MISSISSIPPI DEPARTMENT OF MENTAL HEALTH

ID/DD Waiver

Support Coordination Manual

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Introduction

What is ID/DD Waiver?

Title XIX Section 1915c of the Social Security Act authorizes States to provide types of person-centered services delivered in the home and community. Under a waiver program, a state can waive certain Medicaid program requirements, allowing the state to provide care for people who might not otherwise be eligible under Medicaid. Home and Community Based Services (HCBS) programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing, and are designed to enable people to stay in their homes, rather than moving to a facility for care and supports.

The Intellectual Disabilties/Developmental Disabilities (ID/DD) Waiver provides services and supports for persons diagnosed with an Intellectual and Developmental Disabilities (IDD) and with Autism Spectrum Disorder. The Mississippi Division of Medicaid has administrative responsibility for the ID/DD Waiver. The Department of Mental Health, IDD Community Services Office (CSO) Division of ID/DD Waiver is responsible for the daily operation of the ID/DD Waiver.

The program is designed to offer an array of services throughout the life span:

In Home Supports
In Home Nursing Respite
In Home Respite
Home and Community Supports

Employment Supports
Supported Employment
Job Discovery

Residential Supports
Supervised Living
Shared Supported Living
Supported Living

Behavioral/Crisis Supports
Behavior Support
Crisis Intervention
Crisis Support

Day Supports
Day Services Adult
Prevocational Services
Community Respite

Other Supports
Therapies – PT, OT, ST
Transition Assistance
Support Coordination

Support Coordination Standards and Guidance

Support Coordination is responsible for coordinating and monitoring all services a person on the ID/DD Waiver receives, regardless of funding source, to ensure services are adequate, appropriate, meet person's needs, and ensure the person's health and safety needs are met and addressed. Support Coordination service requirements are outlined in Chapter 44 of the DMH Operational Standards.

Support Coordination must implement the requirements as outlined in the DMH Record Guide; DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities and Substance Use Community Service Providers; the federally approved ID/DD Waiver, and MS Medicaid Administration Code pertaining to ID/DD Waiver Support Coordination.

The ID/DD Waiver Support Coordination Manual provides supplemental information regarding the responsibilities of the ID/DD Waiver Support Coordination staff. *This does not relieve the ID/DD Waiver staff from the responsibility to follow all requirements in the aforementioned documents.*

Note* When the Support Coordination Manual refers to "days" it means calendar days unless otherwise specified. Throughout the SC Manual, you'll see reference to "Rule". The "Rule" number is the DMH Operational Standard that applies.

Part I

ID/DD Waiver Processes and Procedures

A. Support Coordination Requirements

1. Support Coordination (SC) services must be provided by a statewide entity to ensure persons throughout the state have access to ID/DD Waiver services and supports. Support Coordination is provided through one of four IDD Regional Programs (North MS Regional Center, Hudspeth Regional Center, Ellisville State School, and South MS Regional Center). Support Coordination staff must meet requirements set by the Division of Medicaid (DOM) and Department of Mental Health (DMH).

2. Support Coordination (SC) Directors are responsible for hiring and managing SC personnel in accordance to Policies and Procedures at each IDD Regional Program and DMH Operational Standards (Rule 11.3.B. and 11.3.Y.) The SC Director, SC Assistant Director, and/or SC Supervisors are to provide support and guidance to SC. SC Directors and/or the DMH Community Services Office (CSO) will develop ongoing training and provide guidance in improving processes, changes or additions to Center for Medicare and Medicaid Services (CMS) regulations or requirements, or as directed by the DOM.

3. Support Coordinators (SC) assist each person in locating services and supports in the community, monitor and address changing circumstances on an ongoing basis, and address the person's options and choices that are available in the community. A SC's caseload is thirty-two (32) Waiver participants. Due to staff shortage, SC may have persons temporarily assigned and go above their caseload. SC Directors must notify DMH CSO of staffing issues. Refer to Chapter 44 of the DMH Operational Standards for overview of SC requirements and activities.

4. DOM's Long Term Services and Supports (LTSS) System is the electronic record for each person served through ID/DD Waiver. All documentation and activities must be recorded and updated in LTSS. The SC Director or other SC staff assigned by the Director are responsible to train each Support Coordinator concerning use of the LTSS System. LTSS refers to the DMH CSO as "BIDD" as it was formerly named the Bureau of Intellectual/Developmental Disabilities (BIDD). The LTSS User Manual is located in Part VI of the SC Manual.

5. The Support Coordination (SC) Director or assigned staff reviews/approves initial admissions, recertifications, change requests, and readmissions and submits to DMH CSO. The DMH CSO reviews 100% of initial, recertifications, and readmissions. DMH CSO also reviews all PSS Change Request when additional services/hours are requested. Change of provider, updating contact information or other elements of the PSS, removing services without changing the budget or decreasing the budget are actions that are auto approved. Notify your supervisor prior to auto-approving any changes to ensure accuracy. DMH CSO staff review a percentage of all records annually. The SC Director or assigned staff may use the SC Monitoring Tool (located in Part III Supplemental Documents) as a quality assurance measure.

B. Conflict of Interest Requirements

Staff responsible for assessments and case management – Diagnostic and Evaluation

(D&E) staff and Support Coordination – must meet requirements that prevent conflict of interest. Staff cannot be:

a) Related by blood or marriage to the person seeking services, or any paid caregiver of the person
b) Financially responsible for the person seeking services
c) Legally empowered to make financial or health-related decisions on behalf of the person
d) Providers of Medicaid funded HCBS for the person or those who have interest in or employed by a provider of Medicaid funded HCBS

C. Initial Referral, Evaluation and Eligibility Determination Process

1. Referrals for the ID/DD Waiver are received and processed by the Diagnostic and Evaluation (D&E) team at one of the state's five (5) IDD Regional Programs. Each D&E Team consists of at least a psychologist and social worker. Additional team members may be utilized based upon the needs of the person being evaluated, such as dieticians, therapist, etc. All members of the D&E team are licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines. People are evaluated at the Regional Program assigned to the county in which he/she resides. (Refer to Part III Supplemental Documents – Map of Catchment Areas for Evaluation Sites for ID/DD Waiver and IDD Community Support Program)

2. When contacted by a person/family wishing to receive services, D&E staff mails an Application for Services to begin the process for evaluation. A comprehensive assessment determines a person's need for services and supports including identification of any medical, educational, social or other service need. The assessment includes a person's history, identified and documented needs, and information gathered from sources such as family members, medical providers, educators, and social workers, as appropriate.

3. The D&E Team is responsible for contacting the person to schedule the evaluation. If the person referred has a previous psychological evaluation that is determined sufficient for eligibility determination, D&E completes a psychological summary/ addendum that includes the eligibility criteria and social summary. If the previous evaluation was completed at age sixteen or younger, and the person is now 18 or older, it is best practice to consider conducting a full evaluation. Also, if a person has had a significant change in circumstances that may affect his/her level of functioning and needs since the previous evaluation, a full evaluation should be conducted.

4. During the evaluation process, the D&E Team reviews all available service options with the person. This includes ID/DD Waiver and IDD Community Support Program services, other State Medicaid Waiver services, ICF/IID services, and other types of community services that may meet the person's identified support needs.

5. The Personal Record in Medicaid's Long-Term Services and Supports (LTSS) system is established by the D&E staff. The Psychological and Social Evaluation are entered along with other documentation such as consents, previous evaluations, and

documentation from other sources.

6. Eligibility for ID/DD Waiver is determined by D&E. To qualify for ID/DD Waiver, a person must have one of the following:

    a) An intellectual disability characterized by significant limitations in both intellectual and adaptive behavior. The person's IQ score is approximately 70 or below and the disability originated before the age of eighteen (18); or

    b) A severe, chronic disability that meets ALL of the following conditions:

        i. The condition is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disabilities and requires treatment or services to those required for these persons; or autism as defined by the most current DSM.
        ii. Is manifested before the person reaches age 22; and
        iii. Is likely to continue indefinitely; and
        iv. Results in substantial functional limitations in three or more of the following areas of major life activity:
            a. Self-care
            b. Understanding and use of language
            c. Learning
            d. Mobility
            e. Self-direction
            f. Capacity for independent living
            g. Economic self-sufficiency

7. If a person meets ICF/IID level of care requirements, and has expressed an interest in ID/DD Waiver services, he/she must be informed there is a Statewide Planning List and that his/her name can be placed on the list if they desire. It must be documented in writing whether the person did or did not choose to have his/her name placed on the ID/DD Waiver Statewide Planning list. D&E informs the person/family through a letter and/or in the evaluation report(s) that he/she has been determined eligible for ID/DD Waiver and has been referred to Support Coordination to be placed on the ID/DD Waiver Planning List.

8. Persons determined ineligible based on the D&E evaluation process will be notified by D&E staff and informed of their right to appeal the decision. The person has thirty (30) days from the date of Notice of Ineligibility for ID/DD Waiver to appeal the decision to the DMH CSO. (Refer to Part III, ID/DD Waiver Appealing Ineligibility for Waiver Instructions.)

D. Planning List Management

1. The D&E team forwards the following information to the Support Coordination (SC) Department by the 5th of each month (based on the previous month's completed evaluations) for each person whose name is to be placed on the ID/DD Waiver Statewide Planning List:

a) Last Name
b) First Name
c) Medicaid Number (if available)
d) Social Security Number
e) Date of birth
f) Date of application
g) Initial evaluation date
h) Current evaluation date (if applicable)
i) County of residence
j) Services needed
k) DSM Primary Diagnosis and Secondary Diagnosis and

Identify if the person is in or receives the following services per family or LTSS:

a) In an ICF or Nursing Facility
b) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
c) Elderly and Disabled Waiver
d) Independent Living Waiver
e) Traumatic Brain Injury/Spinal Cord Injury Waiver
f) Assisted Living Waiver
g) Enrolled in IDD Community Support Program

2. The Support Coordination Director or assigned staff places the person's name and information on the Planning List .

3. Each Regional Program Support Coordination is responsible for keeping the Planning List updated for their region. A copy of the current Planning List is sent to the State Director of ID/DD Waiver by the 5th of each month. The ID/DD Waiver Director or assigned staff is responsible for maintaining the Statewide Planning List.

4. People who are on the ID/DD Waiver Statewide Planning List are contacted at least annually, in writing, by one of the four (4) Support Coordination Departments to determine if they desire to remain on the ID/DD Waiver Statewide Planning List and to update contact information. Information returned by the person is compared to the current information and is updated as needed. It is the person's/responsible party's responsibility to contact the appropriate Support Coordination Department to update contact or other information any time it changes.

5. Support Coordination Director or assigned staff must document in the Notes section of the Planning List as contacts or other information changes. Other pertinent information such as date person offered enrollment and/or declined, date added back to Planning List, etc. should also be documented in the Notes section.

6. The Future Planning List is a list of persons who do not want immediate enrollment but may consider enrollment in the future. Names for enrollment are not pulled from the Future Planning List. A person may be moved from the Future Planning List to the Planning List at any time by contacting the SC Director. The person is then placed on the Statewide Planning List with the date of initial eligibility for ID/DD Waiver.

7. If a person and/or their family/representative contacts the SC Office to check on status or request to be placed on the planning list and his/her name is not on the Planning List, consult with D&E to see if the person has previous testing and can be added to the list based on the initial eligibility for the ID/DD Waiver.

E. Initial Enrollment

1. A person is initially enrolled in ID/DD Waiver through one of the following:

    a) ID/DD Waiver Planning List – person drawn from Statewide Planning List based on those on the list the longest amount of time. Each person is placed on the Statewide Planning List based on date of initial eligibility for ID/DD Waiver.
    b) Crisis Capacity enrollment – person has family/caregiver crisis or need for specialized behavior services. Family/caregiver crises: death of the primary caregiver; or inability of caregiver to provide care due to acute mental health, behavior, or medical crisis, or other situations in which immediate care for the person is not available. Immediate specialized behavior services: the person poses a documented threat of harm to self or others or destruction of property. A setting with structure and specially trained staff is necessary to ameliorate or mitigate the behavior in order for the person to return to his/her living and/or day setting.
    c) Transition Enrollment – deinstitution from an ICF/IID (public or private) or nursing facility. The person must have been in the ICF/IID or nursing facility for ninety (90) days or more.
    d) PASRR Diversion – diversion of people with IDD from nursing facility placement. The person is identified through the Preadmission Screening and Resident Review (PASRR) process. The person must have been at the nursing facility for less than ninety (90) days.

2. The number of persons enrolling annually is determined by the ID/DD Waiver Director and is based on various factors including legislative funding, the projected average annual budget per person, the number of discharges from the previous fiscal year, etc. The majority of persons will be drawn from the ID/DD Waiver Planning List with a limited number of people enrolling as Crisis Capacity, Transition, or PASRR Diversion.

3. The ID/DD Waiver Director is responsible for notifying each Support Coordination Department of persons to be enrolled from the Planning List or as Crisis Capacity. Transition Coordinators or Regional Program Directors or assigned staff notify the ID/DD Waiver Director of the projected number of public transitions for approval annually. Private ICF or nursing facilities (transition or PASRR Diversion) must request enrollment to the ID/DD Waiver Director. (See Part II Forms for Private ICF/IID-Nursing Facility Transition Referral Form) D & E may also refer a person to the ID/DD Waiver Director for consideration of enrollment as PASRR Diversion. If approved, a Transition Coordinator or Support Coordinator will be assigned.

4. Upon receipt of the list of people to enroll from the Planning List, the Support Coordination Department notifies each person of the opportunity to be enrolled in the

ID/DD Waiver program. The person is notified in writing and/or by phone. All contacts and attempted contacts must be documented in Service Notes in LTSS.

5. Assigned staff from Support Coordination or Transition Coordination notifies appropriate D&E staff in order to initiate the enrollment process. D&E creates the Personal Record for enrollment.

    a) If the evaluation is more than two (2) years old, an Addendum from the D&E Team verifying the person still meets ID/DD Waiver eligibility requirements must be completed. Additionally, the Social Summary must be updated. The record review must document the person continues to meet eligibility requirements and that the results from the most recent psychological evaluation continue to be an accurate reflection of the person's skills, abilities and support needs. This information must be current within ninety (90) days of submission to DMH CSO.

OR

    b) The person receives a comprehensive evaluation due to evidence that the available evaluation results are no longer an accurate reflection of the person due to changes in age, environment, health, etc.

6. The Personal Record in LTSS contains all evaluations including, at a minimum the psychological and social evaluation. Other evaluations such as nutrition, speech/hearing, etc. are completed at the discretion of the D&E team depending on the person's support needs.

7. The Plan of Services and Supports (PSS) meeting is held. (Refer to Section F of SC Manual for instructions in PSS Development and DMH Record Guide for PSS Instructions). This meeting must include the person, guardians/legal representatives/primary caregivers, the Support Coordinator/Transition Coordinator, and (if possible and known before hand) a representative from each agency that will support the person. The person or their representative may invite any others they wish. Representatives from important non-Waiver services should be invited as appropriate and agreed to by the person. The purpose of the meeting is to determine the person's current situation and what supports are needed to help them have the best life possible. The PSS will be completed in the LTSS system.

8. D&E and/or Support Coordination/Transition Coordination will send a referral to DMH CSO staff of need for ICAP by the Independent Contractor (IC). (Refer to ICAP Referral Form in Part II Forms) DMH CSO notifies the IC. The IC is responsible for entering the ICAP into LTSS.

9. The assigned Support Coordinator creates an Application Packet in LTSS after the Personal Record is completed by D&E, and uploads the following documents into LTSS: (Forms/Instructions are located in Part II Forms or DMH Record Guide)

    a) A medical evaluation, current within ninety (90) days of submission to DMH CSO. Obtaining the Medical Evaluation can happen in one of two ways: 1) the family can have their personal physician/nurse practitioner complete it; or

2) a physician/nurse practitioner employed by the Regional Program can conduct the evaluation. (Note: Not all Regional Programs have a staff physician; in that case, the Medical Evaluation must be obtained by the person/family from a physician/nurse practitioner in the community.) The medical evaluation must be signed and dated by physician/nurse practitioner.

b) The ID/DD Waiver Initial Enrollment Agreement/Freedom of Choice of Institution vs Community must be reviewed with the person/legal guardian and be signed within ninety (90) days of submission to DMH CSO.

c) Rights of Persons Receiving Services must be reviewed with the person/legal guardian and be signed within ninety (90) days of submission to DMH CSO.

d) The Consent for Services must be explained to the person/legal guardian and be signed within ninety (90) days of submission to DMH CSO.

e) A Consent(s) to Release Information for each provider identified on the Plan of Services and Supports (and others as needed) must be signed and dated before any information is released to a provider.

f) Support Coordination Grievance and Complaint procedures must be explained to the person/legal representative and be signed within ninety (90) days submission to DMH CSO.

g) The Documentation of Choice of Provider form is completed and signed by the person/legal representative within ninety (90) days of submission to DMH CSO.

h) The Freedom of Choice of Services form is completed with the person/legal guardian within 90 days of submission to DMH CSO.

i) The Regional Program's HIPAA policy is explained and given to the person/legal representative, and an Acknowlegement of Privacy Policy form must be signed within 90 days of submission to DMH CSO.

10. The following documents are uploaded and attached to the Plan of Services and Supports:

a) The Face Sheet which is completed within ninety (90) of submission to DMH CSO

b) The Signature Page which is signed by all who attended the meeting and indicating any significant contributors not at the meeting

c) The Risk Assessment form which is completed by the Support Coordinator with input from those at the meeting

d) The Skills/Notes from the PSS meeting

e) The Physician Recommendation Form for In-Home Nursing Respite, if

needed

f) Requests for Behavior Support, Crisis Support, or Crisis Intervention (if needed)

g) A letter from MS Department of Rehabilitation Services indicating the person has declined their services or has already been discharged by MDRS, if the person is requesting Supported Employment or Prevocational services for the first time

h) The Team Action Memo (if the person is being discharged from an ICF/IID)

i) The CMS 105 Form

j) Signature on File Form

11. DMH CSO reviews all information in the Application Packet and PSS to make a determination regarding whether the person meets all requirements for admission. If further information is needed, the packet will be returned for clarification. Once approved, the information is forwarded to Medicaid through LTSS, and Medicaid generates the Overall Decision (lock-in) date.

12. Notification of approval by DMH CSO and Overall Decision by DOM is received by the assigned SC through the LTSS alert system.

13. Upon approval of an Initial Certification PSS, the Support Coordinator will review the PSS to ensure contact information is correct and reviews the approved service(s) and frequency(ies) to determine if approved as requested, were modified, or denied. An Overall Decision will be completed by the Division of Medicaid. Once the Overall Decision is received, the Support Coordinator will create a Notice of Determination (Initial) in LTSS. The Notice of Determination (Initial) will be sent to the person/primary caregiver, along with a copy of the PSS. The Support Coordinator sends each ID/DD Waiver provider listed on the PSS a Service Authorization, a copy of the PSS, a copy of the Psychological evaluation, Social Summary and/or Interdisciplinary Report, DD Certificate, and a copy of the Medical Evaluation. If the person receives In-Home Nursing Respite, a copy of the In-Home Respite Physician Recommendation Form must also be sent.

14. If the person was denied a service requested or hours requested were reduced, the person/legal representative has a right to appeal. The person has thirty (30) days from the date of Notice of Determination (Initial) to appeal the decision. A copy of the Appeal Procedures must be mailed with the Notice of Determination (Initial). (Refer to Part III, Appealing Reduction, Denial, and Termination Instructions)

F. Plan of Services and Supports Development

1. The Plan of Services and Supports describes the ID/DD Waiver services and all other supports and services a person receives, formal or informal and regardless of the funding source, that assist him/her to remain at home and in the community.

(Refer to PSS Instructions in the DMH Record Guide for further instructions)

2. The Initial Plan of Services and Supports is developed after all evaluation information has been gathered by the Support Coordinator (psychological, adaptive, educational, etc., medical and ICAP). This meeting must include the person, guardians/legal representatives/ primary caregivers, the Support Coordinator, and (if possible and known before hand) a representative from each service and/or provider agency that will support the person. The person or their representative may invite any others they wish. Representatives from important non-waiver services should be invited as appropriate and agreed upon by the person. Examples of non-waiver supports are MDRS, the Arc, Community Mental Health staff, etc.

3. Plans of Services and Supports for recertification and readmission are developed based on the expressed desires of the person as well as all evaluation and other pertinent information, either gathered initially or that has been generated since the last certification. This meeting must include the person, guardian/legal representative/primary caregiver, Supported Decision Maker (if applicable), the Support Coordinator, and a representative from each service and/or provider agency that will support the person. The person or their representative may invite any others they wish. Representatives from important non-waiver services should be invited as appropriate and agreed upon by the person. Examples of non-waiver supports are MDRS, the Arc, Community Mental Health staff, etc.

4. The Support Coordinator reviews with the person the services that are available through the ID/DD Waiver. The services and supports requested on the Plan of Services and Supports (both ID/DD Waiver and non-ID/DD Waiver) are based on what the person believes would be beneficial in supporting him/her in a home and community based setting as well as the recommendations from the evaluation conducted by the D&E Team.

5. The Support Coordinator, person, and other PSS meeting attendees must address all important issues related to the person's support needs and personal preferences for Initial Plans of Services and Supports and for recertification and readmission Plans of Services and Supports. Issues/concerns/desires expressed by the person constitute the basis of the Plan of Services and Supports. There must be documentation in the Support Coordination record to indicate each item was identified and addressed.

6. The needs and desires of the person may be addressed (and documented in the SC Service Notes) in one of the following ways:

    a) Directly by the Support Coordinator

    b) Making a referral to another agency or provider

    c) Service provision (either ID/DD Waiver or non-Waiver)

    d) Needs to be addressed at a later date (with justification why and timelines for follow-up)

e) By natural supports

7. Outcomes

a) The outcomes are the intended results desired by the person receiving services.

b) The outcomes must be personalized and tied to the Important To Section of the PSS.

c) It is the Support Coordinator's job to assist the person in meeting their identified outcomes by locating and coordinating needed supports and services.

d) Outcomes are developed during the PSS meeting with the cooperation of all present.

e) Outcomes are broad statements in the present tense, indicating how the person and those who support them want the person's life to be. Outcomes are written in the following format:

Name – action verb – what/why– so that or in order to – expected result

f) All waiver services must support at least one Outcome; exceptions are Support Coordination, Occupational/Physical/Speech Therapy, Behavior Support, Crisis Support/Intervention, and Transition Assistance. The service provider must be able to justify the amount of services they bill for by their activities which support the Outcomes. Service providers must indicate in the Activity Support Plan what they will do to support each Outcome the service is assigned to. Support Coordinator should assign providers Outcomes that make sense for the service provided. For example, Day Services Adult will not support Outcomes related to employment, nor will Prevocational support Outcomes related to leisure activities.

g) Frequencies an outcome will be supported by each service should be discussed at the PSS meeting. Frequency of each outcome on the PSS is a total number the outcome is supported by each relevant service, non-Waiver service, and natural supports.

8. ID/DD Waiver Services

a) List the ID/DD Waiver services chosen by the person which are necessary to assist him/her in meeting their identified Outcomes.

i. Every Plan of Services and Supports must have Support Coordination listed as a service. The frequency is monthly.

ii. Each service must have a provider and frequency listed when the Plan of Services and Supports is submitted to DMH CSO.

9. Non-ID/DD Waiver Services

   a) If the person is receiving any non-ID/DD Waiver service(s), list the service, the name of the provider and what the service does for the person. These services include EPSDT services and other mental health, medical, social, educational, vocational, recreational, residential supports, etc. *Specialized Medical Supplies is no longer a Waiver service and should be included in the Non-Waiver Services section if applicable.*

   b) If a non-Waiver service is needed and the Support Coordinator is in the process of linking the person with the service, the service would be listed as a referral to be made.

   c) Non-Waiver services are included on the Plan of Services and Supports so the Support Coordinator can ensure all services provided are coordinated to address each person's unique situation. This also helps avoid duplication of services.

10. Frequency

   a) The frequency of services involves two parts depending on the service: 1) the number of hours or days; and 2) if the service is provided monthly, quarterly or annually. Support Coordinators request the frequency based upon the expressed needs of the person and/or family, the Support Level as established by the most current Independent Contractor (IC) ICAP, and other available information.

   b) Some services have limits. They are as follows:

      i. Day Services – Adult and Prevocational Services - the maximum amount is 138 hours per month; in months with 23 working days, a provider can bill up to 138 hours per month; in months with 22 working days, they can bill up to 132 hours/month; in months with 20 working days, they can bill up to 130 hours/ month. *Regardless of the maximum allowable, a provider can only bill for the amount of service provided.*

      ii. In-Home Respite and Home and Community Supports – the number of hours of support is based on the support needs of the person. However, these are the only two services in which a family member may provide. The family member and relationship must be identified in the How/When Used section of the service. Approved family members cannot provide more than maximum of one hundred seventy-two (172) hours per month or forty (40) hours per week. (See Section G. IDD Services and Rule 45.2 and 47.2 for further requirements for family members.)

      iii. Physical therapy – the maximum is three (3) hours per week; *Note special conditions in order for the person to receive therapies under ID/DD Waiver in Section H. ID/DD Waiver Services.*

iv. Occupational therapy – the maximum is two (2) hours per week; *Note special conditions in order for the person to receive therapies under ID/DD Waiver in Section H. ID/DD Waiver Services*

v. Speech/language/hearing therapy – the maximum is three (3) hours per week; *Note special conditions in order for the person to receive therapies under ID/DD Waiver in Section H. ID/DD Waiver Services*

vi. Behavior Support – Behavior Support Evaluation is either less than six hours or more than six hours over three (3) months. Typically there is only one (1) evaluation per certification year. The amount of direct service hours for Behavior Support will be authorized after the completion of the evaluation. The DMH CSO determines the amount of direct service based on recommendations from the Behavior Support Consultant. DMH CSO will consider a request for another Behavior Support Evaluation under certain circumstances such as the previous evaluation was not completed or if behaviors change/worsen. Consult with DMH CSO as needed.

vii. Crisis Support – The maximum amount is thirty (30) days per Certification year. Additional Crisis Support must be approved by DMH CSO as a last resort.

viii. Job Discovery – thirty (30) hours for three (3) months

ix. Supported Employment Job Development – ninety (90) hours per certification year

11. DMH Certified Providers

a) Persons are informed about all certified providers for services they are requesting when the Plan of Services and Supports is developed/revised. Support Coordinators will give persons written literature (approved by DMH CSO), when available, from the provider agencies and if requested by the person.

b) Enter in LTSS the provider number, name, and contact information of the provider the person chooses for each service. In LTSS, contact information for the provider is pulled from DOM Envision. Support Coordinator may need to update to a more appropriate contact person at the agency.

c) A person may have more than one provider for a given service. In this instance, each provider must be authorized for a specific amount of service. The providers cannot exceed the amount for which they are authorized.

12. Start Date and End/Change Dates for ID/DD Waiver Services and Frequencies Form

a) The provider start date is the day listed on the Service Authorization. If the

frequency of the service changes, the provider start date does not change.

b) The frequency start date is the date the approved frequency actually begins. If a person changes providers, the frequency begin date does not change.

13. Plans of Services and Supports are continually reviewed and revised to ensure approved ID/DD Waiver services and non-Waiver services are appropriate and adequate to ensure the person's health and welfare. Support Coordinators review each person's PSS, at a minimum, during the required monthly contacts and quarterly face-to-face visits in the person's service setting(s).

14. All sections of the PSS must be completed. If there is no information available or relevant, indicate this. Do not leave any section blank.

15. All necessary paperwork for the type of PSS (Initial or Recertification) should be completed on or around the same date as the PSS meeting takes place to keep forms from being out of date when the PSS is submitted.

a) The Application Packet must include

i. ID/DD Waiver Enrollment Agreement/Freedom of Choice of Institution vs Community

ii. Documentation of Choice of Provider

iii. Documentation of Choice of Services

iv. Complaint/GrievanceResolution Procedures for SC

v. Person Rights and Options

vi. Medical evaluation within three (3) years of the start date of the current recertification or when an person's condition changes – must include Physician/NP Signature

vii. Consent(s) to Obtain/Release Information (one for each provider)

viii. Consent for Support Coordination Services

ix. Acknowledgement of receipt of the Regional Program's HIPAA policy

b) The ICAP is be entered into LTSS by the Independent Contractor. *Notify DMH CSO by email if IC ICAP not completed in a timely manner.*

c) PSS attachments must include:

i. Risk Assessment form

ii. Face Sheet

iii. Signature Page, signed by all who attended the meeting, and indicating any Significant Contributors who were not at the meeting

iv. Skills/Notes from the PSS meeting that must include, at a minimum: the Relationship Map, Working/Not Working, Important To/For, Great Things About, Things to Know and Do, and any other notes.

v. Physician Recommendation form for IHNR (if needed)

vi. Requests for Behavior Support, Crisis Support, Crisis Intervention, Behavioral or Medical Supervised Living (if needed) and all documents required to request these services

vii. Letter from MDRS if requesting Supported Employment or Prevocational services during recertification

G. ID/DD Waiver Services

This section describes ID/DD Waiver Services and provides helpful information for the Support Coordinator as he/she develops the PSS:

Behavior Support (Chapter 46 DMH Operational Standards) is designed to provide systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment, and training for people whose behaviors are significantly disrupting their progress in learning, self-direction or community integration and/or are threatening to require movement to a more restrictive setting. This service also includes consultation and training provided to families and staff working with the person. The desired outcome of the service is long term behavior change.

- If Behavior Support is indicated/requested, the Support Coordinator must talk with the person/family and all service providers to get a comprehensive picture of the person's behaviors and support needs.
- Initially a Behavior Support Evaluation will be completed to determine the level of supports needed. To request Behavior Support Evaluation, add as a service in PSS and attach the Request for Behavior Support Evaluation.
- Behavior Support is a vital support in order to help the person live successfully in the community. Once Behavior Support Evaluation has been approved, the Support Coordinator must follow up with the BS provider to ensure the evaluation begins as soon as possible.
- Upon completion of the evaluation, a change request for Behavior Support will be submitted and include the following documentation from the Provider: Justification for Behavior Supports, Functional Behavior Assessment, Behavior Support Plan and Medical Verification for Behavior Supports. Refer to the DMH Record Guide for more information on these documents. The Behavior Support Consultant must recommend the number of hours for Behavior Consultant and for Behavior Specialist is needed on the Justification for Behavior Support Services.

- All providers must allow for implementation of the Behavior Support Plan in the service setting regardless if Behavior Support personnel are employed by a different provider (Rule 46.4)
- When a person receives Behavior Support, it is crucial for the Support Coordinator to make sure the person is receiving the hours/support authorized on the PSS.
- The Behavior Support Plan belongs to the person and goes with the person if he/she changes Behavior Support provider. A new Behavior Support evaluation is not necessary unless there is a change in targeted behaviors or there has been a lapse in service of one or more months. A new Behavior Support evaluation will be considered by DMH CSO with sufficient justification.
- The Support Coordinator must keep Behavior Support staff informed if the person changes other service providers, for example new day program or in-home provider, so new staff can be trained on the Behavior Support Plan, as applicable.
- The Support Coordinator should review the person's risks and targeted behavior in their Behavior Support Plan in order to document in how/when used to justify need for continued behavior services.

Community Respite (Rule 27.2) is provided in a DMH certified community setting (not a private residence) and is designed to provide caregivers an avenue of receiving respite while the person receiving support is in a setting other than his/her home. Community Respite provides the person with a place to go which has scheduled activities to address the person's preferences/support needs.

- Community Respite is not used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adult, Prevocational Services, or services provided through the school system.
- Adults (age 18 and older) and children/youth cannot be served together in the same area of the building.
- People who receive Host Home Services, Supervised Living, Shared Supported Living or Supported Living or who live in any type of staffed residence cannot receive Community Respite.

Crisis Intervention (Rule 19.9) provides immediate therapeutic intervention, on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the person or others and/or may result in removal from his/her current living arrangement. Crisis Intervention includes consultation with family members, providers and other caregivers to design and implement personized Crisis Intervention Plans and provide additional direct services as needed to stabilize the situation.

- Three (3) primary service locations – a) in the person's home; b) in an alternate community living setting; or c) in the person's usual day setting excluding school.
- Two (2) service delivery options – a) Daily option – twenty-four (24) hours per day, seven (7) days per week – authorized in seven (7) day segments. Additional segments may be authorized by DMH CSO depending on a person's needs and circumstances; or b) Intermittent option - episodic short-term segments, often less than 24 hours per day with a max of one hundred sixty-eight (168) hours per certification year.
- A Request for Crisis Intervention Services must be attached to the PSS when requesting the service

Crisis Support Services (Rule 19.10) are provided in an ICF/IID and are used when a person's behavioral or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention/Behavior Support. Crisis Support is time-limited in nature and provides the behavioral and emotional supports necessary to allow the person to return to his/her living arrangement.

- There is a maximum of thirty (30) days per stay. Additional days may be authorized by DMH CSO prior to the end of the authorized date. A request for additional days must be submitted in a timely manner with sufficient justification as to why days are needed.
- Support Coordination must maintain contact with Crisis Support staff to check on progress at least weekly. Support Coordination must work with all paid and natural supports to develop a plan of how the person can be supported after Crisis Support.
- If there is a Behavior Support Plan prior to the Crisis Support admission, Support Coordination must notify the Behavior Support provider and send a copy of the Behavior Support Plan to the ICF with the Service Authorization.
- If the person did not have a Behavior Support Plan, behavior instructions may be developed by the Crisis Support Team and shared with family/providers supporting the person.
- A transition/discharge planning meeting is required with the person, legal representative(s)/supported decision maker, Crisis Support Team, Support Coordinator and community service provider(s) and any others the person chooses to attend within five (5) working days of discharge from Crisis Support. The PSS must be updated to reflect changes that occur during the crisis stay, such as medication change, new identified risk, and things people need to know to support the person.
- The Support Coordinator must conduct a face-to-face follow up visit within seven (7) calendar days of discharge to determine any additional needs the person may have.

Day Services-Adult (Rule 27.1) assists and supports retention and/or improvement of skills that afford a person the greatest level of independence possible. Programs are required to provide numerous and varied opportunities to participate in activities in the community rather than in a center-based program. Day Services Adult services are available only to those people who are no longer eligible for services or receiving services from the school system (ages 18 and up**).** Transportation to and from the program and for community participation is provided.

- Documentation that the person ***initially*** enrolling in DSA under the age of twenty-two (22) is no longer receiving school services must be uploaded to attachments in PSS
- The person's support level is based on Independent Contractor (IC) ICAP.

Home and Community Supports (Chapter 47 DMH Operational Standards) are designed to primarily provide access to the community. Staff may assist with other activities such as bathing, meal preparation, eating, dressing, and light housekeeping, as needed. Leisure and community participation activities are the primary focus of the service. It is provided to people who live in their family home.

- Service is provided for people living in a family home and cannot be provided in Supervised Living, Shared Supported Living, Supported Living or any other type staffed residence such as personal care home. The service is also not available to people who are in the hospital, ICF, nursing home or other facility billing Medicaid, Medicare, and/or private insurance.
- Home and Community Support staff may accompany adults or a minor with a parent/legal representative present on a medical visit.

- Providers are responsible for providing transportation to and from community outings within the scope of the service.
- Certain family members may provide Home and Community Supports if 1) they do not live in the same home; 2) are not parents/step-parents, spouse or children of person receiving the service, or (3) are not a person normally expected to provide care for the person receiving the service (such as a representative payee, conservator or legal guardian). Seek advice from your supervisor or DMH CSO for guidance. (Refer to Rule 47.2 DMH Operational Standards for further requirements.)
- An approved family member may provide a maximum of one hundred seventy two (172) hours per month or forty (40) hours per week. Support Coordinator must be notified by provider agency. The family member, relationship and amount of hours provided must be documented in the PSS.
- Amount of hours to be requested is determined by the person's support needs. DMH CSO will approve hours based on the justification for hours in the PSS, person's most current Independent Contractor ICAP, and the average amount of hours received by people with similar skills, abilities, and support needs.
- Support Coordination must consider how/when the service is to be used and whether Home and Community Supports or In-Home Respite is the most appropriate service. Examples of inappropriate Home and Community Supports requests include people with significant medical support needs who spend little or no time in the community or hours requested during night time hours at a time people typically are not in the community.
- Home and Community Supports may be shared by up to three (3) people with common direct service provider. Sharing the service is primarily used when multiple persons/family members live in the same household but can be used to allow people to spend time with friends who also receive services. The person/family must choose to share the service with each other.

Host Homes (Rule 30.5) are private homes where an eligible person lives with a family and receives personal and supportive services. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the physical, social, and emotional well-being of the person in a family environment. People who receive this service must be at least 5 years of age.

- There are currently no certified providers for this service**.**

In-Home Respite (Rule 45.1 and 45.2) provides temporary, periodic relief to those people normally providing care to the eligible person. Staff provides all necessary care the usual caregiver would provide during the same time period (e.g. bathing, dressing, eating, meal preparation, leisure activities). The majority of the service takes place in the family home, but short outings of up to two (2) hours may take place.

- Service is provided in a family home and cannot be provided in Supervised Living, Shared Supported, Supported Living or any other type staffed residence such as personal care home. The service is also not available to people who are in the hospital, ICF, nursing home or other facility billing Medicaid, Medicare, and/or private insurance.
- Employees cannot accompany people to medical appointments.
- Certain family members may provide In-Home Respite if 1) they do not live in the same home; 2) are not parents/step-parents, spouse or children of the person receiving the service, or (3) are not an person normally expected to provide care for

the person receiving the service (such as a representative payee, conservator or legal guardian). Seek advice from your supervisor or DMH CSO for guidance. (Refer to Rule 45.2 DMH Operational Standards for further requirements.)

- An approved family member may provide a maximum of one hundred seventy two (172) hours per month or forty (40) hours per week. The Support Coordinator must be notified by provider agency. The family member, relationship and amount of hours provided must be documented in the PSS.
- Amount of hours to be requested is determined by the person's support needs. DMH CSO will approve hours based on the justification for hours in the PSS, person's most current Independent Contractor ICAP, and the average amount of hours received by people with similar skills, abilities, and support needs.
- Support Coordination must consider how/when the service is to be used and whether Home and Community Support or In-Home Respite is the most appropriate service. Examples of when In-Home Respite is more appropriate includes people with significant medical support needs who spend little or no time in the community or hours requested during night time hours at a time people typically are not in the community.
- In-Home Respite may be received at a 2-person or 3-person rate with other persons in the same household.

In-Home Nursing Respite (Rule 45.1 with exception of Rule 45.1.H. and Rule 45.3) provides the primary care giver(s) a break from the constant demands of caring for their family member who requires support. In-Home Nursing Respite is provided in the person's home and must be provided by a licensed nurse. Activities which typically take place are those that require skilled nursing care along with activities of daily living, meal preparation, and supervision. Examples of skilled nursing include tube feedings, rescue medications, wound care, suctioning, and other treatment required to be provided only by a nurse. The need for medication or activities of daily living (ADLs) alone is not justification for the service.

- Service is provided in a family home and cannot be provided in Supervised Living, Shared Supported, Supported Living or any other type staffed residence such as personal care home. The service is also not available to people who are in the hospital, ICF, nursing home or other facility billing Medicaid, Medicare, and/or private insurance.
- Employees cannot accompany people to medical appointments.
- In-Home Nursing Respite cannot be provided by family members.
- An In-Home Nursing Respite Physician Recommendation Form must be completed by a physician or nurse practitioner and submitted with the PSS initially and upon recertification.
- Person receiving Private Duty Nursing Services through Early Periodic Screening Diagnostic and Treatment (EPSDT) cannot receive In-Home Nursing Respite. There are a limited number of persons that were grandfathered in by Division of Medicaid to receive both services. No new persons will be approved.

Job Discovery (Rule 27.4) results in the development of a plan for achieving integrated employment and/or business plan development for self-employment. It is designed to assist with volunteerism, self-determination and self-advocacy, identifying wants and needs for supports, job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, and employment preparation (i.e. resume development, work procedures). Job Discovery is time-limited. A person must be at least 18 years of age to

participate in Job Discovery. Job Discovery is a more intensive service than Supported Employment and is typically provided to people who have not been able to maintain or find jobs for extended periods of time.

- Cannot exceed thirty (30) hours of service over a three (3) month period
- Person who is currently employed or who is receiving Supported Employment services cannot receive Job Discovery
- Person must be referred to MS Department of Rehabilitation Services (MDRS) but the person may receive Job Discovery upon service approval prior to MDRS involvement.

Prevocational Services (Rule 27.3) promote vocational skill development with the eventual outcome being employment in an integrated workplace in the community, with or without support. Activities generally are not primarily directed at teaching job specific skills, but at broader skills which can be used in a variety of work settings (examples: increasing attention span, improving gross and fine motor skills, etc.). Prevocational Services are time limited and must have a career development goal. Services can be center based or community based. Prevocational Services are available only to those people who are no longer eligible for services or receiving services from the school system (ages 18 and up). Transportation to and from the program and for job exploration activities is provided.

- Documentation that the person initially enrolling in Prevocational Services under the age of twenty-two (22) is no longer receiving school services must be uploaded to attachments in PSS.
- If the person is under the age of twenty-two (22) and no longer receives education services or under the age of twenty-four (24) and requesting Prevocational Services at a 14c work setting, he/she must be referred to MDRS and exhaust all resources before request for Prevocational Services. Documentation from MDRS must be attached to the PSS initially requesting Prevocational Services.
- The person's support level is based on the most current Independent Contractor ICAP.

Shared Supported Living (Rule 30.8) is for people ages 18 and older and is provided in a compact geographical area (e.g. an apartment complex). It is for people who do not require a staff person in the same residence with them at all times. Services include personally tailored supports which assist a person to live in a home or apartment with the greatest degree of independence possible. Staff supervision is provided at the program site anytime people receiving services are present. Staff supervision is also provided in the community. Community participation is to take place when and where people receiving services choose. There is awake staff available 24 hour per day/7 days per week and they must be able to respond to requests/needs for assistance from anyone receiving services within five (5) minutes. Transportation to and from community activities is provided.

- The person's support level is based on the most current Independent Contractor ICAP.

Supervised Living (Rule 30.1) is for people ages 18 and older and provides personally tailored supports which assist a person to live in the community with the greatest degree of independence possible. Support is provided for activities of daily living, meal preparation, cleaning, finances, shopping and other personal pursuits. Access to community activities is available when and where people receiving services choose. They must have access to the community to the same degree as others in the community. There must be staff in the dwelling 24 hours per day/seven days per week who can respond to calls for assistance immediately. Transportation to and from community activities is provided.

- A person's support level is based on the most current Independent Contractor ICAP.

- Support Coordination must identify the number of persons living in the supervised living home in order to enter into LTSS and use correct modifiers on the Service Authorization. Refer to the Procedure Code Fee Schedule.
- Each supervised living home is certified through DMH and must meet health and safety standards as described in Rule 30.4.
- Providers may receive an increased rate for person with significant behavioral and medical needs (described below). Documentation must be completed as outlined in Part III Supplemental Documents and submitted to DMH CSO for review by the Specialized Needs Committee in a timely manner.

Behavioral Supervised Living (Rule 30.2) *is not a separate service than Supervised Living Services* but provides an increased level of support for people with high frequency disruptive behaviors that pose serious health and safety concerns to self or others, including destructive behaviors that may or will result in physical harm or injury to self or others. Behavioral Supervised Living must receive prior approval by the DMH CSO and Specialized Needs Committee. The DMH Specialized Needs Committee will determine the need for ongoing Behavioral Supervised Living at least annually. People who receive Behavioral Supervised Living cannot also receive Behavior Support or Crisis Intervention Services.

- Documentation must be completed as outlined in Part III Supplemental Documents and submitted to DMH CSO for review by the Specialized Committee in a timely manner.
- Generally, Behavioral Supervised Living will be approved for the certification period. However, the Specialized Needs Committee occasionally approves Behavioral Supervised Living with a specific time limit, for example six months. It is the Support Coordinator's responsibility to track when the additional support expires and submit substantiating documentation to justify continued support prior to the expiration date with ample time for the Specialized Needs Committee to make a determination.
- In order to provide Behavioral Supervised Living, a provider must first be approved through Certification and DMH CSO.

Medical Supervised Living (Rule 30.3) *is not a separate service than Supervised Living Services.* Medical Supervised Living provides additional support for people with chronic physical or medical condition(s) requiring prolonged dependency on medical treatment for which skilled nursing intervention is necessary. Medical Supervised Living cannot be received unless the person requires frequent nursing oversight to include a minimum of monthly nursing assessments by the registered nurse. Medical Supervised Living must receive prior approval by the DMH CSO and Specialized Needs Committee. The DMH Specialized Needs Committee will determine the need for ongoing Medical Supervised Living at least annually, before recertification.

- Requests for Medical Supervised Living must include documentation as outlined in Part IV Supplemental Documents and submitted to DMH CSO for review by the Specialized Needs Committee. The Specialized Needs Committee determines eligibility for Medical Supervised Living.
- Short Term Medical Supervised Living for sixty (60) days may be approved for persons who need additional medical support to recover from an illness or procedure. Refer to Rule 30.3.L. for additional information.
- Generally, Medical Supervised Living will be approved for the certification period. However, the Specialized Needs Committee occasionally approves Medical Supervised Living with a specific time limit, for example six months. It is the Support

Coordinator's responsibility to track when the additional support expires and submit substantiating documentation to justify continued support prior to the expiration date with ample time for the Specialized Needs Committee to make a determination.
- In order to provide Medical Supervised Living, a provider must first be approved through Certification and DMH CSO.

Supported Employment (Rule 27.5) supports people in finding and keeping a job in the community. Supported Employment is provided as two (2) distinct activities – Job Development (finding a job) and Job Maintenance (working with job coach). Activities such as job exploration and applying for jobs are part of Job Development. Assistance on the job to ensure the support necessary to be successful is part of Job Maintenance. Support is to be faded as the person learns the job and performs it successfully in an independent manner or supported employment can continue indefinitely, depending on the person and his/her particular level of support needs. A person cannot otherwise be eligible through the MS Department of Rehabilitation Services or their school district.

- Person must be referred to MDRS and exhaust all resources prior to requesting Supported Employment
- Support Coordination must receive documentation from MDRS and attach to the PSS when initially requesting Supported Employment
- Employment must be in an integrated work setting compensating at least minimum wage. Name of employer and type of duties should be included in the How/When Used and in the Employment section.
- The amount of hours monthly depends on the employer needs or typical working hours and addressed in the PSS in How/When Used and Employment section.
- Supported Employment may also assist the person in self-employment. (Rule 27.5.J.) Self-employment job coach is limited to max of fifty-two (52) hours per month of at home assistance and thirty five (35) hours per month in the community.
- Providers should not be searching for a job for a person who is not approved for Supported Employment or Job Discovery unless the person can work alone and does not need a job coach.
- Job Maintenance and Self Employment has the same Supported Employment procedure code

Supported Living (Rule 30.6) is provided to people who reside in their own homes (either owned or leased). The purpose is to increase and enhance independent living. Supported Living provides direct assistance with activities of daily living such as grooming and personal needs, as well as instrumental activities of daily living which include assistance with planning and preparing meals, cleaning, transportation or assistance in securing transportation, assistance with ambulation and mobility, supervision of the person's safety and security, banking, shopping, and budgeting. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the person's home, depending on the type of emergency. People receiving Supported Living must be at least 18 years of age.

- The amount of service hours are determined by the level of support required for the person. The maximum amount of hours shall not exceed eight (8) hours per twenty-four hour period.
- People living with caregivers, whether family or other, would receive different services such as In-Home Respite or Home and Community Supports.
- People may live independently in their own home or apartment. People who live in a home or apartment owned or operated by the agency provider must have a lease or

written financial agreement. If Supported Living in a provider owned or controlled setting, the setting must have four (4) or fewer people living in the home. The residence can be a Supervised Living setting if the person so chooses.

- Supported Living for community participation activities may be shared with up to three (3) persons who may or may not live together. The person must agree to share the service with others.

Therapies (Occupational Therapy, Physical Therapy, and Speech/Language Therapy) are only reimbursable under the ID/DD Waiver for persons over the age of 21 that receive therapy in their home. Therapies are not reimbursable under the ID/DD Waiver at a therapist office/clinic, outpatient department of a hospital, or physician office/clinic. Therapy services should only be provided in the beneficiary's home when it is not feasible to be rendered in a provider's office, clinic, or hospital setting and cannot be strictly for convenience of the person or their family. Therapy services must be justified in the Plan of Services and Supports.

- Therapy services are not certified through Department of Mental Health and thus are not referred to in DMH Operational Standards. Therapy provider must be a Division of Medicaid approved provider. (Refer to Guidance from Division of Medicaid located in Section III Supplemental Documents)
- The Physician's office and/or the beneficiary's family must send an order or prescription to the Support Coordinator if the physician determines therapy is medically necessary and cannot be rendered in a provider's office, clinic, or hospital setting. The order or prescription must include a letter from the physician supporting justification for services provided in the home.
- A copy of the physician order and letter must be in the attachments of the PSS with the initial or change request PSS adding any of the therapies to the Waiver Services section. Upon approval of the PSS, a copy of the physician's order must be sent to the therapy provider with the Service Authorization.

Transition Assistance (Chapter 48 DMH Operational Standards) is one-time financial assistance for people who transition from an institution (ICF/IID or a Nursing Home) to a less restrictive community living arrangement such as home with their family or to a house or apartment where they receive Supervised Living, Shared Supported Living or Supported Living services, or a Host Home living arrangement. Examples of items which can be purchased include: essential furnishings, linens, and security deposits, initial stocking of pantry, exterminator services, assistance with moving expenses, utility set up fees, and adaptive equipment (not covered under Medicaid). There is a one-time, life time maximum amount of assistance of $800 per person. Only expenses for items purchased may be reimbursed. These items cannot be available from another source.

- Transition Assistance only applies to people transitioning from an ICF (public or private) or from a licensed nursing facility. It does not apply to people transitioning from MS State Hospital or other psychiatric inpatient programs.
- Persons transitioning from an ICF or nursing home must be approved as a transition enrollment through DMH CSO

H. HCBS Final Rule

1. On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule effective March 17, 2014 which amends the requirements for qualities of home and community-based settings. These requirements reflect CMS's

intent that persons receive services and supports in settings that are integrated in and support full access to the greater community. The Final Rule applies across all HCB Services with additional requirements for residential and day program settings. (Refer to Part III Supplemental Documents – Home and Community-Based Services (HCBS) Final Rule flyer for additional information)

2. The Support Coordinator must inform the person and family concerning Final Rule requirements and give them a copy of the Final Rule Flyer during initial enrollment, at change of primary caregiver, and if the person moves from home to community living setting (Supervised Living, Shared Supported, or Supported Living).

3. The Support Coordinator must have an understanding of the Final Rule requirements and is responsible for monitoring compliance and providing education to the person/family and provider as needed. Discuss issues of concern with your supervisor and seek guidance from DMH CSO as needed.

4. The HCBS Final Rule set requirements for person-centered planning.

    a) The PSS is developed by the Support Coordinator with the person directing the plan to the greatest extent possible. The person chooses who is at the PSS meeting (family/responsible party, providers, and anyone else the person chooses). The PSS occurs at least annually and at times/location convenient to the person.

    b) The PSS contains the elements required by the Final Rule such as important to; important for; choice of services/providers; risks; person's skills, abilities, and support needs; meaningful person-centered activities.

    c) Providers must ensure services are person-centered and based on what the person needs/wants in order to have a meaningful life and to ensure autonomy and independence to the greatest extent possible.

        i. Services should not be regimented and staff should not be choosing all activities and schedules. The person must be a part of the planning process. Activities should be designed with what is meaningful and important to each person. Providers must offer a variety of activities.

        ii. People have a right to control their own schedules and activities to the greatest extent possible. They cannot be required to participate with any particular activity and must be offered other alternatives. They are not required to participate with a group.

        iii. Services allow opportunities for engaging in community life.

        iv. Providers should look for ways to enhance and optimize independence.

        v. Community integration should be to the same degree as other people without disabilities. Community integration should include interacting

with non-disabled members of the community, not just other people receiving or providing services. Reverse integration alone is not sufficient to meet the requirements of the Final Rule. An example of reverse integration is when a person would like to take an art class and the provider has someone come to the day program rather than taking the person to an art class in the community. Although having people from the community come to the day program or residential setting is allowed, the goal is to connect the person to the community as much as possible.

5. The HCBS Final Rule protects the person's rights of privacy, dignity, and respect.

    a) The person must be treated with dignity and respect. The Support Coordinator nor any HCBS staff should use baby-talk such as "baby", "sweetie", or "honey". The person should be called the name he/she wants to be called.

    b) Person has the right for privacy and has the right to spend time alone unsupervised unless there is an assessed risk/support need that would jeopardize the person's health and safety.

    c) Any modification/restriction to a person's rights must be associated with the person's specific needs/risks and addressed in the PSS (documented in Risk Assessment and Person-Centeredness sections). A person with any limitations or restrictions must be addressed with the specific circumstances and techniques in the Person Centeredness section.

6. The HCBS Final Rule ensures people have a choice of settings including non-disability specific settings.

    a) "Non-disability specific" in the context of this regulation means that among the options available, the person must have the option to select a setting that is not limited to people with the same or similar types of disabilities. This could include other services based out of their home or a provider-controlled setting that includes people with and without disabilities. It may also include non-HCBS services and supports such as HUD Housing or other residential setting (owned or rented by the person), YMCA or fitness center for day activities, etc.

    b) The person's support needs and abilities must be considered to assist the person/family to determine the most appropriate setting. For residential settings, financial resources for room and board must also be considered.

    c) Setting options are identified and documented in the Plan of Services and Supports in the Person-Centeredness section, as well as the person's choice.

7. The HCBS Final Rule ensures people have a choice of services and who provides them.

    a) People must be provided opportunities to seek employment and work in

competitive, integrated settings. Support Coordinators are required to discuss employment opportunities and available supports initially and at least annually at PSS meetings. Support Coordinators assist people access employment opportunities at any time the person expresses interest in work.

b) Providers are not allowed to "bundle" services (example: requiring a person living in their Supervised Living home to receive all services from them).

c) Service options and the person's choice is documented in the Plan of Services and Supports.

8. The HCBS Final Rule includes additional requirements for persons living in residential settings and attending congregate day settings. Any modification or restriction of the rights below must be associated with an identified risk and documented in the PSS as stated above.

   a) People have the right to privacy and right to secure their belongings. For day programs, people must be offered a place to secure their belongings if they choose to do so. Persons living in a residential setting must be offered a key to their home and to their bedroom. If they choose not to have a key initially, they must receive one at any time they choose to do so. If they choose to share a bedroom, each person must be offered a place to secure their belongings such as a lockable closet, cabinet, or foot locker.

   b) People have the right to have visitors.

   c) People have the right to eat what, when, and where they want.

   d) Homes should be typical to other homes in the neighborhood and not appear "institutional" or be isolating compared to other homes in that community.

   e) People have the right to choose where they live including choice of roommate/housemate.

   f) People have freedom to furnish and decorate their room within the lease agreement. Person and housemates have the freedom to furnish and decorate common areas as they choose.

   g) People have control of their own personal resources.

   h) Person must have a lease or legal agreement to protect from eviction.

   i) The setting must be physically accessible.

9. Documentation by Support Coordinator of compliance with the HCBS Final Rule is done in the Person Centeredness section and the Things People Need to Know section of the PSS. Even though a person may not be able to speak or has a guardian, the person must have input in choice of services, providers, living arrangements (including roommate), control of personal resources, and choice of activities at home and in the community to the greatest extent possible. If there are

any restrictions or modifications of the person's rights, it must be connected to a risk and must be documented in the PSS.

I. Specialized Needs Committee

1. The DMH Specialized Needs Committee (SNC) was constituted to address the need for an avenue to review and approve/disapprove requests for:

    a) Behavioral Supervised Living
    b) Medical Supervised Living
    c) Crisis Reserved Capacity Slots

2. The DMH Specialized Needs Committee is comprised of a representative from an advocacy organization, a Registered Nurse, a Behavior Consultant, and a Licensed Psychologist, and will make the determination if a person needs level of support to receive Medical or Behavioral Supervised Living and if someone is appropriate to be enrolled in the ID/DD Waiver via a Crisis Reserved Capacity slot.

3. The Specialized Needs Committee meets on Mondays at 1:30pm to review documentation received by DMH CSO, through the LTSS system, on or before Wednesday of the prior week.

4. The Support Coordinator is responsible for tracking persons approved for Behavioral or Medical Supervised Living. For Behavioral Supervised Living, the Behavior Support Staff must send a copy of the Functional Behavioral Assessment, Behavior Support Plan, and Quarterly Reports to be uploaded by the Support Coordinator in attachments. The Support Coordinator must ask for required documentation to be submitted with the recertification in a timely manner so that he/she can submit the recertification at least forty-five (45) days prior to the end of the certification period. It is a good practice to contact the provider no later than the end of the third quarter of the certification period to assure information is available to submit with recertification. Support Coordination should inform DMH CSO in the Overview Comment section and an email that a recertification will need to be reviewed by the Specialized Needs Committee, so that it can be reviewed in a timely manner. At times the Specialized Needs Committee approves supports on a temporary basis. Support Coordinator is responsible for tracking when it ends or needs to be reviewed for continued services.

5. If Crisis Capacity enrollment is approved by the Specialized Needs Committee, the approval documentation will be sent to the Support Coordination Director for enrollment. Enrolling approved people should take priority over others, as it is crisis capacity.

J. Managing Crisis Situations/Requesting Crisis Support

1. Per 2020 DMH Operational Standards (Rule 19.10), Crisis Support is provided in an ICF/IID (NMRC, HRC, BRC, ESS, SMRC) and is used when a person's behavior or family/primary caregiver situation becomes such that there is a need for immediate

specialized services that exceed the capacity of Crisis Intervention or Behavior Support Services.

2. Crisis Support requests may include the following:

    a) Behavioral Issues
        i. People who have exhibited high risk behavior, placing themselves and others in danger of being harmed
        ii. Directly causes serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others or animals
        iii. Sexually offensive behaviors
        iv. Less intrusive methods have been tried and failed
        v. Criminal behavior
        vi. Serious and repeated property destruction

    b) Family/other Issues
        i. The primary caregiver becomes unexpectedly incapacitated, and the person's support needs cannot adequately be met by other ID/DD Waiver Services.
        ii. The primary caregiver passes away, and the person's support needs cannot adequately be met by other ID/DD Waiver Services.
        iii. The person is in need of short-term services in order to recover from a medical condition that can be treated in an ICF/IID rather than a nursing facility.
        iv. The primary caregiver is in need of relief that cannot be met by other ID/DD Waiver Services.

3. During conversation with person, family and providers, ensure follow-up and proactivity on any situation that may become a crisis. The goal is coordination of available resources (Waiver and Non-Waiver) to prevent the need for Crisis Support Services.

    a) Include the person in decision making processes as much as possible, make sure they are being listened to and given informed choice.
    b) Exhaust community resources (link to CMHC, MCeRT, Office of Consumer Supports)
    c) Has Behavior Support been offered and/or utilized
    d) Assess situation and notify Supervisor
    e) Notify DMH CSO when all efforts above have been exhausted and there is need for higher level of support or assistance with options

4. If one of the Regional Centers can support a person in Crisis, Support Coordinator will submit a Change Request PSS with appropriate and supporting documentation. Ensure all sections of PSS are updated. (This may include but is not limited to Waiver Supports, medications, Risks, admission to acute psychiatric facilities, behavior supports and serious incidences.) Approval from the DMH CSO is required for admission to an ICF/IID for Crisis Support Services. Support Coordination should notify DMH CSO by email as soon as they are aware the person is being admitted to Crisis Support. Support Coordination has up to five (5) days to submit a change

request PSS for Crisis Support.

5. During a person's crisis situation (Crisis Support, Crisis Stabilization, Crisis Intervention, Inpatient Psychiatric), Support Coordinator should be documenting everything in Service Notes. This may include but is not limited to conversations with Crisis Coordinator, providers, families; information sent and received, PSS updates, etc. All contacts should be documented in real time and not wait for one monthly Service Note. Frequency of contacts depend on the person's circumstances and need for additional services and supports. (Note minimum contact requirements for Crisis Support under Section G. ID/DD Waiver Services.)

6. Discharge plans should be in progress from time of admission and throughout the stay. Does person need a new living arrangement, provider, more hours, new services? All should be in place before end of Crisis stay to prevent the need for return and Support Coordination should follow up regularly to ensure services remain appropriate.

K. Electronic Visit Verification (EVV)

1. In December 2016, Congress enacted the 21st Century Cures Act which requires states to implement Electronic Visit Verification (EVV) for Medicaid financed personal care and home care services by January 1, 2020 and January 1, 2023, respectively, to avoid reduction in federal Medicaid Funding.

2. Electronic Visit Verification (EVV) is a process that uses technology to verify provider visits for personal or home care services.

3. The Division of Medicaid initially required EVV for all In-Home Nursing Respite and Home and Community Supports. EVV for these services is mandatory and not optional. In 2021, it was determined In-Home Respite and Supported Living services would also require EVV. The implementation of EVV for In-Home Respite and Supported Living is expected to begin in 2022.

4. Currently, EVV is provided through MediKey. The purpose of MediKey is to electronically verify a provider staff visit to a person. This is done through the use of a designated landline or a One-Time Password (OTP) device.

    a) A person with landline may use an Interactive Voice Response phone system to verify visits. The provider staff member(s) record voice prints to clock-in and clock-out when providing the service. The process has two different phone numbers: 1) for voice print recording and 2) service verification line to clock-in and clock-out.

    b) The One-Time Password (OTP) token is a key fob-like device. Support Coordinators decide which persons are able to receive an OTP device and are responsible for assigning the OTP device. The device may be assigned if there is the potential for a landline to be unavailable to the provider staff.

5. Medicaid contracted with FEI to enhance software. CareVisit is a comprehensive full-featured Electronic Visit Verification software product that enables state agencies, managed care organizations, and case managers to monitor service delivery and expedite reporting. MediKey will continue to be an option for EVV if providers choose to do so. Medicaid will provide training for Support Coordinators and providers once the program is implemented.

6. Support Coordination Directors or assigned staff will provide training and guidance to Support Coordinators on EVV processes.

L. Change Request PSS

1. Changes to the PSS should be made as soon as they are requested. If a Recertification is in progress, the Support Coordinator will request to have it returned so that the Change Request can be completed. If a Recertification has been approved but is not yet active, it should be discarded in order to allow for a Change Request that needs to take effect before the Recertification date. The Recertification can then be resubmitted, noting that a last minute Change Request was required.

2. Change Requests can include services being added, services being removed, change of providers, change in amounts of services, uploading new documents, and updating any information on the PSS (i.e. contacts, doctors, family situation, employment, etc.).The reason for the Change Request should be addressed in the Overview Comment section of the PSS.

3. Change Requests should come from the person being supported or their family. If the person cannot speak for themselves and does not have family or other natural supports, a request can come from a provider. In all cases, the Support Coordinator should speak with the person and their natural and paid supports to determine what is needed, and how best to meet those needs. Changes should not be requested solely for the convenience of the provider.

4. The Change Request should include:

    a) The amount(s) and type(s) of services requested. If this is a change to an existing service, the old entry will be adjusted to show a new end date, and a new entry will be made with the requested changes. Start and end dates are erased when a Change Request PSS is created. Support Coordination must review each service to ensure Start Date and End Date are correct.

    b) A detailed justification for each requested service, including why a change is needed. Include history of when and why a person was approved for amount of hours over current support level.

    c) Changes to current living arrangements and natural supports.

    d) Changes to person’s current abilities, desired community participation activities, and employment

e) Any new documentation required by new or extended services. This includes but is not limited to: Physician Recommendation Form for In-Home Nursing Respite; Behavior Support Plan, Functional Behavior Assessment, Justification for Behavior Support, and possibly Quarterly Reviews when asking for continued Behavior Support; letter from MDRS when requesting Prevocational or Supported Employment; letters from doctors when the reason for increased services involves the health of the person or their primary caregivers. Updated Choice of Provider and Choice of Services forms should be included as appropriate.

f) Ensure PSS indicates that a person was offered a choice of provider and services, that they chose their living arrangement, have choice about their day, control over resources and are not restricted by staff. If a person does not have choice and control and/or are restricted by staff, this must be addressed with appropriate reasoning and documentation.

5. Ideally, changes should occur at the beginning and end of months, but this is not always possible. If a monthly service must be changed to a new provider in the middle of a month, additional service entries will be required to show the old and new providers at partial rates. If the change is a new service, or only a change in the amount of a service, indicate it as taking place at the start of the current month. It is important to not Delete any services that were approved during the current Recertification period. If an upcoming Recertification must be called back for a Change Request, all services and amounts that were approved during any part of the current Recertification period must appear on the Change Request PSS. Support Coordinator must notify <u>both</u> providers of the change prior to effective date.

6. Change of provider, updating contact information or other elements of the PSS, removing services without changing the budget or decreasing the budget are actions that are auto approved. If the LTSS system allows the Support Coordinator to approve (auto approve) the change request instead of submitting to DMH CSO for review, the Support Coordinator must ask a supervisor to review before approval.

7. Upon approval of a Change Request PSS, the Support Coordinator will review the PSS to ensure all information is correct. Service entries which are no longer active (due to change in amount, change of provider, or end of service) should have their status changed in LTSS to “Deactivated” (not “Deleted”) so they will not appear on the Notice of Determination letter as active services. After this is done, the Support Coordinator will create a Notice of Determination (Change Request) in LTSS. A copy will be sent to the person/primary caregiver, along with a copy of the PSS. Service Authorizations and a copy of the PSS will be sent to all of the Waiver service providers impacted by the change.

8. If the person was denied a service requested or hours requested were reduced, the person/legal representative has a right to appeal to DMH CSO. The person has thirty (30) days from the date of Notice of Determination (Change Request) to appeal the decision. A copy of the Appeal Procedures must be mailed with the Notice of Determination (Change Request). (Refer to Part III, Appealing Reduction, Denial, and Termination Instructions)

9. DEACTIVATING ID/DD WAIVER SERVICES: The purpose of deactivating a service/provider/frequency instead of deleting or zeroing them out, is to ensure that the total cost of the PSS is calculated. If a service/provider/frequency is deleted or zeroed out, the cost of that line is not calculated in the total cost of the PSS. Deactivating the service allows the cost of the service that was provided (e.g. 4 months, 6 months, etc.) to be counted toward the total PSS cost. Additionally, deactivating a service allows readers to easily see the service/provider/frequency, in the active PSS is no longer being used.

   Support Coordinators can "Deactivate" a service/provider/frequency that is no longer being provided to a person in a Change Request PSS only. When a Change Request PSS is created, by revising an active Initial or Recertification PSS, all services from active Initial or Recertification PSS are carried over to the Change Request PSS.

10. A service can be deactivated in any of the following scenarios only for Change Request PSS, and only after appropriate changes have been made to start/end dates and number of months.

    - Changing a Provider(s) for a requested service
    - Changing the frequency of a service
    - Terminating a service a person no longer wants

    a) In order to deactivate a service in a Change Request PSS, the SC clicks "Manage" on the Waiver Supports section of the PSS. This will lead them to the "Manage" options for the service. The "Deactivate" choice will be above "Delete."

    b) The SC clicks "Deactivate" to deactivate the service/frequency/provider. A pop up called "Deactivate Service" similar to the "Quick View" will displayed so the SC can edit the:

        i. Frequency Information (decrease the frequency to the number of months that have already been provided to the person)
        ii. Service Start Date and Service End Date (the Service Start Date should remain the same, but the Service End Date should be the day before the effective date of the Change Request PSS)
        iii. Service Outcome

    c) The SC must provide a Reason for Deactivation in the text box in order to finish deactivating a service/provider/frequency.

    d) Once all information is entered, the SC clicks the "Continue" button to deactivate the service/frequency/provider. A confirmation prompt will be displayed to confirm if the SC wants to deactivate this service/frequency/provider.

e) Upon clicking “Continue,” the SC should see a “Success” message. The service status then changes to “Deactivated.” The original service will be seen under the “Deactivated” services with a status of “Inactive Original.

f) When a service is deactivated, SC will be required to update the Shared Planning section of the PSS to remove any outcomes associated with the deactivated service (if it is not replaced with a different amount of the same service).

g) Deactivated services will be carried over from one Change Request PSS to another, but they will not be carried over to a Recertification or Initial PSS. SC will not have the “Deactivate” option in Recertification or Initial PSS.

M. Recertification Process

1. Continuing eligibility for the ID/DD Waiver must be determined at least annually. A PSS meeting will be held no more than 90 days before the end of a person’s Certification period. (See PSS Instructions in the DMH Record Guide.) This meeting must include the person, guardians/legal representatives/primary caregivers, the Support Coordinator, and (if possible and known before hand) a representative from each agency that will support the person. Providers must be notified well ahead of time, to allow them to schedule staff to attend. Program Directors may attend if invited by the person, but direct support staff must be present. The person or their representative may invite any others they wish. Representatives from important non-Waiver services should be invited as appropriate and agreed to by the person. The purpose of the meeting is to determine the person’s current situation and what supports are needed to help them have the best life possible. The PSS will be completed in the Long-Term Services and Supports (LTSS) system and includes such information as:

    a) The Overview Comment Section should include any new services, changes in services/frequencies, and identify request to continue a change made in previous certification year. Also state if the person is requesting to continue Behavior Support, Behavior Supervised Living or Medical Supervised Living.

    b) The amount(s) and type(s) of services requested

    c) A detailed justification for each requested service

        i. Days and times service(s) typically provided

        ii. How the service supports the person

        iii. If a relative is providing the service for HCS or In-Home Respite

        iv. If there were changes in the previous certification year and if the changes were permanent or temporary. If temporary, provide

justification to continue.

d) Current living arrangements and natural supports.

e) Description of person's current abilities, desired community participation activities, and employment.

f) Person Centered and positive information about the person's strengths, likes and dislikes, preferences, and hopes/dreams for the future, based on what is important to the person, balanced with what is important for the person.

g) The Need to Know section must include details of how to support a person, ensuring how any risks are addressed. The Need to Know section is a summary of the PSS and what a direct care provider needs to know when supporting a person.

h) Ensure PSS indicates that a person was offered a choice of provider and services, that they chose their living arrangement, have choice about their day, control over resources and are not restricted by staff. If a person does not have choice and control and/or are restricted by staff, this must be addressed with appropriate reasoning and documentation.

2. All documents required for recertification must be signed by the person/legal guardian within ninety (90) days prior to the end of the person's certification period (lock-in end date). The following are required:

d) The Application Packet must include

x. ID/DD Waiver Enrollment Agreement/Freedom of Choice of Institution vs Community

xi. Documentation of Choice of Provider

xii. Documentation of Choice of Services

xiii. Complaint/GrievanceResolution Procedures for SC

xiv. Person Rights and Options

xv. Medical evaluation within three (3) years of the start date of the current recertification or when an person's condition changes – must include Physician/NP Signature

xvi. Consent(s) to Obtain/Release Information (one for each provider)

xvii. Consent for Support Coordination Services

xviii. Acknowledgement of receipt of the Regional Program's HIPAA policy

e) The ICAP, which can be completed up to 135 days before the end of a person's certification period, is be entered into LTSS by either the Support Coordinator or by the Independent Contractor. The Support Coordination Director receives a list of the people whose ICAPs are to be completed by Support Coordinators. *Notify DMH CSO by email if IC ICAP not completed prior to 45 days before recertification. Document in Overview Comment if submitted late due to IC ICAP.*

f) PSS attachments must include:

viii. Risk Assessment form

ix. Services & Frequencies form

x. Face Sheet

xi. Signature Page, signed by all who attended the meeting, and indicating any Significant Contributors who were not at the meeting

xii. Skills/Notes from the PSS meeting that must include, at a minimum: the Relationship Map, Working/Not Working, Important To/For, Great Things About, Things to Know and Do, and any other notes.

xiii. Physician Recommendation form for IHNR (if needed)

xiv. Requests for Behavior Support, Crisis Support, Crisis Intervention, Behavioral or Medical Supervised Living (if needed) and all documents required to request these services

xv. Letter from MDRS if requesting Supported Employment or Prevocational services during recertification

g) Any documentation received or sent during the certification period must be uploaded immediately to the Person's Profile/Attachments/IDDD/ Other. This includes but is not limited to:

i. The Notice of Certification letter and any Determination of Change Request letters that are not generated in LTSS

ii. Service Authorizations with all required signatures and dates

iii. Termination Summary (if applicable)

iv. Any other letters or emails sent or received regarding the person

v. Activity Support Plan(s) for ID/DD Waiver services that require such

vi. The IDD Employment Profile if receiving Job Discovery

vii. Guardianship/Conservatorship paperwork (uploaded to Person's Profile/IDD/Attachments/Guardianship)

3. The following information must be submitted to DMH CSO for recertification within forty-five (45) days of the person's certification lock-in end date:

   a) Plan of Services & Supports submitted through LTSS system

   b) Application Packet created in LTSS system (with documents as listed above)

   c) All evaluation reports for anyone who has had an evaluation since their last recertification. These will be attached to the Application Packet through the Personal Record created by the Regional Center's D&E department.

4. DMH CSO has forty-five (45) days from the date of receipt of information to make a determination regarding whether the person meets all requirements for recertification. If approved, the information is forwarded to Medicaid through LTSS, and Medicaid generates the certification (lock-in) date.

5. When the Support Coordinator receives notification through LTSS that there is an approved recertification for the person, he/she sends the appropriate Notice of Certification letter and a copy of the PSS to the person indicating the action(s) taken (including any changes to or denials of requested services).

6. If a person's support level significantly changes, as indicated by the ICAP, an updated Personal Record will be required. D&E determines if the person continues to meet level of care for ID/DD Waiver. Contact DMH CSO for guidance as needed.

7. Service Authorizations and a copy of the PSS are sent to providers of all approved services. If Evaluations were updated during the certification year, a copy of the updates must also be sent to the providers.

8. Upon approval of a Recertification PSS, the Support Coordinator will review the PSS to ensure all information is correct. An Overall Decision will be completed by the Division of Medicaid. Once the Overall Decision is received, the Support Coordinator will create a Notice of Determination (Recertification) in LTSS. Copies will be sent to the person/primary caregiver along with a copy of the PSS.

9. If services are reduced, terminated, or request to add or increase service is denied, Support Coordinator will inform person/family of the appeal process by mail and phone call.

10. If the person was denied a service requested, hours requested were reduced, or a service was terminated, the person/legal representative has a right to appeal to DMH CSO. The person has thirty (30) days from the date of Notice of Determination (Recertification) to appeal the decision. A copy of the Appeal Procedures must be mailed with the Notice of Determination (Recertification). (Refer to Part III, Appealing Reduction, Denial, and Termination Instructions.)

N. Readmission Process

1. People can be readmitted to the ID/DD Waiver if their discharge date is within the same fiscal year (FY = July 1st – June 30th).

2. Determination of readmission outside of the same fiscal year is made by the ID/DD Waiver Director. The ID/DD Waiver Director makes a decision for readmission depending on the circumstances of the discharge, length of time since discharge, number currently enrolled and to be enrolled for fiscal year, and based on budget constraints. If the person cannot be readmitted at the time of request or if the person has been discharged for more than six months, his/her name will be put on the Statewide Planning List with the initial eligibility date for ID/DD Waiver. Reasons for discharge from the program include: being in a hospital and/or swing bed for more than 30 days, being admitted to an inpatient psychiatric hospital (such as MS State Hospital) for more than 30 days, being admitted to an ICF/IID facility, being admitted to a nursing home or rehabilitation facility, moving out of state, loss of Medicaid coverage, voluntary withdrawal, and no longer meeting eligibility requirements for the program.

3. If a person's readmission is denied because the person no longer meets ICF/IID level of care requirements, Support Coordination notifies the person/family and sends notice of appeal process. Contact DMH CSO for guidance as needed.

4. If a person is discharged because the environment or the person poses a threat/risk to service providers, the person/legal guardian has the right to appeal the discharge. The outcome of the appeal will determine whether readmission can take place.

5. If a person discharged because he/she was in the hospital or rehabilitation facility for more than thirty (30) days, he/she can be readmitted in the same fiscal year. If a new fiscal year, Support Coordination must contact DMH CSO for permission to re-enroll.

6. A person discharged due to loss of Medicaid coverage or moving out of state must regain Mississippi Medicaid coverage in order to be readmitted.

7. The Director of ID/DD Waiver has the discretion to consider extenuating circumstances related to requests for readmission after a discharge of any type.

8. Readmissions are entered into LTSS as an initial PSS and Application Packet. If the Independent Contractor ICAP is less than one year old and there have been no circumstances that indicate decline in support needs, D&E or Support Coordinator may complete the ICAP for readmission. The decision as to whether the person has had decline in his personal support needs is made by D&E in their review and update of the Personal Record. If D&E determines there has been a decline or if the Independent Contractor ICAP is more than one year old, the person must be referred for an Independent Contractor ICAP.

9. When the Support Coordinator receives an approved readmission, he/she follows

the same process of all initial approvals and sends the appropriate Notice of Certification letter and a copy of the PSS to the person indicating the action(s) taken (including any changes to or denials of requested services).

10. If the person was denied a service requested, hours requested were reduced, or a service was terminated, the person/legal representative has a right to appeal to DMH CSO. The person has thirty (30) days from the date of Notice of Determination (Initial) to appeal the decision. A copy of the Appeal Procedures must be mailed with the Notice of Determination (Recertification). (Refer to Part III, Appealing Reduction, Denial, and Termination Instructions.)

11. Service Authorizations and a copy of the PSS must be sent to providers of approved services. If the psychological evaluation was updated, a copy of it must be sent as well.

O. Support Coordination Service Notes

1. Documentation in the Service Notes must begin with the first contact by the Support Coordinator or others in the Support Coordination Department, before, during and after admission, as allowed in LTSS.

2. Support Coordinators are required to have at least one monthly phone contact with each person/legal guardian and quarterly face-to-face contacts to observe each service a person receives at least once per year. All contacts or communication concerning the person are documented in LTSS Service Notes section.

3. Service notes should be entered in a timely manner if not immediately after they take place to ensure information is available to address needs/concerns that may arise. Issues of health and safety should be documented in real time, preferably the same day or end of next day. All service notes must be entered as designated by SC Director or no later than the last day of the month.

4. Contact notes should be labeled accordingly based on type of contact (monthly, quarterly, provider contact, etc)

5. After addressing type, location/time and people present, give a summary of visit/contact such as: what person was doing, how day was going, PSS meeting information (when applicable) and any other information obtained during contact.

6. For required information: Do not just restate the question/item. Be specific, give examples, relate answers to the person's Outcomes/Important To where appropriate. The service note should paint a picture of the person's life, and how their services are supporting them. Documentation must be personalized.

7. Follow up to previous contacts: This may include change requests completed, behavior concerns or any other follow up done since last contact. Any contact with or about the person must be documented in the Service Notes.

8. **Monthly Contacts** – Monthly contacts must begin during the month of the lock-in begin date. Documentation of contacts must be personalized.

    a) Monthly contacts must consist of one or more of the following:

        i. A minimum of one (1) telephone (verbal) contact – at least one with the person and/or one with the legal guardian/caregiver. A phone call with a provider will not suffice, as this would not be person centered. If the person does not use words to speak or does not have a caregiver/ family member, Support Coordination must conduct a face-to-face visit.

        ii. A non-quarterly face-to-face visit with the person and a phone contact with the legal guardian/caregiver if the person is unable to represent themselves.

    b) Support Coordinators must ensure privacy is protected during all contact with the person.

    c) Support Coordinators must stay in contact with each person/legal guardian to be able to determine any emerging support needs so they can be addressed as quickly as possible.

    d) Phone contacts with the person/legal guardian are not required in the months in which quarterly visits are conducted. However, if a person is unable to represent him/herself and the legal guardian/primary caregiver is not present during the quarterly visit, a phone call to the legal guardian/primary caregiver must take place and address all required components for Monthly Contacts.

    e) If a Support Coordinator visits the person while he/she is at the Regional Program for an evaluation, and all requirements for a monthly contact are met, the visit can count as face-to-face visit, and a phone call is not required. This may not count as a quarterly visit.

    f) If a person is not yet receiving any of the services on his/her approved Plan of Services and Supports, it may be necessary to have more frequent contact with the person/legal guardian informing them of the efforts being made to locate providers and to ensure all of their non-ID/DD Waiver service needs are being met.

    g) If there are new providers of any service(s) a person receives, the person/legal guardian must be informed, even if they express satisfaction with the current provider(s) on the PSS. If new services become available to the person, the person/legal guardian must be informed, even if the person/legal guardian expresses satisfaction with the current service(s) on the PSS. Satisfaction with services and providers is a central component of ID/DD Waiver services.

    h) If the requirements for monthly contacts are not met, there must be documentation to explain the circumstances that prevented the contact(s).

i) Documentation requirements for monthly contact include:

i. Location/date/time: (indicate type of contact and if this contact was by phone or in person)

ii. Persons present: (if applicable; give name and relation to person)

iii. Follow up from previous issues: (previously identified risks or injuries; progress or actions on the issue)

iv. Health and Welfare: (happy with living environment; illnesses; doctor visits; need for consultation; adaptive equipment or home modifications needed; medication changes or issues; changes in health; health issues of primary caregivers) Contact the primary caregiver/legal guardian if there is one, make sure they know of person's needs.

v. Serious Incidents: (injuries; hospitalizations; loss of caregiver; loss of home)

vi. Changes in living arrangement/family situation since last visit: (moved-make sure to update Person's Profile; people moving into or out of the home; caregiver change that affects the person; make sure LTSS is updated appropriately)

vii. Satisfaction with Services: (waiver & non waiver; include job if they get Supported Employment)

viii. Services delivered/received according to PSS: (yes/no)

ix. Need for new services or change to services/provider: (waiver & non waiver; address plan to make needed changes)

x. Review of Utilization Report: (waiver & non waiver; note if there is a discrepancy and the course of action taken) In review, Support Coordinator should indicate the amount of hours authorized and also the amount of hours used for month of report. Support Coordinators must document in Service Notes when hours were reviewed with person/family and reason for significant difference between approved and utilized hours, if applicable.

xi. Lock In Verification: (does the start/end date on the Lock In Verification Report (LIVR) match the Lock In information in LTSS; note discrepancies and action taken)

9. **Quarterly Visits:** Quarterly face-to-face visits must begin within three (3) months of the person's lock-in begin date. This includes people who are readmitted to the ID/DD Waiver; time lines associated with any previous lock-in begin date are void.

a) Documentation of contacts of Quarterly Visits must be personalized.

b) There must be at least four (4) visits during a person's certification year.

c) Quarterly visits must take place in setting(s) where the person receives ID/DD Waiver services.

d) Quarterly visits must take place with the person and legal guardian, even if separate contacts are required. Contact with the legal guardian can be by phone.

e) When someone receives more than one ID/DD Waiver service, the Support Coordinator must visit all service settings, with the person present, during the person's certification year. At least one (1) visit must take place in the home regardless if a person receives any services in the home setting.

f) Service specific quarterly visit requirements are listed below.

    i. Services provided in the home – The Support Coordinator must make at least one (1) quarterly visit during the person's certification year while direct support staff is in the home. If the person receives two (2) in-home services, the Support Coordinator must see each type of provider in the home at least one time per certification year. If there are more than two (2) staff people for a service, it may not be possible to see both staff providing services, but attempts to do so should be made.

    ii. Crisis Support– the Support Coordinator must visit the person at least one (1) time during the Crisis Support stay.

g) If the Support Coordinator is unable to conduct a quarterly visit within the specified time lines because of extenuating circumstances such as the person is in the hospital, the legal guardian is out-of-town, the person is not at home at the scheduled time, etc., he/she must document the reason(s) why and reschedule the missed visit at the earliest time possible. The visit must take place. If a Quarterly Visit is not conducted during a specific quarter, this must be documented in Service Notes.

h) Detailed documentation of quarterly contacts is maintained in the Service Note section of LTSS.

i) All elements included in LTSS must be appropriately addressed and include the following:

    i. Ensure visit type is indicated.

    ii. Location/time: (of the visit; include date)

    iii. Persons present: (give name and relation to person – person must be present for Quarterly Visit)

iv. Service Observed: (you can say none if it is a home visit with no provider present; each service seen once per certification period; one home visit per certification period; address if service not being provided or provider not present during attempt to observe service)

v. Follow up to previous contacts: (previously identified risks or injuries; progress or actions on the issue) This may include change requests completed, behavior concerns or any other follow-up done since last contact.

vi. Person/Family's Satisfaction with Services: (waiver & non waiver; include job if they get Supported Employment) List current services and providers.

vii. Need for new services/changes in services or providers: (waiver & non waiver)

viii. Health/welfare/Medical: (happy with living environment; illnesses; doctor visits; need for consultation; adaptive equipment or home modifications needed; medication changes or issues; changes in health; health issues of primary caregivers; contact payee if there is one, make sure they know of person's needs)

ix. Serious Incidents: (injuries; hospitalizations; loss of caregiver; loss of home)

x. Changes in living arrangement/family situation since last visit: (moved-make sure to update Person's Profile; people moving into or out of the home; caregiver change that affects the person; make sure LTSS is updated appropriately)

xi. Amount/frequency on PSS appropriate to remain in home/community: (not appropriate if not using; address plan to make needed changes)

xii. Services delivered/received according to PSS: (yes/no; do Outcomes remain appropriate)

xiii. Review of Activity Support Plans: (is the provider doing the things listed)

xiv. Participate in valued activities: (give examples; community involvement; hobbies; social/family events)

xv. Utilization Review: (waiver and nonwaiver; note if there is a discrepancy and the course of action taken) Support Coordinators must document in Service Notes when hours were reviewed with person/family and reason for significant difference between approved and utilized hours, if applicable.

xvi. Medicaid/Social Security: (changes; letters regarding; change in payee)

xvii. Inform of new providers: (list them or n/a)

xviii. Provider Feedback: (all waiver providers must be contacted every quarter, provider feedback can be a separate Service Note)

1) Person's progress towards meeting outcomes on the Activity Support Plan

2) Any significant events that have taken place with person

3) Any needs person might have that are not being addressed

4) Other information the Support Coordinator should know

10. **In addition to Monthly and Quarterly Contact**, other pertinent information required to be maintained in Service Notes includes, but is not limited to the following:

a) All contacts Support Coordinators make about a person. Document the reason for the contact as well as the content of the contact.

b) All follow-up activities that take place as a result of issues identified during required Monthly or Quarterly Contacts or at any other time.

c) Calls from third parties such as wheelchair providers, nurses in doctor's offices, etc.

d) The Support Coordinator's activities in helping people get what they need (ID/DD Waiver and other services).

e) Calls to providers to ask questions about or discuss someone's services.

f) Serious incidents the Support Coordinator is made aware of either by phone or in person. Provide details about the incident and any action(s) taken by the Support Coordinator.

g) Calls from providers. Include the name of the provider (agency and staff person), the service, the issue(s) and any necessary follow-up actions needed as a result of the call.

h) When, why and what type of information is received about a person.

i) When, why and what type of information is sent to a provider or other party about a person.

j) Changes in services/providers. Changes in providers or services cannot be at the request of a provider. The person/legal representative must request the change. Circumstances in which the Support Coordinator would contact the person/legal guardian about changes include:

k) If a chosen provider will no longer be providing services. The Support Coordinator would notify the person/legal guardian that the provider will no longer be providing services and offer them choices of other provider(s) of the service(s).

l) If a provider contacts the Support Coordinator requesting a change(s), the Support Coordinator must contact the person/legal guardian to determine if the change is being requested by them and if they agree with the requested change.

m) Discharge from the ID/DD Waiver. The reason(s) for discharge from the ID/DD Waiver must be documented in the Service Notes.

n) Change in Support Coordinators. Document how people are informed of the change and arrangements for them to meet their new Support Coordinator.

o) Other situations based on person circumstances.

p) Sending and Receipt of Paperwork including, but not limited to Service Authorizations, PSS, Medicals, Referrals, etc.

P. Transfers

1. If a person transfers from one Regional Program catchment to another, he/she is NOT discharged from the ID/DD Waiver. His/her LTSS record is transferred from the sending Regional Program to the receiving Regional Program by changing the county of residence in the Person's Profile/Profile Overview/Person's Demographics section of LTSS to the county they are moving to within the receiving Regional Program's catchment. In a timely manner, sending Regional Center's Support Coordination Director should notify receiving Support Coordination Director of change via email so a Support Coordinator can be assigned, and services can resume upon move. County should remain in both catchment areas until all information has been added to LTSS (Notes, Service Authorizations, etc).

2. The sending Regional Program informs the family about who to contact regarding their move. Additionally, the person's sending Support Coordinator follows up with the receiving Regional Program to ensure contact has been made.

3. It is the receiving Regional Program's responsibility to talk with the family about service providers in their new area. Depending on the service, he/she may keep his/her same provider, or he/she may have to choose a new one based on the area to which he/she is moving. However, it should be explained that keeping the same agency does not mean they will have the same staff.

4. It is the responsibility of the receiving Regional Program to update the PSS to include the new provider(s).

5. Service Authorizations

a) If a person is NOT going to have a new provider of Home and Community Supports/In-Home Nursing Respite/In-Home Respite, a zero Service Authorization does not have to be sent by the sending Regional Program; however the contact person and his/her contact information will need to be updated. An updated Service Authorization will be sent to the providers. That is the responsibility of the receiving Regional Program.

b) If a person is moving to a new Supervised Living or Shared Supported Living setting, there must be a new Service Authorization with his/her new address. This is to be sent to the provider by the receiving Regional Program.

c) Provider's service end/begin dates will be updated by receiving Regional Program.

6. Careful coordination between the Support Coordinators helps ensure there is no break in service for the person. The new provider agency(ies) should be chosen before the person moves, with the provider(s) notified of when the move will occur. The sending Support Coordinator will complete the change request if the family has chosen a new provider and date that they will begin services. In instances when services in new catchment area are unknown, the SC completes a change request to change Support Coordination and end current service dates in PSS. The SC would then notify the receiving SC change had been completed.

7. Document the steps taken in the Service Notes in real time so it is clear what is taking place.

8. The sending Support Coordinator should copy all Service Notes for the person's entire certification year and upload into LTSS Attachments/Other of the person's record. The receiving Support Coordinator will not have access to the Service Notes entered by the previous Support Coordinator once the transfer is final.

9. After the above steps have been completed, the sending Support Coordination Director/Supervisor should review the record before un-assigning the Support Coordinator.

10. The receiving Regional Program submits the CMS 105 Form once the person's residence in the new catchment area is established and services have started. A copy of the 105/Action Form should be uploaded to the Person's Profile/Attachments/IDDD/Other and copy sent to DMH CSO.

Q. Discharges

1. Reasons for discharge from the program include: being hospitalized for more than 30 days, being admitted to an ICF/IID facility, being admitted to a nursing home or rehabilitation facility, moving out of state, loss of Medicaid coverage, voluntary withdrawal, no longer meeting eligibility requirements for the program, and death of the person.

2. In the case of no longer meeting eligibility requirements, the Support Coordinator

must work with the person and their support system to see if eligibility can be re-established. This primarily applies to loss of Medicaid or change in Medicaid status.

3. In the case of voluntary withdrawal, the Support Coordinator must send a Voluntary Discharge form to the person and document that this has been done. If they send the form back, upload the form to LTSS. Every effort should be made to make sure that the person is offered all services which might be of benefit to them, to find appropriate and acceptable providers, and to make referrals to other services if the IDD Waiver program is unable to meet their needs.

4. In case of discharge due to the person in hospital/inpatient psychiatric and/or nursing home or rehabilitation facility more than thirty (30) days, the Support Coordinator must continue to follow after discharge if the person intends to readmit to ID/DD Waiver within ninety (90) days and/or once the medical or behavior crisis is resolved. Consult DMH CSO as needed.

5. If a discharge must be completed, the Support Coordinator and/or their Supervisor/Director is to Discard or Close all in progress PSS and Application Packets. DMH CSO can assist with closing Application Packets if needed. A PSS that has been submitted to DMH CSO must be discarded at the SC Director level. The Support Coordinator must update and finalize all Service Notes, explaining the reason for discharge and noting the date it will be effective. The Support Coordinator must send "zero" Service Authorization(s) to all providers and document in Service Note. Once signed Service Authorization(s) are returned from provider(s), the Service Authorization(s) are uploaded in attachments in LTSS. A CMS 105 form is completed, showing the reason for discharge. The CMS 105 form is uploaded to the Person's Profile section of LTSS, and a copy sent to DMH CSO. The Support Coordinator must be unassigned from the person by the Support Coordination Director or assigned Supervisor. An Overall Decision is then to be created in LTSS, closing the person out of the program.

6. Please note that **the Overall Decision must be the final step**, as submitting it will prevent the previous steps from being completed.

7. The effective date of the Overall Decision must be in line with when the person could no longer receive services. The date they died; the date they moved out of state; the date they entered an ICF/IID, nursing, or rehabilitation facility; the 30th day of hospitalization; the date Medicaid coverage was lost or changed; or the date they chose as the last date of service if voluntarily withdrawing.

R. Reporting Serious Incidents

1. Providers are required to notify the Office of Incident Management at DMH of any Serious Incident as indicated Chapter 15 of the DMH Operational Standards. Serious Incidents are those of a serious nature that may result or have resulted in injury, death, or legal intervention. Examples include abuse, neglect, suicide attempt, death, elopement, emergency hospitalization or treatment. Providers are also required to report any Serious Incident to the person's Support Coordinator.

2. If a Serious Incident occurred in the presence of the SC, the Support Coordinator must report the incident to DMH Office of Consumer Support. Refer to Chapter 15 of

the DMH Operational Standards for types of serious incidents and timeline for reporting. Some serious incidents must be reported within eight (8) hours of discovery or notification and others within twenty-four (24) hours.

3. Since Support Coordinators must assure the health and safety of persons receiving ID/DD Waiver services and are mandatory reporters, SC are required to report all Serious Incidents to the Office of Consumer Support (whether SC was witness to incident or not). (See Part III, Incident Reporting Form)

4. DMH Office of Consumer Support is located at 239 North Lamar Street, Suite 1101, Jackson, MS 39201. The report should be emailed through secure email to veronica.vaughn@dmh.ms.gov and falisha.stewart@dmh.ms.gov and cc: ID/DD Waiver Director. If additional information needs to be reported or if further assistance is needed, SC may contact the Office of Consumer Support at (601)359-6149 or 1-877-210-8513 (DMH Helpline).

5. Information needed when contacting the DMH Office of Consumer Support:

   a) Date and time of Incident/Event

   b) Name of Person receiving services

   c) Name of Provider (agency and staff name)

   d) Detailed account of incident/event/complaint

   e) Names of people involved including witnesses, if applicable

6. Suspicion of abuse, neglect, and/or exploitation must also be reported to:

   a) Attorney General's Office/Medicaid Faud Unit
   https://www.ago.state.ms.us/divisions/medicaid-fraud-control-unit/abuse-neglect-and-exploitation-complaint-online-form/

   b) Mississippi Department of Human Services
   1-800-222-8000

7. Other information pertaining to Serious Incidents:

   a) If provider or family informs SC of incident, report anyway (even though they should report as well). SC should inform the person/provider/family of the process and contact information for reporting a Serious Incident.

   b) Inform supervisor, Regional Center Director, Director of DMH CSO

   c) Ensure information is documented in Service Notes

   d) Add to serious incident section of PSS

   e) Evaluate services needed, whether Waiver or Non-Waiver: for example,

someone moving to Supervised Living or other residential program from home; a new provider or other additional service

f) Follow-up – there should be documentation of outcome (whether everything is better or change occurred)

8. Complaints/Events are not Serious Incidents and can be handled through the grievance process of the providing agency. The SC should remind the person/legal representative of the grievance process of the provider. The SC should encourage the person/family to talk with the provider to see if their concerns can be addressed. If the person feels the process is not working or they are not being heard, the SC can offer to set up a meeting to discuss the complaint with the provider and person. If the person/legal representative is still unsatisfied or is unwilling to meet, the SC should provide the person/legal representative contact information for the Office of Consumer Supports through the DMH Helpline phone number 1-877-210-8513 to report a complaint. If the person is unable to report for themselves, the SC should assist by reporting the complaint to the DMH Office of Consumer Support.

S. Billing Procedures

1. ID/DD Waiver Support Coordinators must follow Billing Guidelines set by the Division of Medicaid (DOM).

2. ID/DD Support Coordination Departments may bill at the rate set by DOM (1 unit per month).

3. The ID/DD Waiver Support Coordinator is required to keep detailed service notes that describe all contacts with the person, family, service providers and other people or entities as needed to manage/coordinate the person's support and services.

T. Division of Medicaid Reports/Reporting Discrepancies

ID/DD Waiver Monthly Lock-In Verification Report

1. The ID/DD Waiver Monthly Lock-In Verification Report verifies each person is eligible for Medicaid and is appropriately locked-in to the ID/DD Waiver. A person is appropriately locked-in by their current certification begin and end dates.

2. Designated Support Coordination Department staff are to compare the Monthly Lock-In Verification Report (LIVR) upon receipt from Medicaid to the Support Coordination Department's list of people who are currently enrolled in the ID/DD Waiver. If a discrepancy is found, this information should be reported on the ID/DD Lock-In Verification Issues form. Discrepancies may include a person's name that is missing, a person's name on the report that should not be listed, the lock-in information is incorrect, etc. The review of the report as well as the findings should be documented in the Service Notes each month.

3. Location Codes (Loc Code)

   The location codes are as follows:

   01 = North Mississippi Regional Center Support Coordination

02 = Hudspeth Regional Center Support Coordination

03 = Ellisville State School & Ellisville State School/Magee Support Coordination

05 = South Mississippi Regional Center Support Coordination

4. The ID/DD Lock-In Verification Issues form must be submitted to the DMH CSO fifteen (15) days from the receipt of the report from Medicaid each month. The ID/DD CSO combines the reports from all four (4) Support Coordination Departments and sends it to Medicaid. Medicaid researches the issues, makes corrections/comments and returns it to the ID/DD CSO. Upon receipt of information from DOM, the ID/DD CSO will forward the information to each Support Coordination Department.

ID/DD Waiver Documentation of Possible Discrepancies in Service Documentation

1. The ID/DD Waiver Documentation of Possible Discrepancies in Service Documentation documents possible discrepancies in the amount/type of service a person receives on the Monthly Utilization Report. The report contains information about the person's utilization of services two (2) months prior to the receipt of the report.

2. Support Coordinators must compare the amount(s)/type(s) of services a person receives with the Monthly Utilization Report to ensure only the amount(s)/type(s) services approved on the Plan of Services & Supports are provided. Additionally, the Support Coordinator reviews the Monthly Utilization Report with the person/legal representative at least one time per month to verify the services are being provided as billed. The Support Coordinator must document their review in the Service Notes and includes the number of hours used for the month.

3. The Documentation of Possible Discrepancies in Service Definition form must be completed whenever the Support Coordinator becomes aware of a discrepancy between the type/amount of service authorized on the Plan of Services & Supports and the type/amount of service billed based on claims information in the Monthly Utilization Report. The form is submitted to the DMH CSO within fifteen (15) days of receipt from Medicaid. DMH CSO then forwards the discrepancies to Medicaid.