Title 23: Division of Medicaid

Part 208: Home and Community-Based Services (HCBS) Long-Term Care

Chapter 6: Bridge to Independence (B2I)

Rule 6.2: Eligibility

A. To participate in the B2I demonstration project, the person:

1. Must reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or a nursing facility for at least ninety (90) consecutive days with at least one (1) day of the stay reimbursed by Medicaid.

2. Cannot have received short-term rehabilitation services reimbursed under Medicare during the ninety (90) day stay requirement.

3. Must be eligible for one (1) of the following Medicaid Home and Community-Based Services (HCBS):

   a) Assisted Living (AL) Waiver,

   b) Elderly and Disabled (E&D) Waiver,

   c) Independent Living (IL) Waiver,

   d) Intellectual Disability/Developmental Disability (ID/DD) Waiver,

   e) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, and/or

   f) Community Mental Health Center (CMHC) Services/Rehabilitation Option of the State Plan.

4. Must meet the level of care criteria for an ICF/IID or a nursing facility and, if not for the provision of HCB long-term care services, the person would continue to require the level of care provided in the facility.

B. Qualified residences for transitioning persons must meet one (1) of the following criteria:

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

2. An apartment with lockable access leased to the transitioning person which includes living, sleeping, bathing, and cooking areas over which the person or the person's family has domain and control, or

3. A residence in a community-based residential setting in which no more than four (4)

unrelated persons reside.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with CMS approved Operational Protocol (eff. 11/04/2014) eff. 09/01/2015; New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.3: Covered Services

The following services are available to B2I persons as documented in the Plan of Services and Supports (PSS):

A. Transition Care Management, defined as transition care planning occurring for up to one-hundred eighty (180) days pre-discharge from the institution and post-transition care planning for three hundred sixty-five (365) days following transition into the community.

1. Transition Care Management includes:

a) Crisis Support, defined as a response to the transitioning person and/or person's caregiver who is experiencing a crisis event during the transition process.

1) The service must be available twenty-four (24) hours a day, seven (7) days a week.

2) Initial contact may take place over the telephone, but if the situation is determined to be an emergency, the provider must provide in-person support.

3) Staff must be available to meet with the person in transition, as well as any other member of the person-centered planning team, to resolve the crisis and thereby enable the person to remain in the community.

b) Person-Centered Planning (PCP), defined as a process directed by the person or family with long-term care needs which:

1) Identifies the strengths, capacities, preferences, needs and desired outcomes of the person.

2) Includes participants freely chosen by the person or family who are able to serve as important contributors.

3) Assists the person to identify and access personalized paid and non-paid services and supports.

4) The person identifies planning goals to achieve those personal outcomes in collaboration with those that the person has identified, including medical and professional staff.

5) The identified personally-defined outcomes and the training supports, therapies, treatments and/or other services the person is to receive to achieve those outcomes as part of the Plan of Services and Supports (PSS).

6) Meets all the following minimum PCP service contact requirements:

   (a) Initial PCP meeting held within thirty (30) days of the person choosing a B2I provider,

   (b) Pre-transition PCP meeting held a minimum of every thirty (30) days,

   (c) Post-transition PCP meeting held a minimum of every sixty (60) days, and

   (d) Interim PCP meetings held as circumstances change, the person and/or guardian or legal representative requests a meeting, and/or the needs of the person require that the team meet on a more frequent basis to best coordinate care.

7) Includes the following documentation in the enrolled person's record:

   (a) Discovery interviews including, but not limited to, Community Navigator Notes, dates, and individuals interviewed, such as the person and caregivers,

   (b) Activities and observations including, but not limited to, activity, location, Community Navigator Notes, and dates,

   (c) Profile,

   (d) Dated Action Plans from each PCP meeting,

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

   (f) Minutes from all PCP meetings.

8) Includes the development of the PSS which is retained in the person's record and contains:

   (a) B2I services, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided,

(b) Other services received, regardless of payer source, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided, and

(c) Narrative of services, supports, needs and outcomes.

9) Includes a Risk Mitigation Plan, defined as a comprehensive and pro-active safety/risk mitigation plan developed to address any safety issue/risk that has been identified through discovery and planning. The Risk Mitigation Plan must be retained in the person's record and address any safety issue/risk in the following categories and include a detailed mitigation plan for any safety issue/risk including, but not limited to:

(a) Medical and physiological,

(b) Behavioral and psychiatric,

(c) Environmental including, but not limited to, living conditions or loss of a home,

(d) Financial,

(e) Activities of daily living including, but not limited to, loss of natural supports,

(f) Service disruption,

(g) Legal including, but not limited to, prior convictions and recidivism risk,

(h) Natural disaster plan including, but not limited to, fire, flooding, hurricane and earthquake evacuation plan including emergency contact information,

(i) B2I provider staff contact number available twenty-four hours a day, seven days a week (24/7),

(j) Emergency contact numbers including, but not limited to, 911, local law enforcement office, local hospital, and regional CMHC, and

(k) A written and oral explanation of appropriate responses to emergencies, including health or mental health emergencies versus situations in need of immediate attention, including broken medical equipment or failure of a service provider to make an appointment.

2. Transition Care Management must be provided by a qualified community navigator who cannot be the person's HCB waiver/CMHC case manager and who meets the criteria in one (1) of the following:

a) Licensed social worker (LSW) with valid state license and a minimum of one (1) year of relevant work experience,

b) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),

c) Registered nurse (RN) with valid state license and a minimum of one (1) year of relevant work experience, or

d) Others with relevant experience and training with a minimum of a bachelor's degree and one (1) year of work experience in a social or health service setting or a comparable technical and human service training will be considered and approved by the Division of Medicaid, B2I.

3. The community navigator must document in a narrative form in a Community Navigator Notes section in the record all contacts made with, about and/or on behalf of the person and include:

a) Date of the service,

b) Beginning and end time of the service,

c) Type of contact including, but not limited to, face-to-face, phone, e-mail, PCP meeting notes and activities, meetings and third party calls,

d) Who the contact was with including, but not limited to, the person, family member, community/natural resource, service providers, and housing partners,

e) Reason for the contact as well as the content and issues discussed,

f) All follow-up activities,

g) When, why, and what type of information is received about or by the person,

h) When, why, and what type of information is sent to another party about the person,

i) Any change in services,

j) Other situations based on individual circumstances, and

k) Community navigator's signature.

4. A Community navigator must provide the following minimum service contacts:

a) Face-to-face meeting with the person and interested parties scheduled within ten (10) days of a B2I provider receiving referral,

b) One (1) contact per week with the person and/or family which includes during the Pre-Transition period up to one hundred eighty (180) days and the Post-Transition period during the first ninety (90) days,

c) One (1) face-to-face visit per month with the person Pre-Transition and Post-Transition, not including PCP meeting,

d) One (1) PCP team meeting every thirty (30) days Pre-Transition and every sixty (60) days Post-Transition with the initial PCP meeting held within the first thirty (30) days after the Consent to Participate Phase II is signed, and

e) One (1) contact per month with an assigned HCB waiver/CMHC case manager to ensure service coordination during the Post-Transition period.

5. A community navigator's case load cannot exceed:

a) A total of thirty (30) persons, or

b) Fifteen (15) persons in each of the following categories:

1) Pre-Transition refers to persons for whom a community navigator is providing Transition Care Management services on an ongoing basis prior to transition up to one hundred eighty (180) days and in the first ninety (90) days after transition.

2) Ninety (90) days Post-Transition refers to persons 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 HCB waiver/CMHC case managers.

B. Life Skills Training, defined as assisting persons with transitioning to the community through independent living skills that include, but are not limited to, money management, the use of technology, accessing community resources, employment skills development, grooming and personal hygiene, and interpersonal relationships with others in the community.

1. A life skills service plan must be developed with the person's input to address life skills needed which must be contained in the person's record and include:

a) Date of life skills service plan,

b) Life skills to be addressed,

c) Activities used to meet the life skill need, and

d) Date of goals met and improvement of life skills.

2. Documentation of services provided must be retained in the person's record and contain:

a) Date of the service,

b) Beginning and end time of the service delivery,

c) Description of the service, and

d) Signature of staff person providing service.

C. Peer Supports, defined as counseling from peers with similar circumstances who may be able to share their own experiences with the person to reduce feelings of isolation and to promote inclusion.

1. Peer supporters must meet the following criteria:

a) Be a resident of Mississippi,

b) Self-identify as a current or former recipient of disability services for persons with physical, intellectual, developmental, and/or mental disabilities,

c) Complete all training required by the provider agency,

d) Demonstrate a minimum of six (6) consecutive months in self-directed recovery and/or of successful community living, and

e) Demonstrate emotional readiness to provide supports to a peer.

2. Documentation of services provided must be retained in the person's record and contain:

a) Date of the service,

b) Beginning and end time of the service delivery,

c) Description and summary of the service, and

d) Signature of staff person providing the service.

D. Caregiver Support, defined as a service to enable the caregiver to transition into a more active role and to assist identified and qualified caregivers of persons enrolled in B2I to cope with stress and to develop caregiver skills in order to help them become a source of support for the transitioning person. Caregivers qualified to receive caregiver support must perform or assist the person in one (1) or more life activities, such as finances, health care, or general decision making, and includes:

1. Peer-to-Peer service designed for identified caregivers of the person enrolled in B2I to assist with the management of stress and the development of caregiver skills and must be

provided by an individual who must:

a) Identify as a former or current caregiver of someone with a physical, intellectual, developmental or mental disability,

b) Complete all training required by the provider agency, and

c) Demonstrate emotional readiness to provide emotional support to another caregiver and understand when to seek professional help for a caregiver.

2. Individual Therapy Support, defined as services designed to assist identified caregivers of the person enrolled in B2I through therapy/counseling sessions and must be:

a) Provided by an individual who holds a master's degree and professional license as a licensed professional counselor (LPC), licensed psychologist, licensed certified social worker (LCSW) or licensed marriage and family therapist (LMFT), and

b) Documented in the person's record and contain:

1) Date of the service,

2) Beginning and end time of the service delivery,

3) Description and summary of the service, and

4) Signature of staff providing service.

E. Transportation, defined as any appropriate form of transporting the person from one (1) location to another to maximize community inclusion for the person.

1. Documentation of services provided must be retained in person's record and contain:

a) Date of service,

b) Time of service,

c) Destination to and from, and

d) Signature of staff providing service.

F. Security and Utility Deposits, defined as specific up-front costs to establish a residence in the community with detailed receipts retained in the person's record.

G. Household Furnishings and Goods, defined as, but not limited to, essential items and furnishings, appliances, household supplies, and pantry items required to set-up a household in the HCB setting based on the needs of the person with detailed receipts retained in the

person's record.

H. Moving Expenses, defined as moving costs associated with a transition for items transported from the facility in which the person is residing to their new community residence or community-based setting and may also cover commercial transportation of household furnishings from a store to the person's community residence or community-based setting with detailed receipts retained in the person's record.

I. Environmental Accessibility Adaptations, defined as certain required modifications completed by a licensed and bonded contractor to the person's residence to enable the care of the person in a HCB setting with detailed receipts retained in the person's record. Only persons enrolled in the E&D or ID/DD Waivers are eligible for Environmental Accessibility Adaptations.

J. Durable Medical Equipment (DME), defined as medically necessary equipment, based on the person's PSS, which allows for community living. Only persons enrolled in the E&D, ID/DD or AL Waivers are eligible for DME.

K. Extended Pharmacy, defined as up to three (3) additional prescriptions over the Medicaid five (5) prescription limit allowed in the State Plan for a total not to exceed eight (8) prescriptions per month with no more than five (5) of which may be non-generics.

    1. The person is only eligible for the extended pharmacy benefit if their prescriptions are in excess of the Medicaid monthly prescription limit.

    2. Community navigators must assist the person in managing the extended pharmacy benefit to access needed pharmacy services under existing options in the Mississippi State Plan.

    3. Community navigators must coordinate with the person's community providers including, but not limited to, physicians and pharmacists for medication management.

    4. The person enrolled in B2I should utilize preferred medications on the Universal Preferred Drug List (PDL) and the Ninety (90) Day Maintenance List when possible, to maintain the person on the least amount of prescriptions required for therapeutic benefit.

L. Adaptive Equipment/Technology, defined as an assistive equipment/technological device which includes an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, used to increase, maintain, or to improve the person's level of independence, ability to access needed supports and services in the community or maintain or improve the person's safety with detailed receipts retained in the person's record.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

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