PROVIDER PROCEDURE MANUAL

September 2012

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B2I PROVIDER PROCEDURE MANUAL

I) General

Bridge to Independence (B2I) is Mississippi's Money Follows the Person initiative, a six (6) year federal demonstration grant funded by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Bridge to Independence proposes to help rebalance the state's long-term care system by establishing a person-driven and sustainable long-term care system in which older adults (65+) as well as persons with physical, mental, intellectual and developmental disabilities living in qualified institutions have choice and access to a full array of quality services in the community.

The purpose of this manual is to set forth the minimum requirements for providers of Bridge to Independence (Money Follows the Person) transitional services. Bridge to Independence participants may receive transitional services for 365 days upon discharge from a qualified nursing home or intermediate care facility for the mentally retarded (ICF/MR). Transition Care Management, for the purpose of planning a discharge, is the only B2I service which the provider may bill while an individual is still residing in a qualified institution.

This manual also provides maximum annual service limits and the maximum limits for one-time allowable expenditures for supporting participants in transitioning to the community.

This manual has been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid Bridge to Independence demonstration grant. Bridge to Independence is a time-limited program meant to assist the state in developing best practices; therefore, the Provider Procedure Manual will be updated as needed to reflect identified needs and best practices. Medicaid will promptly inform providers of any changes that may be incorporated into long term policy.

It is the provider's responsibility to assure that the business's employees at all locations are knowledgeable of the demonstration grant requirements and have access to Medicaid and other information pertinent to the performance of their duties.

This manual provides information for the initial implementation of the B2I initiative. As the program evolves and automated systems are put in place, updates will be provided.

II) Staff Training

1) A minimum of 20 hours of initial in-service training (excluding orientation) are required the first year. Additionally, a minimum of 10 hours of in-service training are required annually thereafter.

2) Training areas include, but are not limited to:

   a) Person-Centered Planning (PCP), and

   b) Home and Community Based-Services.

III) Referrals and Eligibility Criteria

1) Referrals are identified in three (3) ways.

   a) Residents (NH and ICF/MR) and their caregivers may self-refer at any time.

   b) Individuals in Nursing Homes (NH) will be identified by answering "yes" to Question 500 B of the Minimum Data Set (MDS).

   c) Individuals in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) will be indentified by answering "yes" to the question "Would you like to speak to someone about returning to the community?" during their annual review.

2) Referrals are received by phone or secure fax (601) 359-6294 using the Initial Referral Form (DOM B2I.3). Should a nursing home use the electronic referral system, Transition to Community Referral (TCR) and indicate B2I. They will be contacted by phone to complete a B2I Initial Referral Form (DOM B2I.3).

3) Eligibility Criteria:

   a) Reside in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded for at least 90 consecutive days, less any short term rehabilitative days,

   b) At least one of the required 90 days must be funded by Medicaid,

   c) Qualify for one of the following Medicaid Home and Community-Based Services:

      1. Independent Living (IL) Waiver
      2. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver
      3. Intellectual Disability/Developmental Disability (ID/DD) Waiver
      4. Elderly and Disabled (E&D) Waiver
      5. Mental Health State Plan Services (Rehabilitation Option)

   d) Move to a qualified residence, which must pass a U.S. Department of Housing and Urban Development Housing Quality Standards inspection and is a:

      1. A home owned or leased by the transitioning individual or the individual's family member, or

2. An apartment leased to the transitioning individual, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control, or
3. A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

NOTE: Personal Care Homes (licensed/unlicensed) are not considered a qualified residence.

4) Services:

a) **Services available to each participant are dependent on Home and Community Based-Services the individual qualifies/receives. See Attachment A HCBS Services and 365-Day B2I Demo Supports.**

b) Providers must bill according to approved procedure codes. See Attachment B Procedure Code and Fee Schedules.

IV) Initial Referral Process

1) The B2I DOM staff receives Initial Referrals by fax or completes it by phone.

2) **Initial Referral (DOM Form B2I.3)** must be:

a) Completed with agreement and input from the individual and/or guardian. Referrals received from other sources, such as advocates, will be followed up with a call to the resident and/or guardian.

b) Completed as fully as possible.

c) Submitted to DOM B2I via the secure fax server (601) 359-6294.

d) Retained in the individual's record.

3) DOM staff contacts the individual or family to discuss providers, informed choice, and consent to participate. DOM staff asks permission to send provider information through NH social worker, ICF/MR Transition Coordinator.

4) DOM staff contacts NH Social Worker or ICF/MR Transition Coordinator and sends information on all possible providers asking him/her to:

a) Review options with potential participant,

b) Indicate provider choice and sign Freedom of Choice (DOM Form B2I.4), and

c) Return to DOM via secure fax.

5) **Freedom of Choice Selection Form (DOM Form B2I.4)**

a) The NH Social Worker (or designee), ICF/MR Transition Coordinator is responsible for discussing the provider options with the potential participant and obtaining individual's and/or guardian's signature(s) indicating choice.
b) The NH Social Worker, or designee, ICF/MR Transition Coordinator, will complete and fax form to DOM within five (5) business days.
c) The form is reviewed at DOM and faxed by DOM to chosen provider with Initial Referral form.
d) The form is retained in the individual's record.
e) Forms not received by at DOM within fourteen (14) days will be considered closed referrals.

6) Provider has ten (10) business days to initiate contact with potential participant and/or guardian to schedule face-to-face meeting to discuss B2I and program options.

7) The B2I provider is responsible for reviewing records of legal representation in the participant's medical file and obtaining signature of legal representative where appropriate on all B2I forms.

8) **Surrogacy Verification (DOM Form B2I.13)**

a) If participant has a designated surrogate, he/she must sign Surrogacy Verification (DOM Form B2I.13).

b) The form is retained in the individual's record.

9) At initial face-to-face meeting Consent to Participate Phase I (DOM Form B2I.5) is signed. Potential participant and/or guardian have seven (7) business days from date Phase I is signed to make a decision to pursue or decline B2I.

Consent to Participate Phase II (DOM Form B2I.3) is signed indicating decision.

NOTE: Phase II can be signed at initial meeting if the seven (7) business days are not needed to make decision.

10) **Consent to Participate (DOM Form B2I.5)**

a) The B2I provider is responsible for discussing the form and obtaining individual's and/or guardian's signature(s) on Phase I, II and III of the form.
b) The form is a three (3) phase form completed and signed by the individual and/or parent/guardian.
c) Phase I (Exploring Your Options) is signed after:
    1. Community Navigator explains B2I in full to the individual and/or parent/guardian. It does not obligate the potential participant.

2. The individual has seven (7) business days from date signed to make decision to pursue or decline B2I.

d) Phase II (Transition to Community Planning) is signed after:
   1. Potential participant has made an informed decision regarding B2I participation.
   2. Up to Seven (7) business days after initial meeting with Community Navigator

e) Phase III (Transitioning to the Community) is signed:
   1. At least than thirty (30) days before transitioning to the community.
   2. Potential participant has understanding that they will be moving from NH or ICF/MR to a qualified home in the community.

f) The form is retained in the individual's record and a copy is provided to the individual and/or guardian.

11) If potential participant consents to participate in Phase II of B2I, the following forms must be completed:

a) **Consent to Participate National Quality of Life Survey (DOM Form B2I.6)**

1. The B2I provider explains Consent to Participate National Quality of Life Survey to the participant and/or guardian.
2. Applicable forms are completed, signed by the participant and/or guardian, and witnessed.
3. The completed forms are retained in the participant's record and a copy is provided to the family.
4. Completed forms are sent to DOM B2I using the secure fax server (601) 359-6294.

b) **Contact Information Form (DOM Form B2I.7)**

1. The B2I provider completes Section I, pre-transition.
2. Update Section II once Phase III (Transitioning to the Community) of consent to participate is signed.
3. Update form as needed with any moves during 365 day transition period. (If needed use additional forms.)
4. Completed and updated forms are sent to DOM B2I using the secure fax server (601) 359-6294.

c) **Bill of Rights (DOM Form B2I.8)**

1. The B2I provider is responsible for explaining the individual's rights and responsibilities if they choose to participate, and for obtaining appropriate signatures.
2. The form is retained in the individual's record and a copy is provided to the individual and/or guardian.

The DOM-B2I staff is responsible for:

1. Reviewing the Initial Referral Form within three (3) working days of receipt,

2. Determining if the initial screening requirements have been met,

3. Contacting the referral source/resident/guardian for additional information in order to determine appropriateness for the program, and provider selection.

4. Determining appropriate provider options.

5. Contacting facility and ensure provider options are explored fully.

6. Ensuring Freedom of Choice is signed.

7. Signing and forwarding the Initial Referral Form and Freedom of Choice via fax to the B2I provider.

8. Notifying referral source and/or resident if initial eligibility requirements are not met.

The B2I Provider is responsible for:

1. Contacting the individual and/or guardian within 10 days of receipt of referral to schedule face-to-face visit.

2. Providing individual with information needed to make a decision regarding participation in Bridge to Independence. Giving the individual seven (7) business days to make decision to pursue or decline B2I. Community Navigator must initiate contact after seven (7) business days for a decision.

3. Notifying DOM of referral status via B2I Status Form (DOM Form B2I.9) and Consent to Participate Form (DOM Form B2I.6). These forms are retained in the individual's record.

V) Status Update

The B2I provider is responsible for notifying DOM B2I staff of an individual's status in the B2I Demonstration via the **B2I Status Form (DOM Form B2I.9)**. The B2I Status Form provides DOM updates on the individual's status and allows Envision payment system updates for tracking and billing purposes. This form must always accompany signed supporting documentation. (i.e., Consent to Participate or Discharge Form.) This form will be used for eight (8) actions:

a) **Referral Closure/Declined B2I**
   1. If potential participant declines services at Phase I or Phase II of Consent to Participate.
   2. Sections of form to be competed:

a. Date form completed,
b. Date of action, which is date declined B2I,
c. Individual name,
d. Medicaid number,
e. B2I provider information, contact name, telephone number, and office location,
f. Referrals made on participant's behalf at the time of closure or discharge, and
g. Other pertinent information, if needed.

3. Accompanied by Consent to Participate (B2I.5) indicating declination by signature (Phase I or Phase II).

b) **Pre-Transition Status (Participant are eligible for 180 days pre-transition status)**

1. If individual consents to B2I Phase II (Transitioning to Community Planning) of Consent to Participate.
2. Sections of form to be competed:
   a. Date form completed,
   b. Date of action, which is date Phase I is signed,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location
   f. Anticipated HCBS Waiver
   g. Other pertinent information, if needed.
3. Accompanied by Consent to Participate (B2I.5) indicating participation, Phase I and Phase II must be signed, Consent to Participate National Quality of Life Survey (B2I.6) and Contact Information (B2I.7) with Section I completed.

c) **Proposed Admission** (At least 30 days prior to proposed transition from the facility)

1. Transition date from facility has been proposed and POC and Safety Plan are ready for review.
2. B2I Phase III (Transitioning to the Community) of Consent to Participate has been signed.
3. Sections of form to be competed:
   a. Date form completed,
   b. Date of action, which is proposed date of transition from facility,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Type of qualified residence,
   g. Type of HCBS waiver or mental health rehab service, and
   h. Other pertinent information, if needed.
4. Accompanied by Consent to Participate (B2I.5) Phase III indicating transition

and Contact Information (B2I.7), with Sections I and II completed.

d) **Transition Verification**
1. Completed and Faxed Date of Transition to Verify Transition transpired
2. Sections of Form to be completed :
   a. Date form completed
   b. Date of Action, which is day of transition
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Type of Qualified Residence,
   g. Type of HCBS Waiver, and
   h. Other pertinent information
3. Accompanied by copy of 317 from facility indicating discharge from the facility.

e) **Discharge**:
1. B2I benefits are ending due to 365-day service limit being met, **or**
2. Voluntary/involuntary discharge before 365- day service limit is met, **or**
3. Discharge during the pre-transition process.
4. Sections of Form to be completed:
   a. Date form completed,
   b. Date of action, which is date of discharge,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Reason for discharge, giving specific information,
   g. Referrals made on participant's behalf at the time of closure or discharge, and
   h. Other Pertinent Information, if needed.
5. Accompanied by Discharge Form (B2I.11)

f) **In-active Status**
1. If individual is being placed into inactive status.
2. Sections of form to be completed:
   a. Date form completed,
   b. Date of action, which is date of discharge,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Referrals made on participant's behalf at the time of closure or discharge, and
   g. Other Pertinent Information, if needed

3. Accompanied by a written summary/justification of why participant is moving into inactive status and what steps have been taken to resolve the issue.

g) **Reinstate Active Status**

1. If substantial advancements have been made in issue that lead to inactive status
2. Section of form to be completed
   a. Date form completed,
   b. Date of action, which is date of discharge,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Other Pertinent Information, if needed
3. Accompanied by a written summary/justification of advancements made and next steps needed to complete successful transition.

4. The completed form must be submitted to DOM B2I, via the secure fax server (601) 359-6294.

h) **Extension**

1. If initial 180 days pre-transition status is nearing 150 days and there will not be a transition by 180 days but a transition is foreseeable within a 30 day extension. An extension request can be made.
2. Extension must be requested 30 days before the current pre-transition date ends.
3. Extensions will only be granted for 30 day periods.
4. Section of the form to be completed.
   a. Date form completed,
   b. Date of action, which is date of discharge,
   c. Individual name,
   d. Medicaid number,
   e. B2I provider information, contact name, telephone number, and office location,
   f. Other Pertinent Information, if needed
5. Accompanied by a written summary/justification of transition plan with dates of actions/events that will move the transition to completion.

VI) Plan of Care

1) Implementation timelines:

a) POC must be submitted for to DOM for review at least 30 days prior to participant's proposed enrollment (discharge from facility) into B2I.

1. POC must be retained in participant's record and contain:
   a. B2I services, amounts, provider and beginning and end dates.
   b. Other services received (regardless of payer source) including provider, amounts, and beginning and end dates.

c. Narrative of service supports, needs and outcomes.

b) DOM will notify B2I provider of approval, denial or changes of Plan of Care and Safety Plan via B2I status form DOM USE ONLY section

2) Provider monitoring of participant's POC:

a) Continuous: The POC is continuously monitored by the Community Navigator through phone and face-to-face contacts with the participant and/or family.

b) Monthly: The POC is reviewed monthly by the Community Navigator during the face-to-face visit and completes a progress note that is placed in the participant's record.

c) 60 days: The POC is reviewed at least every two (2) months through a person-centered planning team meeting.

d) As needed/requested: POC can be reviewed at any time when needs or circumstances have changed and/or the individual and/or guardian requests review.

VII) Safety Plan/ Risk Mitigation

A comprehensive and pro-active safety/risk mitigation plan developed to address any safety/risk that has been identified through discovery and planning.
Implementation timelines:

a) Safety/Risk Mitigation Plan must be submitted for review and approval at least 30 days prior to participant's proposed enrollment (discharge from facility) into B2I.

b) A Safety Plan must be approved and in place prior to discharge from facility by the Community Navigator with input from the participant and the person-centered planning team including the caregiver, discharging facility, community navigator, receiving providers (i.e., Waiver/Mental Health Rehab service provider). It must be signed no more than 30 days prior to discharge by the individual and/or guardian, the Community Navigator and receiving provider.

c) The Safety Plan must address any risks in the following categories and include a detailed mitigation plan for any cited areas of concern including, but not limited to:

1. Medical and physiological,
2. Behavioral and psychiatric,
3. Environmental (i.e., living conditions),
4. Financial,
5. Activities of daily living (i.e., loss of a home/loss of natural supports),
6. Service disruption,
7. Legal (i.e. prior convictions, recidivism risk),

8. Natural disaster plan (i.e., flooding and/or hurricane evacuation plan, including emergency contact information),
9. Other.

d) The Safety Plan also must include and/or address:

1. Twenty-four seven (24/7) contact number for B2I provider staff
2. Emergency contact numbers including 911, local sheriff's office, local hospital, and regional Community Mental Health Center, etc.
3. A written and oral explanation of appropriate response to emergencies (i.e. health or mental health emergency) versus situations in need of immediate attention (i.e. broken medical equipment or failure of a service provider to make an appointment)

e) A copy of the Safety Plan must be provided to anyone providing services to the participant including waiver case managers and peer supporters. The Safety Plan must be reviewed by the Community Navigator as needed and at a minimum, monthly during face-to-face contact. This review must be recorded in the participant's record.

f) DOM will notify B2I provider of approval, denial or changes of Plan of Care and Safety Plan via B2I status form DOM USE ONLY section

VIII) Services

1) **Transition Care Management (Community Navigation)**
Pre-discharge transition planning up to 180 days. As well as Transition care management up to 365 day after discharge from facility.

a) One B2I provider staff is assigned to a participant as the Community Navigator (CN). (Services are billed as one unit per 15 min for any case management service provided.)

b) All contacts Community Navigators make with, about and/or on behalf of a participant must be documented in narrative form in a Notes Section of the file and include:

1. Reason for the contact as well as the content.
2. All follow-up activities.
3. Calls from third parties.
4. The Community Navigators' activities in helping people get what they need.
5. Calls to providers, resources, etc., to ask questions about or discuss services or supports.
6. Calls from service providers or natural supports including:

a. Name,

b. Service agency,
c. Issue(s) discussed, and
d. Any necessary follow-up actions needed as a result of the call.
7. When, why, and what type of information is received about a person.
8. When, why, and what type of information is sent to another party about a person.
9. Any changes in services.
10. Other situations based on individual circumstances.

c) Documentation of services provided must include:

1. Date of the service.
2. Time of the service (beginning and end).
3. Type of contact (face-to-face, phone, e-mail, PCP activities, and meetings, etc.).
4. Who the contact was with (participant, family member, community resource, housing location, housing client participation, housing partners (specify)).
5. Summary of contact must address:
   a. Plan of Care (POC) (services and effectiveness, problems, successes),
   b. Crisis/Safety Plan (review for changes or updates),
   c. Health and welfare needs,
   d. Community needs, and
   e. Risk mitigation.
6. Community Navigator's signature.

d) Minimum service contact requirements include:

1. Face-to-face meeting with participant and interested parties must be scheduled within ten (10) days of B2I provider receiving referral.
2. At least one contact per week with family and/or participant. (Pre-Transition (up to 180 days) and 90 days Post-Transition).
3. At least one (1) face-to-face visit per month with participant (Pre- and Post-Transition).
4. At least one (1) person-centered planning team meeting every 30 days Pre-Transition and every 60 days Post-Transition). Initial PCP meeting must be held within the first 30 days after Consent to Participate Phase II is signed.
5. At least one (1) contact with assigned Waiver/Rehab Services Case Management per month to ensure service coordination (Post Transition).

e) In situations where a participant does not have a qualified residence identified, providers can bill for housing location under Transition Care Management.

1. Where possible, potential participants should be provided and shown at least three (3) housing options prior to a selection.
2. Medicaid encourages Transition Care Management providers to work closely with local housing partners and designated DOM B2I housing designees to identify housing options for participants.

3. To assist Medicaid and its designated housing partners in formulating a housing plan for the transitioning population, all Transition Care Management housing location services must be billed using modifier CG with the procedure code T1016 for Transition Case Management on the CMS 1500 form. Housing location includes time spent identifying housing options and/or cooperative work through partner entities to locate housing options.

f) A Community Navigator's case load is not to exceed 30 total participants or 10 in each of the categories listed below:

1. ***Active*** status refers to clients for whom a Community Navigator is providing Transition Care Management services on an ongoing basis as prescribed in the timeline above prior to transition up to 180 days and in the first 90 days after transition.
2. ***Inactive*** status refers to clients for whom a Community Navigator has completed all possible aspects of the person-centered planning process but clients' transitions have been put on hold pending resolve of a documented issue such as location of desired housing.
3. ***Post 90-days*** refers to participants for whom a Community Navigator is continuing to provide ongoing Transition Care Management services but whose primary health care oversight and management responsibilities have been turned over to appropriate waiver/CMHC case managers.

g) Qualifications for Transition Care Management (Community Navigation) must meet one of the following criteria listed below. **No one individual can serve as a participant's Community Navigator and traditional case manager.**

1. Social workers must be licensed to practice in Mississippi with a bachelor's degree in social work and have at least (1) one year of full-time experience in direct care service to older adults and persons with physical, intellectual and developmental disabilities, or serious mental illness.
2. Case managers must have at least (1) one year of relevant work experience AND be certified by the Department of Mental Health after a thorough program review indicates the program has met all case management standards for mental health providers as specified in the DMH Minimum Standards OR case managers must possess a bachelor's or master's degree in Rehabilitation Counseling or a related field.
3. Others with relevant experience and training and at least a bachelor's degree and one (1) year of work experience in a social or health service setting or comparable technical and human service training will be considered.

2) **Crisis Management**

A twenty-four hours a day, seven days a week (24/7) in person response to individuals in crisis during the 365 day eligible period. Initial contact may be via telephone, but in the event of a true crisis, staff will be available to meet with the individual in and any other members of the team of service providers to ameliorate the crisis and mainitain

the individual in the community.

a) The B2I provider must be available to the participant and/or guardian twenty-four hours a day, seven days a week (24/7) and ensure that after regular business hours:

    1. The phone is answered by a staff person and is not a recording or menu of options.
    2. The staff person who answers the phone has access to resources needed to assess and manage a crisis (i.e., Safety Plan) in order to triage the situation.

b) Documentation of services provided must be retained in the participant's record and include:

    1. Date of the service,
    2. Time of the service delivery (beginning and end),
    3. Description/summary of the service and resolution,
    4. Relevance of the service to the participant's POC,
    5. Signature of staff person providing service.

c) Services must be billed in 15 minute increments and are paid only when services are provided.

3) **Life Skills Training**

To assist individuals with transition to the community through independent living skills. Life skills may include but are not limited to, money management, the use of technology, accessing community resources and household functions.

a) Instruction of life skills to the participant must be provided by an employee of a B2I provider who has completed all training required by the provider.

b) Documentation of the Life Skills Plan must be retained in the participant's record and contain.

    1. Date of service plan,
    2. Life skills to be addressed,
    3. Activities used to meet the life skill need,
    4. Date of goals met/skills improved.

c) Documentation of services provided must be retained in the participant's record and contain:

    1. Date of the service,
    2. Time of the service delivery (beginning and end),
    3. Description of the service,
    4. Signature of staff person providing service.

d) Services must be billed in 15 minute increments, during which services are provided to assist the participant in re-acclimating to life in the community.

4) **Peer/Mentor Support Services**

To assist the transitioning individual throught the use of peers who may be able to share their own experience to reduce feelings of isolation and promote inclusion.

a) Include a wide range of activities to assist individuals in their individualized recovery/resiliency process.

b) Medicaid providers of Bridge to Independence peers are responsible for screening peers for emotional readiness and training peers to ensure competency in appropriate interaction with a participant and understanding of when a situation requires intervention by a licensed health care provider.

c) Peer supporters must meet the following criteria:

1. Be a resident of the state of Mississippi.
2. As a provider, self-identify as a current or former recipient of disability services for persons with physical, intellectual, developmental, and/or mental disabilities.
3. Have completed all training required by the provider agency.
4. Demonstrate a minimum of six (6) consecutive months in self-directed recovery and/or of successful community living.
5. Demonstrate emotional readiness to provide supports to a peer.

d) Documentation of services provided must be retained in participant's record and contain:

1. Date of the service,
2. Time of the service delivery (beginning and end),
3. Description/summary of the service,
4. Signature of staff person providing service.

e) Services must be billed in 15 minute increments, during which services are provided to assist the participant in building relationships as well as having a peer resource.

5) **Caregiver Support**

Designed to assist identified and qualified caregivers of Bridge to Independence participants cope with stress and develop caregiver skills in order to help them become a source of support for the transitioning individual. Caregivers qualified to receive caregiver support must perform or assist the participant in one or more life activities, such as finances, health care, or general decision making.

Includes two types of support services:

1. Peer-to-Peer service is designed for identified caregivers of Bridge to Independence participants to assist with the management of stress and the development of caregiver skills.

    a. Qualifications include:

        (1) As a provider, individual must identify as a former or current caregiver of someone with physical, intellectual, developmental, or mental disability.

        (2) Caregiver peer must complete training offered by provider agency. Caregiver must demonstrate emotional readiness to provide emotional support to another caregiver and understand when to seek professional help for a caregiver.

2. Individual Therapy Support is designed to assist identified caregivers of Bridge to Independence participants through therapy/counseling sessions.

    a. Qualifications include:

        (1) Individual therapy services in this category must be provided by an individual who holds a master's degree and professional license, such as Licensed Professional Counselor, Psychologist, Licensed Clinical Social Worker, or Licensed Marriage and Family Therapist.

        (2) Caregiver support professional providers identified above must complete training offered by the provider and approved by the Division of Medicaid specific to caregiver support professional services.

b) Documentation of services provided must be retained in participant's record and contain:

    1. Date of the service,
    2. Time of the service delivery (beginning and end),
    3. Description/summary of the service,
    4. Signature of staff person providing service.

c) Services must be billed in 15 minute increments, during which services are provided to assist the caregiver with the development of caregiver skills as well as having a peer resource.

6) **Transportation**

Designed to maximize community inclusion for B2I participants. Transportation is not limited to medical related issues.

a) Transportation is any form of moving an individual from one location to another as

most appropriate based on a transportation needs assessment.

b) Services are billed per ride, with a maximum of 52 rides per 365 days.

c) Documentation of services provided must be retained in participant's record and contain:

1. Date of trip,
2. Time of service,
3. Destination, and
4. Signature of participant.

7) **Program of Assertive Community Treatment (PACT)**
Only participants with mental illness leaving a qualified facility and receiving Medicaid community-based services through either the Mental Health State Plan (Rehabilitation Option) or Targeted Case Management are eligible to receive PACT services.

a) Program of Assertive Community Treatment is defined as multidisciplinary therapeutic programs provided in the community in which individuals that would traditionally need inpatient care and treatment can be maintained in a less restrictive/community-based setting.

b) The aim of PACT is to address the varied needs of adults with serious and persistent mental illness in a mobile treatment team approach/environment.

c) PACT services include a self-contained treatment milieu based on the level of need of the individual.

d) Services include:

1. Psychiatric service/assessment/treatment (including telepsychiatry),
2. Nursing,
3. Peer support,
4. Medication monitoring/evaluation,
5. Vocational,
6. Transportation,
7. Housing,
8. Employment services, and
9. Administrative case management.

e) Provider requirements listed below are:

1. ACT/PACT teams must be certified by the Department of Mental Health and maintain all standards set forth by the Department of Mental Health.
2. ACT/PACT services must be provided by staff members who are certified/ qualified/credentialed/licensed to provide the service required.

3. Psychiatric services must include services provided by a psychiatrist or psychiatric mental health nurse practitioner.
4. Nursing services must be provided by a registered nurse.
5. Peer support is a person-centered service that allows consumers/ family members the opportunity to direct their own recovery and advocacy processes. Peer Support Service is a helping relationship between peers and/or family members that are directed toward the achievement of specific goals defined by the client. Services are provided by a self-identified consumer/family member (past or present) of mental health services who has successfully completed a minimum of Certified Peer/Family Support Specialist Basic Training, and has documentation of such as recognized by the DMH.
6. Medication monitoring – The intentional face-to-face interaction between a physician or nurse practitioner and a consumer for the purpose of:
   a. Assessing the need for psychotropic medication,
   b. Prescribing medication; and
   c. Conducting regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.
7. Administrative Case Management – The coordination and monitoring of services integral to helping participants access needed medical, social, educational and other services in order to attain their highest level of independent functioning.
8. Vocational Specialist – Individual who locates and secures vocational training for the individual for the purpose of working toward obtaining skills to secure employment.
9. Transportation Specialist – Individual who assists the participant with securing the needed transportation to employment, medical appointments and recreational/leisure activities that will ensure community inclusion.
10. Housing Specialist – Individual who locates, secures, and assists the participant with gaining and maintaining housing.
11. Employment Specialist – An individual that maintains a resource of community employment options. This individual will conduct job discoveries, job placement, job coaching and will be a liaison with the participant and his/her employer.

f) Documentation Requirements

1. In addition to all documentation requirements set forth by the DMH minimum standards, the case record must contain:

   a. A daily progress summary for each participant which meets the documentation criteria for PACT daily total of time spent with the participant.
   b. A physician's order for the service stating that inpatient care would be necessary without the service.
   c. A written report of treatment recommendations/changes resulting from a treatment plan review and the signature of each staff present when the case was reviewed.

g) Services must be billed in 15 minute increments, during which PACT services are provided.

8) **Security and Utility Deposits**

Bridge to Independence participants are eligible for one-time security and utility deposits when moving into a house or apartment that is not already leased by a caregiver.

a) Services must be billed at reimbursement for cost. Detailed receipts must be submitted along with the CMS 1500 to DOM for billing purposes.

b) Detailed receipts must be retained in the participant's files.

9) **Household Furnishing and Goods**

Participants are eligible for a one-time household furnishing and goods cost when moving into a house or apartment and are in need of essentials to assist with startup costs.

a) Services must be billed at reimbursement for cost. Detailed receipts must be submitted along with the CMS 1500 to DOM for billing purposes.

b) Detailed receipts must be retained in the participant's files.

c) Household Furnishing and Goods Worksheet (DOM Form B2I.10)
Is used to assess essential items needed for transition.

10) **Moving Expenses**

Participants are eligible for one-time moving expenses for items that need transported from the facility in which they are residing to their new community residence. Moving expenses may also cover commercial transportation of household furnishings, such as a couch, from a store to the participant's residence.

a) Services must be billed at reimbursement for cost. Detailed receipts must be submitted along with the CMS 1500 to DOM for billing purposes.

b) Detailed receipts must be retained in the participant's files.

11) **Home Adaptation**

Only participants enrolled in the Elderly and Disabled Waiver or Intellectual Disabled/Developmental Disabilities Waiver are eligible for home adaptations/structural changes such as wheelchair ramps, widened doorways, lowered cabinets and other accessibility modifications through B2I based on a needs assessment.

a) Services must be billed at reimbursement for cost. Assessment of need, estimates of services, detailed receipts must be submitted along with the CMS 1500 to DOM for billing purposes.

b) Adaptions must be performed by a licensed and bonded contractor.

c) Assessment of needs and detailed receipts must be retained in the participant's files.

12) **Durable Medical Equipment**

Only participants enrolled in the Elderly and Disabled Waiver or Intellectual Disabled/Developmental Disabilities Waiver are eligible to receive Durable Medical Equipment through B2I based on medical necessity for community living.

a) Durable medical equipment must be obtained and billed through traditional DME suppliers.

b) A prescription and/or Medical Supply Certificate for Medical Necessity (CMN) must be completed and signed by the ordering physician, nurse practitioner, or physician assistant. CMN should indicate B2I at the top of form.

c) Notify DOM B2I staff via email (B2I@medicaid.ms.gov) of request made for DME, including Community navigator name and agency, transition date, requested items and justification.

d) Any facilitation of this process will be documented in the Contact Summaries including offering and selection of DME provider.

13) **Therapy Services (Physical Therapy, Occupational Therapy, Speech Therapy)**

Only participants enrolled in the Independent Living Waiver or Traumatic Brain Injury/Spinal Cord Injury Waiver are eligible to receive PT/OT/ST through B2I When in excess of therapy services covered in state plan services, either in amount, duration and scope. These services are cost effective and necessary to prevent re-institutionalization. The purpose of therapy services is maintenance to prevent loss of gains obtained during rehabilitation phase of therapy.

a) PT/OT/ST must be obtained and billed through traditional PT/OT/ST providers.

b) Denial from Health Systems of Mississippi must be received in order to pursue Therapy through B2I.

c) A prescription and/or Certificate for Medical Necessity (CMN) must be completed and signed by the ordering physician. CMN should indicate B2I at the top of form.

d) An evaluation must be performed/completed by a state-licensed therapist of the same discipline as the requested therapy. The therapist performing the evaluation must complete the evaluation form.

e) A therapy plan of care must be developed by a therapist in that discipline. The therapy plan of care must be approved by the prescribing physician.

f) If assessed as needing PT/OT/ST and State Plan service limits have been exhausted or therapy is not a covered service due to scope, providers must submit written justification and any supporting documentation (HSM denial, CMN, Evaluation, &POC) to DOM via secure fax with the Therapy Authorization Form (DOM Form B2I.12)

g) DOM will approve/deny the request and return the authorization to B2I provider in writing within seven (7) business days.

h) Retain the Therapy Authorization in the participant's file.

i) Approved providers can be found by using the search feature on MS Envision website. https://msmedicaid.acs-inc.com/msenvision/providerSearch.do

j) Any facilitation of this process will be documented in the Contact Summaries.

k) B2I providers must forward approved, signed Therapy Authorization Form (DOM Form B2I.12) to PT/OT/ST providers for services to begin.

14) **Extended Pharmacy**

Extended pharmacy benefits are billed at Point of Sale (POS). Allows up to three (3) additional prescriptions over the five (5) allowed in state plan for a total of eight (8) prescriptions per month. The Community Navigators goal is to assist the transitioning individual in managing their pharmacy benefit to access needed pharmacy services under existing options by coordinating with physicians, utilizing generic medications and 90 day supply of maintenance medication allowed in the state plan. Ultimately, assisting the transitioning individual with the best and most affordable plan for their pharmaceutical needs.

IX) Person-Centered Planning

1) Implementation timelines:

a) Within 30 days of participant choosing B2I.

b) **Held a minimum of every 30 days (pre-transition).**

c) Held a minimum of every 60 days (post-transition).

d) As circumstances change, the individual and/or guardian requests a meeting, and/or the needs of the participant require that the team meet on a more frequent basis to best coordinate care.

2) Required documentation:

a) Interviews: notes, dates, and persons interviewed, such as resident and caregivers.

b) Activities and observations: activity, location, notes, and dates.

c) Profile (as developed),

d) Dated Action Plans from each PCP meeting,

e) Sign-in sheets of all meetings and dates, and

f) Notes from all PCP meetings.

g) Profile and Action Plan submitted to DOM via secure fax, 5 days after initial PCP meeting.

X) Discharge

1) When a B2I provider discharges an enrolled B2I participant:

a) Complete a B2I Status Form (DOM B2I.9) that contains:

1. Date form completed,
2. Date of Action, which is the date of discharge,
3. Participant's name,
4. Medicaid number,
5. B2I provider information, contact name, telephone number, and office location,
6. Reason for discharge giving specific information.
7. List of referrals or resources made on participant's behalf at the time of closure or discharge.

2) Complete the Discharge (DOM Form B2I.11) indicating end dates and if:

a) Discharge due to 365 -day service limit,

b) Discharge is due to voluntary withdrawal from B2I services, or

c) Discharge is involuntary and the reason.

3) Submit forms to DOM B2I on the secure fax server (601) 359-6294.

a) B2I Status Form (DOM B2I.9), and

b) Discharge (DOM Form B2I.11).

XI) Status Categories

1.) Active Status

Active status refers to clients for whom a Community Navigator is providing Transition Care Management services on an ongoing basis as prescribed in the timeline above prior to transition up to 180 days and in the first 90 days after transition.

To initiate Active Status from Inactive Status, CN must submit B2I status form indicating active Status accompanied by a written summary of why the participant is moving into active status and what advances have been made to remedy the issue that lead the participant into inactive status.

2.) Inactive Status

Inactive status refers to clients for whom a Community Navigator has completed all possible aspects of the person-centered planning process but clients transitions have been put on hold pending resolve of a documented issue such as location of desired housing.

A participant may move into Inactive Status one of two ways.

1) Community Navigator initiates the inactive status
2) DOM can exercise the ability to move someone into inactive status.

To initiate the Inactive "Hold" Status, the CN must submit B2I status form indicating Inactive Status accompanied by a written summary of why the participant is moving into Inactive status and what steps have been taken to locate housing or to remedy the issue that is moving participant into inactive status.

DOM will respond to request by returning the B2I status form to B2I provider with approval of inactive status in the DOM use ONLY portion of the status form.

B2I providers are only permitted to bill 4 units per month of CN while participant is in hold status. Requirements include at least one (1) phone contact per month with inactive participant to determine if any advances have been made toward issue that moved them into inactive status. CN should also contact any resources that individual is working with to help resolve the issue.

Participants that have been in inactive status for 3 months with no advancements in issue that lead them to inactive status. CN must initiate a meeting to discuss discharge from the B2I program. At the time advancements are made they can be re-referred for B2I services.

XII) Grievances, Appeals & Fair Hearing Rights

1) Grievance process: A grievance is a complaint filed about unfair treatment and the grievance process provides for prompt resolution of issues not relating to appeals.

Grievance procedures cannot interfere with a participant's freedom to make a request for a fair hearing or direct access to a fair hearing.

a) B2I providers must establish a grievance system that includes written policies and procedures that assure participants and families:

1. Reasonable assistance in completing forms and other procedural steps.
2. Interpreter services, if needed.
3. Toll free numbers to file oral grievances.
4. Acknowledgement of receipt of a grievance.
5. Receive information regarding the right to file grievances, and requirements and timeframes for filing.

2) Appeals and Fair Hearing Rights

a) An appeal is a formal request to change a decision.

b) The right to appeal is an essential component of the B2I program. As such, the State provides individuals an opportunity to appeal a decision and request a Fair Hearing.

c) The appeal and fair hearing process may be requested or initiated when a participant or family:

1. Are denied the services of choice or the provider of choice.
2. Has services denied, suspended, reduced or terminated that are already authorized Medicaid-covered services.

d) B2I providers must establish an appeal and fair hearing process that include written policies and procedures that assure participants and families:

1. Reasonable assistance in completing forms and other procedural steps.
2. Interpreter services, if needed.
3. Acknowledgement of receipt of an appeal.
4. Provide information regarding the right to file appeals, and their requirements and timeframes for filing including:
   a. How to obtain a hearing
   b. Right to representation at a hearing
   c. Right to continuation of benefits during a Fair Hearing appeal. If the B2I provider's Action in a Fair Hearing is upheld, the participant or family may be liable for the cost of any continued benefits.

e) Notice of Action

1. B2I providers must provide appropriate and timely Notice of Action of any decision to:

a. Deny a service authorization request, or
b. Authorize a service in an amount, duration, or scope that is less than requested or agreed upon.

2. The Notice of Action must be:

   a. Written in language that is easily understood.
   b. Available in alternative formats.
   c. Written in a manner that takes into consideration those with special needs.

3. Contents of the Notice of Action:

   a. Description of the action the provider has taken or intends to take.
   b. Explanation for the action.
   c. Notification that the participant or family has the right to file an appeal.
   d. Procedures for filing an appeal.
   e. Notification of participant or family's right to request a Fair Hearing.
   f. Notice that the participant and family have the right to have benefits continued pending the resolution of the appeal.

4. Timeframes for the Notice of Action:

   a. B2I providers must give notice of at least ten (10) calendar days before the date of any action to terminate, suspend or reduce services.
   b. In the event of fraud or abuse, the notice may be reduced to five (5) days.
   c. The period of advance notice may be shortened to one (1) day:

      (1) In the event of the death of the participant.
      (2) By written request of the participant or family to terminate services.
      (3) When the participant's admission to an institution makes her/him ineligible for further services (i.e., after 30 consecutive days).
      (4) When the participant's whereabouts are unknown and contact information is invalid.
      (5) When the participant moves out of the jurisdiction of B2I services (out of state).
      (6) When a physician prescribes a change to the level of care.

5. The Fair Hearing Appeals Process must incorporate the following provisions:

   a. Appeals must be filed within a reasonable timeframe, not to exceed thirty (30) calendar days from the date on the Notice of Action.
   b. Appeals may be either oral or in writing; however, any oral request to appeal must be followed by a written and signed appeal.
   c. The B2I provider may be required by DOM to participate in any review, appeal, fair hearing or litigation involving issues related to B2I.

d. The B2I provider must continue the benefits/services to the participant and family if the Fair Hearing process requirements are met, until one of the following occurs:

(1) The appeal is withdrawn.
(2) Fair Hearing decision is made.
(3) Authorization expires or authorization service limits are met.

6. B2I providers must provide the grievance, appeals and fair hearing rights information to all subcontractors at the time they enter into a subcontract.

7. The B2I provider must provide the family with a copy of the signed and completed form used to describe and document that the participant and family are offered the opportunity to request a fair hearing.

XIII) Serious Incident Reports

1) Serious incidents are defined as any occurrence that results in injury, neglect, exploitation or death of the B2I Participant.

2) Serious incidents must be reported in writing within twenty-four (24) hours or the next business day to DOM B2I. Written reports must include the following:

a) Provider name and address,

b) Date, time and place of event,

c) Date and time staff notified of event,

d) Name of B2I participant,

e) Name of any staff involved if abuse, neglect, or misconduct are alleged,

f) A written description of events and actions, and

g) All written reports including outcomes.

XIV) Quality Management

All B2I providers will be monitored for compliance with state and federal requirements via the On Site Compliance Review (OSCR) process.

a) OSCRs will be conducted to evaluate assurances concerning the protection of the participant health and welfare financial accountability and other elements.

b) The OSCR process will monitor a B2I provider in three domains:

1. Administration: This area comprises the organizational structure and management of the B2I program. Administrative functioning is evaluated through the review of such information as staff credentials and training, utilization review documents and incident reports, etc.

2. Program: This area comprises the philosophy and structure of the B2I provider's approach to treatment (what they believe constitutes good treatment and how they plan to carry it out). The program is evaluated through the review of program policy and procedure manuals, staff training schedules, and staff interviews.

3. Services: This area comprises the manner in which a B2I provider translates into services provided to participants. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each participant. Special emphasis is placed on the Plan of Care and Community Navigation.

XV) Assessment for Quality of Life

The B2I program requires that Quality of Life surveys (QoL) be administered and data submitted to our National Evaluator. The QoL is designed to collect information from Medicaid participants transitioning out of institutional care as a result of the Money Follows the Person program and measure how quality of life is affected by the transition program. The QoL survey assesses B2I participant status across seven (7) domains: living situation, choice and control, access to personal care, respect/dignity, community integration and inclusion, overall satisfaction with life, and health status. The QoL survey will be administered at three (3) points in time:

a) Baseline – Just prior to transition to the community (approximately 2 weeks prior)
b) First follow up – 11 months post-transition to the community
c) Second follow-up – 24 months post-transition to the community.

The B2I Provider:

1. Completes the Contact Information Form (DOM Form B2I.7).

2. Completes the Consent to Participate National Quality of Life Survey Form (DOM Form B2I.6).

3. Completes the B2I Status Form (DOM Form B2I.9) one (1) month before transition.

4. Sends completed signed forms to DOM.

The DOM interviewer:

1. Receives the contact form and contacts the B2I provider (identified contact person) for assistance, if needed, in scheduling a meeting with the family.

2. Assures QoL surveys are completed in a timely manner.

3. Conducts the QoL survey for each B2I participant at:

    a) Baseline – Just prior to transition to the community, approximately two (2) weeks prior,
    b) First Follow up – 11 months post-transition to the community,
    c) Second follow-up – 24 months post-transition to the community, and

4. Enters QoL survey into electronic database.

5. Submits data to National Evaluator.

XVI) Timeline

1) Initial Referral Form received at DOM. DOM has three (3) days to contact potential participant and/or guardian.

2) DOM staff contacts facility to provide potential participant and/or guardian provider information for Freedom of Choice (FOC) Provider Selection.

3) Facility returns FOC to DOM within five (5) days of receipt.

4) DOM forwards Initial Referral and FOC to selected provider within three (3) days of receipt.

5) The B2I provider schedules a face-to-face visit within ten (10) days of receiving referral and FOC from DOM.

6) Community Navigator provides information about B2I to potential participant and family and has Phase I of Consent to Participate signed. If declined, process stops. Consent to Participate sent to DOM via secure fax server (601) 359-6294.

7) Resident/family has seven (7) business days to make decision to pursue B2I services. Community Navigator must initiate contact after seven (7) business days for a decision. Phase II of Consent to Participate signed. If declined, process stops. Consent to Participate and B2I Status Form sent to DOM via secure fax (601) 359-6294.

8) Provider sends B2I Status form and Consent to Participate (Phase I and II completed) to DOM indicating Bridge to Independence status.

9) DOM will notify provider when B2I status has been processed in system.

10) Discovery Begins

11) Once participant consents to participate, Community Navigation begins. Community Navigator must schedule the first person-centered planning meeting within 30 days of signature on Phase II.

12) Once a Qualified Residence is determined, the Community Navigator will initiate the appropriate HCBS referral (E&D, IL, TBI/SCI, ID/DD or Mental Health State Plan (Rehabilitation Services)).

13) Provider sends B2I Status Form and Consent to Participate (Phase I, II, and III completed) to DOM indicating B2I status. This occurs approximately one (1) month before facility discharge. This allows for coordination of facility discharge date, HCBS and B2I enrollment date to ensure no gaps in service. This also allows B2I providers to bill for all B2I services that an individual qualifies for after discharge from the facility.

14) DOM will notify provider when B2I status has been processed in system.

15) Approximately two (2) weeks prior to facility discharge, DOM contacts potential participant to complete first of three (3) Quality of Life surveys (QoL).

16) Transition to Community.

17) Continued minimum contact required for participants (CN contacts and PCP requirements.)

18) Three (3) months prior to B2I discharge, discharge planning begins.

19) Provider sends B2I Status form and Discharge Form. This occurs approximately one (1) month before B2I discharge.

20) DOM will notify provider when B2I status has been processed in system.

XVII) Attachments:

A. HCBS Services and 365-Day B2I Demo Supports
B. B2I Procedure Codes and Fee Schedule

XVIII) Forms

Initial Referral (DOM Form B2I.3)
Freedom of Choice Selection Form (DOM Form B2I.4)
Consent to Participate (DOM Form B2I.5)

Consent to Participate National Quality of Life Survey Form (DOM Form B2I.6)
Contact Information Form (DOM Form B2I.7)
Bill of Rights (DOM Form B2I.8)
B2I Status Form (DOM Form B2I.9)
Household Furnishings and Goods Worksheet (DOM Form B2I.10)
Discharge Form (DOM Form B2I.11)
Therapy Authorization (DOM Form B2I.12)
Surrogacy Verification (DOM Form (B2I.13)