is finalized.

- 4. The Division of Medicaid should continue to obtain feedback from the Medicaid-approved home care provider agencies regarding the user interface of the state's electronic visit verification system Medikey to identify potential areas for improvement and when opportunities for technical assistance and training may be needed. The Division of Medicaid should also continue working with FEI Systems on any business and operational improvements to the Medikey system as necessary.**

DOM agrees with the PEER recommendation to continue working with FEI Systems to implement improvements in the Medikey system based on provider feedback. DOM has scheduled individual meetings with a variety of provider agencies to obtain additional feedback on Medikey functionality to incorporate in future upgrades.

- 5. The Division of Medicaid should work with the Centers for Medicare and Medicaid Services to amend the requirements within the most recent Elderly and Disabled Waiver submission to allow home care provider agencies to obtain CPR Certification from an online vendor as an additional option to in-person training.**

The Elderly and Disabled Waiver was amended with an effective date of 10/1/2019 to remove the language prohibiting online CPR certification. The amendment was approved by CMS on December 3, 2019, and DOM is currently working to update the Administrative Code and Quality Assurance Standards to be consistent with the waiver language.

- 6. The Division of Medicaid should review, update, and align the requirements within the CMS-approved Elderly & Disabled Waiver application, the requirements set forth in Administrative Code Title 23, and the Personal Care Services Quality Assurance Standards specific to personal care attendants. The Division of Medicaid should then clearly communicate to all active and future Medicaid-approved home care provider agencies on the existing requirements, as we as clarify any newly-created or previously-eliminated requirements.**

DOM added language to the Elderly and Disabled Waiver application as well as the Medicaid Administrative Code noting that providers must comply with the Quality Assurance Standards as defined by DOM. Additionally, DOM created a webpage dedicated to Home and Community Based Waiver providers where

training information and provider requirements are made available in an easy to access format. Communications were sent to all current personal care providers via a newly created email list serv on August 15, 2019 providing links to the new page on the DOM website as well as links to the Medicaid Administrative Code and the CMS approved waiver application. In addition to the creation of the webpage and provider list serv, DOM is working to create and implement provider type specific webinar training sessions in 2020 to improve provider education.

- 7. The Mississippi State Department of Health should continue to work with the home care provider agencies to identify a feasible option in the development of a training program or mechanism to allow for recertification of Certified Nurse Aides who are under the employ of these home care providers.**

DOM agrees with the PEER recommendation that the Mississippi State Department of Health continue to work with home care providers to pursue options to allow for recertification of Certified Nurse Aides who provide care in home settings.

- 8. The Division of Medicaid should continue monitoring the number home care provider agencies that apply and are approved to provide waiver services since the implementation of their mandatory orientation process.**

DOM agrees with the PEER recommendation to continue monitoring the number of applicants and approved providers.

- 9. The Division of Medicaid should consider expanding the current orientation process for prospective personal care service applicants and in-home respite service applicants to require existing providers to attend as well. The Division of Medicaid could require this periodically or after any substantive requirement changes, as warranted. This could potentially provide clarification on the current requirements for providing services through the Elderly and Disabled Waiver.**

DOM currently offers annual Provider Workshop training sessions in multiple locations across the state. Staff from the DOM Office of Long Term Care attend each session to present information on changes in requirements and answer provider questions. To offer a more flexible training solution for providers who are unable to attend in person, DOM is working to create and implement provider type specific webinar training sessions in 2020 to improve provider education. These sessions, once recorded, would be available to all providers via the dedicated Home and Community Based Service providers' page on the DOM website.

- 10. The Division of Medicaid should periodically review the service provider selection and placement of waiver participant by both planning and**

development district and provider agency. This would allow for an additional method to monitor referrals to identify case management agencies who may have disproportionately referred waiver participants to services within their own agency.

DOM agrees with the PEER recommendation to continue to periodically review the selection of service providers by waiver participants to ensure a conflict-free process.

11. The Division of Medicaid should consider the potential for implementing and measuring health-outcome quality metrics for their home and community-based services waiver programs. For example, since the purpose of the Elderly and Disabled Waiver is to allow participants to stay in their home and community instead of institutionalization, the Division of Medicaid could potentially measure how long the participant receives services before transitioning to an institutional setting, or how often the participant in the waiver is admitted to an emergency room department for care.

DOM agrees with the PEER recommendation to consider measuring additional quality health-outcome quality metrics for waiver populations. A team of DOM staff along with a representative from our Utilization Management/Quality Improvement Organization contractor participate in monthly meetings to discuss Long Term Services and Supports Quality Initiatives.

12. The Division of Medicaid should continue exploring the feasibility of potential options for improvements to providing long-term services and supports, such as value-based payments.

DOM agrees with the PEER recommendation to continue exploring options for improvements to the provision of long-term services and supports, including opportunities to implement value-based payment methodologies.

We appreciate the external review conducted by PEER and the opportunity to review and offer our responses. As always, your staff was courteous, professional, and thorough in preparing this report, and we look forward to implementing the recommendations. If you have any questions, please do not hesitate to contact my office.

Sincerely,



Drew Snyder
Executive Director

PEER Committee Staff

James A. Barber, Executive Director

Legal and Reapportionment

Ted Booth, General Counsel

Ben Collins

Barton Norfleet

Administration

Alicia Russell-Gilbert

Deborah Hardy

Gale Taylor

Quality Assurance and Reporting

Richard Boada

Tracy Bobo

Performance Evaluation

Lonnie Edgar, Principal Analyst

David Pray, Principal Analyst

Jennifer Sebren, Principal Analyst

Kim Cummins

Matthew Dry

Samuel Hearn

Matthew Holmes

Taylor Mullins

Sarah Williamson

Julie Winkeljohn

Ray Wright

Performance Accountability

Linda Triplett, Director

Kirby Arinder

Debra Monroe-Lax

Meri Clare Ringer

