Community Transition Services
Frequently Asked Questions
Revised 10/12/2020

CONFLICT OF INTEREST		
1	Question	What conflict of interest protections are required for community transition services (CTS)?
	Answer	The conflict of interest standards for Medicaid State Plan services authorized through 1915(i) of the Social Security Act specify the following standards: Conflict of interest standards ensure, at a minimum, that persons performing evaluations, assessments, and plans of care functions are not: • Related by blood or marriage to the individual, or any paid caregiver of the individual • Financially responsible for the individual • Empowered to make financial or health-related decisions on behalf of the individual • Providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. Since there is more than one provider of transition services in every area of the state, the conflict of interest protections mentioned in the 4th bullet point above are not applicable.
2	Question	May CTS staff work with non-CTS MI Choice applicants? Could part of their hours be allocated to non-CTS individuals?
	Answer	Staff who provide Transition Navigation services may NOT also provide supports coordination services to MI Choice participants. Transition Navigators may work with other non-waiver clients that are served by your agency. The agency could only bill for the time the Transition Navigator worked with CTS clients.
3	Question	Please provide more clarification on housing versus Transition Navigator roles.
	Answer	Because the tasks related to Housing services and Transition Navigator services were combined, there is no longer a distinction between the two services.
4	Question	If a participant needs to move and requires assistance with the housing search, do we also need to have transition navigator services in place?
	Answer	Since transition navigation services and housing services were combined into Transition Navigation Case Management services to obtain CMS approval, this is a moot question. Individuals in need of housing services would automatically have a transition navigator. To obtain reimbursement for those services, you would need to have a CTS Notice approved in the CTS Portal.

BILLING FOR TRANSITION SERVICES		
1	Question	How are the dates of service handled after October 1, 2018? Currently, when someone enrolls in MI Choice, the date of service for transition services is equal to their MI Choice enrollment date.
	Answer	All transition services will be billed on the date the service was delivered, or in the case of home modifications, the date the service was completed.
2	Question	Since we are using 15-minute increments for billing purposes for transition navigation, do we count all start and stop times, or look at this in the aggregate per day?
	Answer	The number of units of transition navigation provided in a day should be derived from the total (aggregate) amount of time spent with or on behalf of the beneficiary or beneficiaries on the day being billed. You must incur at least 8 minutes to bill for a 15-minute unit.
3	Question	How do I classify hospital bed sheets and reusable blue pads?
	Answer	There are two specific codes for reusable blue pads. T4537 is used for “an incontinence product, protective underpad, reusable, bed size, each” or just “Reusable underpad bed size” for short. T4540 is used for “an incontinence product, protective underpad, reusable, chair size, each” or just “Reusable underpad chair size” for short”. Hospital bed sheets may go under Linens, using code T2028, Specialized Supply, not otherwise specified, waiver.
4	Question	Can an individual who is not affiliated with an agency provide the HCBS Personal Care services?
	Answer	No, at this time individuals would not be able to bill for the services provided. This may change as we implement Atypical provider enrollment in CHAMPS and an Electronic Visit Verification system.
5	Question	What are the fee and frequency screens for each of the service codes for transition services?
	Answer	The CTS Services Grid dated October 12, 2020 contains this information. This information is also available on the transition services website.
6	Question	If we are not currently enrolled in Medicaid as a provider, do we need to obtain an NPI to do so? If so, what taxonomy codes should I use?
	Answer	Transition services providers will be classified as Atypical providers. Many Atypical providers are unable to obtain NPI numbers. Once CHAMPS can enroll Atypical providers, you will receive a CHAMPS Provider ID. This can be used in place of an NPI for billing purposes. You will need to determine the most appropriate taxonomy code for your business. MDHHS Provider support may be able to assist you in choosing that code.
7	Question	There has been mention of prior authorization for some transition services. What does this mean?
	Answer	Because of the nature of some transition services, fee and frequency screens are not appropriate. When this is the case, the prior authorization process is used to approve

BILLING FOR TRANSITION SERVICES		
		a specific reimbursement rate for the services received by an individual. This method will be used for home modifications. Additionally, there may be instances when someone has a legitimate need for a more expensive item, or for more than the frequency limit allows. The prior authorization process will be used to authorize these services and to assure that they are the most prudent use of Medicaid funding. Until CHAMPS is properly programmed, continue using the Exceptions Process in the CTS Portal to request an exception to the fee and frequency screen.
8	Question	Will rent and groceries be reimbursable?
	Answer	Claims for Rent and Groceries cannot be submitted to CMS as a Medicaid claim. Michigan will continue reimbursing for these services using State general funds. Please see the CTS Services Grid dated October 12, 2020 for instructions on how to bill for these services.
9	Question	If a participant passes away after the transition, is the agency responsible for recovering the items purchased for their transition?
	Answer	No, the items purchased for transition do not need to be recovered. However, agencies may wish to advise families of ways to donate the items, such as Goodwill, Easter Seals, Volunteers of America, etc.
10	Question	What is the anticipated time from submission of billing to payment to the provider?
	Answer	MDHHS anticipates being able to reimburse providers within 30 days of submitting a paper expense form. This will depend upon how complete and accurate the billing is. Once billing is conducted electronically through CHAMPS, the process should be much quicker.
11	Question	If a Center for Independent Living completes a home evaluation, how is that service billed?
	Answer	All services must be billed through the transition agency (the agency that has the current CTS Notice). All providers of transition services on the person-centered service plan must submit billing to the transition agency. The transition agency will then submit a claim to MDHHS. The transition agency is responsible for paying the transition service provider.
12	Question	How do two entities work with one individual because Compass will not allow this?
	Answer	All services must be billed through the transition agency (the agency that has the current CTS Notice). All providers of transition services on the person-centered service plan must submit billing to the transition agency. The transition agency will then submit a claim to MDHHS. The transition agency is responsible for paying the transition service provider.
13	Question	We see that Navigators may set up a PERS. Does each individual program pay for the ongoing PERS fees?
	Answer	The type of PERS included as a Transition Service is limited to those that do not have ongoing monthly fees and are a one-time purchase.
14	Question	Will we receive reimbursement for individuals who are on a spend down after transition?

BILLING FOR TRANSITION SERVICES		
	Answer	MDHHS will cover all post transition services, regardless of spend down status through March 1, 2019. After that, individuals on a spend down will need to be informed that transition services will not be covered unless their spend down is met each month.
15	Question	Can follow along continue for as long as the person continues to meet criteria I, II, and III?
	Answer	Yes. The goal of transition services is to provide a warm transfer to a case manager from a home and community-based program. However, not all individuals who transition will require or want to enroll in another program. When this is the case, transition services may continue until the individual no longer qualifies for them.
16	Question	How can we purchase temporary incontinence supplies for beneficiaries since J&B will not provide these while the individual is in the nursing facility?
	Answer	Medicaid covers incontinence supplies. It is true that individuals must have their Medicaid record indicate they are no longer in the nursing facility before the State's incontinence supplier (J&B Medical) will cover the supplies. If individuals are not able to otherwise obtain incontinence supplies, transition navigators may request an exception for a short-term supply of incontinence supplies. This request may be completed using HCPCS codes T1999,T4537, or T4540.
17	Question	Is there a list of medical supplies and equipment covered by Medicare and Medicaid?
	Answer	Yes. Lists for medical supplies and equipment covered by Medicare may be found at the following website: https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage If a beneficiary has a specialized Medicare plan, such as a Medicare Advantage Plan or a Special Needs plan, additional medical supplies and equipment may be available through that plan. Lists for medical supplies and equipment covered by Medicaid may be found at the following website: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-151016--,00.html This list is updated quarterly, so it is a good idea to bookmark this website and check it periodically rather than print out the database.
18	Question	We received a payment, but it was significantly less than what we requested. Will we receive a breakdown of approved or rejected charges?
	Answer	MDHHS staff are working with each transition agency to approve submitted expenditure reports. Angela Westbrook and Amanda Farley are working with the CILs, Dorothy Yonchewski is working with the waiver agencies. If you have a question about your reimbursement, please contact them directly.

TRANSITION SERVICES AND MI CHOICE		
1	Question	If we receive referrals for individuals in a nursing facility, they have a home to return to and the primary need is for MI Choice services, does the individual have to use CTS to transition? Could a team conduct the waiver assessment in the nursing facility and upon discharge, classify the individual as waiver eligible and transitioned?
	Answer	Yes. From the information provided, the individual is not in need of transition services. This is a discharge from the nursing facility for someone who requires MI Choice services in the community. This individual would be eligible for SSP classification if a NFT-WOS indicator is added in status tables.
2	Question	Is it accurate that CTS referrals will not go on the MI Choice waiting list until a waiver referral is made?
	Answer	Yes. Individuals should never be placed on the MI Choice waiting list until they are properly screened and potentially eligible for MI Choice. If during the completion of the CTA, an individual expresses interest in MI Choice and is likely eligible for MI Choice, the Transition Navigator should make a referral to the chosen MI Choice waiver agency to have them placed on the MI Choice waiting list.
3	Question	How do waiver agencies notify MDHHS when a person has been assessed in a nursing facility and transitions with waiver, but did not utilize any transition services?
	Answer	MDHHS is notified of the individual's eligibility for SSP classification when a NFT-WOS indicator is added in status tables.
4	Question	What if an individual intends to enroll in Waiver but then close (die/change mind) prior to discharge and a freedom of choice is not completed?
	Answer	If the individual does not transition, for whatever reason, a freedom of choice form is not required.
5	Question	Do all referrals have to come through the transition program? Is a nursing home social worker able to choose to refer straight to Waiver and bypass the navigation process?
	Answer	Yes. When a beneficiary does not require transition services, a referral may be made directly to the MI Choice program. The individual will still receive priority on the MI Choice waiting list because they are residing in a nursing facility.

TRANSITION SERVICES FORMS		
1	Question	Will we now have to have a separate consent form for clients?
	Answer	The answer to this question depends upon how your release of information and consent form is currently worded. MDHHS will need to review your current forms to make this determination.
2	Question	Will there be a CTS handbook or CTS marketing material?
	Answer	Yes, the design teams have worked on CTS marketing materials. These can be obtained by going to http://www.hpclearinghouse.org. Once there, click on "Order Here", then "Transition Services" and you can order directly from the website. There is a limit of 100 brochures and 30 posters.

TRANSITION SERVICES FORMS		
		A CTS handbook is currently under development. We hope to have this available in the next couple of months.
3	Question	Can MDHHS provide an Action Notice example?
	Answer	Yes, examples of action notices, both advanced and adequate will be available on the transition services website. Details on what needs to be included in Action Notices is available in the link below starting on page 12. https://www.michigan.gov/documents/mdch/ADMN_HEARING_PAMPHLET_MARCH_2008_227657_7.pdf
4	Question	Will there be a MDHHS conflict-free consent our Transition Navigators can use or do we need to create our own?
	Answer	Agencies should use their own forms.
5	Question	Regarding the Transition Services Eligibility Worksheet - is this to be done on each person we work with (mandatory)? Does it get attached to their record in the Portal?
	Answer	Yes, you need to complete this for each person you work with and attach it to the record in the portal. With the new Compass release of October 5, 2020 this is now electronic and will automatically calculate as you complete the CTA.
6	Question	What if the participant refuses to sign documents?
	Answer	Standard practice is that when an individual refuses to sign a document, the transition navigator writes “refused” or “refused to sign” on the signature line and initials what was written.

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
1	Question	When the Transition Navigator meets the consumer and while conducting the CTA, it is determined the consumer needs assistance locating housing, can the Transition Navigator assist the consumer with their housing search? If so, can the Transition Navigator bill for this time?
	Answer	Yes, the transition navigator may bill for time spent locating housing.
2	Question	Can the Transition Navigator assist the consumer with completing applications, and getting supporting documents and bill for that time?
	Answer	Yes, the transition navigator can assist with completing applications and obtaining supporting documents as a method to assist with linking the individual to services within the person-centered transition plan. This time is billable.
3	Question	Since the Section Q/LCA process provides all options for community resources to the nursing facility resident, is this something the Transition Navigator can do?
	Answer	Yes, it would be appropriate to have a Transition Navigator meet with Section Q/Local Contact Agency referrals and discuss their options with them. This can be a billable activity, if a CTS notice is put in the system and approved.

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
4	Question	Does documenting and signing narrative entries regarding the assessment and care planning activities include the time to document the activities done to implement the plan? If no, what part of documenting is not considered billable?
	Answer	All parts of documenting the activities the transition navigator has performed on behalf of the individual by that transition navigator are billable.
5	Question	If a transition navigator transitions a participant to MI Choice, PACE or Home Help the same month of their Medicaid redetermination and for some reason after transition they lose their Medicaid (maybe all the proper paperwork was not obtained), they would most likely end that program they transitioned to due to losing Medicaid coverage. I know that in normal cases where someone continues to have Medicaid the Navigator can step back in to assist with transition barriers after the transition if needed. But, in this instance could a navigator step back if needed to assist the person to get their Medicaid reinstated? If so, could the transition navigator bill for this service?
	Answer	In most cases, if the transition navigator was assisting with the Medicaid redetermination you would just need to wait to bill for the services until after the Medicaid was reapproved. There may be some cases where the individual will lose Medicaid coverage because of spend-down status or income after transition. In those cases, the navigator will need to educate the participant about this possibility as part of the decision-making process for going forth with the transition, prior to transitioning.
6	Question	As a supervisor of transition navigators, I review case files for quality assurance purposes. Is this time billable as a transition navigation service?
	Answer	No. This is a quality assurance activity and is not a billable transition navigation service.
7	Question	We have discussed how unsuccessful attempts to contact a consumer are non-billable. Is this strictly regarding phone calls? What if a transition navigator goes to a nursing facility to see a consumer and the consumer has left to go, for example, to a doctor's appointment? Another scenario could be if a navigator goes to a consumer's house (someone who has transitioned) and the consumer isn't there. I am sure that our staff could leave a note, etc. Outside of travel time, is this sort of attempt billable?
	Answer	No, these trips are not billable because there has not been any contact with or on behalf of the beneficiary.
8	Question	What information does MDHHS need to see when reviewing expenditure reports?
	Answer	MDHHS looks at the following when reviewing monthly expenditure reports: • Beneficiary must have a Notice approved in Compass. • Beneficiary needs to have active Medicaid or pending Medicaid application during the month services were provided. • All services provided must have a documented need in the person-centered services plan. • In addition, all services submitted for reimbursement must be documented on the Transition Plan, (formerly pg. 21 of CTA) with the date, service type, expenditure amount and beneficiary agreement (initials or signature).

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
		• Approved prior authorizations (exceptions), as required, for services before the service is provided. Services provided without approval will not be reimbursed. ○ MDHHS will review case by case basis for unforeseen circumstances. • Only services provided during or after the Community Transition Assessment will be reimbursed. • Each HCPCS code can only be billed once per day. Multiple services provided on same day should be added together, with a breakdown of each cost in the comments. This is in preparation for when all billing goes into CHAMPS. • If beneficiary has been in the process of transition for over a year, a new CTA and eligibility criteria worksheet needs to be attached to the COMPASS record.
9	Question	Does MDHHS reimburse credit card use fee?
	Answer	Yes. MDHHS does cover this fee, it should be included in the total service amount.
10	Question	How do we reimburse MDHHS?
	Answer	All reimbursements to MDHHS will be reflected on the monthly expenditure report in which the date of service occurred. The expenditure line that needs to be reimburse should be duplicated but the expense amount should be changed to a negative. Submit that report to MDHHS for review at the same time you're submitting the current monthly expenditure report. After MDHHS has been approved the change and the most current expenditure amount, the FSR in EGrAMS will need to have corrections added. Click here for how to enter corrections.
11	Question	Will MDHHS approve home modifications on rental properties?
	Answer	MDHHS may approve home modifications on rental properties, as long as the rental agreement does not specify that the proprietor is responsible for the modification. The proprietor must also agree to have the modification completed.
12	Question	Will MDHHS approve home modifications for AFCs?
	Answer	No. MDHHS cannot approve home modifications for business properties that are not private rental properties.

FREEDOM OF CHOICE FORM AND NURSING FACILITY LEVEL OF CARE		
1	Question	Do we need proof of Section Q or a Freedom of Choice form for CTS eligibility?
	Answer	No. Transition Navigators will need to submit documentation to MDHHS to verify the individual meets the needs-based criteria for receipt of transition services. A document to assist individuals with this process has been distributed to all transition agencies. This document should be completed for each individual and uploaded in the CTS Portal with the CTS Notice.
2	Question	Do we need to get a copy of the LOCD?
	Answer	Transition agencies are not required to obtain a copy of the LOCD. However, the transition agency may need to obtain a copy of the freedom of choice form. If a transition agency needs information on an individual's LOCD, they may contact MDHHS staff to have a copy sent to them. This only applies to CILs that do not currently have access to CHAMPS.

FREEDOM OF CHOICE FORM AND NURSING FACILITY LEVEL OF CARE		
3	Question	Should we be filling out top section of Freedom of Choice indicating how the person does or does not score in?
	Answer	No, transition navigators are not responsible for conducting the level of care determination and individuals using transition services are not required to meet the nursing facility level of care to qualify for services. However, the transition navigators should know whether an individual qualifies for the nursing facility level of care to assist in providing education to the individual regarding services or programs they may qualify for in the community.
4	Question	Do we need to use the DHHS freedom of choice form? Or can we just use the facilities form?
	Answer	MDHHS only has one Freedom of Choice form that is applicable to all long-term services and supports programs. Transition navigators should obtain a copy of the completed Freedom of Choice form from either the nursing facility (if the individual no longer meets nursing facility level of care) or the home and community-based services provider (if the individual meets nursing facility level of care and is enrolling in a HCBS program upon transition).
5	Question	Regarding the Freedom of Choice form – What if upon initial assessment, it is unclear if the individual will meet LOCD at discharge. Should we be completing the Freedom of Choice form?
	Answer	No. The transition navigator should discuss continued eligibility for the nursing facility level of care with nursing facility staff. The transition navigator should also discuss all possibilities with the individual. The individual should make an informed choice about which program they wish to seek upon transition. If this is the waiver program, then the waiver agency should be contacted to schedule an initial interview in the nursing home.

DIFFERENCES BETWEEN THE OLD AND THE NEW		
1	Question	Please clarify whether we need to re-open prior clients with an assessment for transition services with a navigator to access post transition housing assistance.
	Answer	Transition Navigators are responsible for assessing, person-centered transition plan development, care plan monitoring, and linking to services. When an individual requires the post-transition housing assistance available, MDHHS will need to verify the individual qualifies for this service and approve the person-centered service plan.
2	Question	The CTS iSPA application indicates that individuals must be transitioning to settings that meet Home and Community Based Services Settings criteria. There are many state rate homes that have not been evaluated and would likely not meet criteria. For individuals who are transitioning without MI Choice, does this mean they cannot transition to these homes?
	Answer	No. Individuals who wish to transition to homes that do not meet the Home and Community-Based Settings Criteria may transition there. However, part of the education provided to the individual will be that transition services will need to end if

DIFFERENCES BETWEEN THE OLD AND THE NEW		
		they choose this location. Another option is to have the home evaluated to see if it meets criteria. If so, services could be continued.
3	Question	How are we to reflect closure to transition services to the state since this will no longer be via notice of transition into the Waiver program?
	Answer	Following the release of COMPASS 3.20, agencies will need to submit a "Close Notice" record, the new terminology for case closure. MDHHS has added two more reasons to close a transition record: ○ No longer need Transition Services ○ Reevaluation If the individual transitioned, do not submit a close notice record until the transition results have been entered.
4	Question	What about Security Deposit reimbursement? Will we still need to recoup that amount, and if so, where do we send it?
	Answer	No. When an individual moves the agency will not be responsible to recoup the security deposit from the proprietor.
5	Question	How should we handle MI Choice waiver referrals. If my agency is making the referral to the MI Choice Waiver agency, who is responsible for transition navigation and follow along?
	Answer	The transition navigator is responsible for transition navigation and follow along. This includes making sure there is a smooth transition to MI Choice and the waiver agency is implementing the person-centered service plan. Waiver agencies are responsible for meeting with individuals to conduct the MI Choice assessment while they are still in the nursing facility. This is essential to ensure MI Choice services can be in place at the time of transition.
6	Question	If someone is closed in Compass and you reopen them within 90 days do you need a new CTA?
	Answer	Yes, a new CTA must be completed.
7	Question	How often should someone be reassessed?
	Answer	All transition services beneficiaries are required to be assessed at least annually, or upon a change in condition. In most cases, when someone transitions to their home, this is considered a change in condition and would require another CTA to be completed.
8	Question	In the CTS Portal is "transition date" still used as the actual transition date or as the date we are done working with the person after transition (when they are stable/safe)?
	Answer	The transition date is the actual date of transition from the nursing facility to their home.
9	Question	Sometimes medical equipment is not covered for a participant for various reasons. If we obtain a denial for a specific item from a provider (meaning, if Medicare and Medicaid have denied payment for the item), can we submit the item as an Exception in the Portal for consideration of payment as a transition service?

DIFFERENCES BETWEEN THE OLD AND THE NEW		
	Answer	Yes, but you would need to include a good reason for why the item is still needed even after being denied by Medicare and Medicaid.
10	Question	We have recently worked with individuals on the Healthy Michigan Plan or Freedom to Work Medicaid where they can have higher or no asset limits to become eligible for Medicaid. We previously looked to their ability to pay on their own in these circumstances. Is there a limit that MDHHS would suggest for us requesting that the individual pay for their own services?
	Answer	All individuals must meet the needs-based criteria to qualify for Transition Services. The specific services required should be determined in the person-centered service plan. Individuals who are Medicaid eligible are eligible to receive Medicaid services. This includes the transition services that are specified in the 1915(i)SPA. While individuals who qualify for Medicaid benefits through the Healthy Michigan Plan or Freedom to Work may have additional assets, they often have limited incomes. These individuals often will not otherwise qualify for home and community-based services programs. They may need to use their assets to pay for additional services in the community. These decisions should be made during the person-centered planning process. Any time a Medicaid-funded transition service is denied, you must send the beneficiary the appropriate notice. Please note that the State-funded services (all covered by the S9986 code – rent, debt, groceries, appliances, and court fees) are NOT Medicaid-funded services.
11	Question	How long may we provide follow along?
	Answer	There is no longer a six-month limit on follow-along services. However, individuals must continue to be eligible for transition services to continue their provision. MDHHS encourages a “warm” transfer from the transition navigator to the case manager or supports coordinator from a home and community-based program such as PACE, MI Choice or MI Health Link. This warm transfer means that there can be some overlap between transition navigation and other case management, but the goal is to have the transition navigator discontinue services and allow the new case manager to handle ongoing services for the individual. This shift from transition services to home and community based services should generally take a month or less.
12	Question	Transition agencies are required to provide the participant a copy of their person-centered service plan. What is the preferred format for this? How frequently should we provide a copy to the participant?
	Answer	Federal regulations require that beneficiaries receive a copy of their person-centered service plan that is understandable to them. MDHHS has not mandated a specific format for this. The important thing to remember is that the person must understand the plan and agree to it. Transition navigators must provide a plan in a format that the beneficiary is able to understand. A copy of the person-centered service plan should be provided to the beneficiary upon the initial development of the plan and then when changes are made to the plan.
13	Question	At the beginning of the process there was a discussion on tracking timeframes from referral to first point of contact. Is there going to be more direction on this so that we

DIFFERENCES BETWEEN THE OLD AND THE NEW		
		can work on determining if there is a less manual way to track this? how/when will we report this out?
	Answer	Transition agencies are required to track referrals as explained at the September 27, 2018 CTS meeting. The exact data required from each transition agency are: • The date the referral was received • The date you first contacted the beneficiary or their representative • The date the individual was first assessed or interviewed (first in-person visit) • Receiving Transition Services • Date of Transition Services Interview MDHHS provided a referral reporting template that needs to be submitted 15 days after the month ends.
14	Question	How do we do transfers for follow along?
	Answer	To transfer a beneficiary's case to another transition agency to provide transition navigation services after the transition, the original transition agency needs to close the case in Compass. The new agency can then submit a new CTS Notice and continue the transition navigation services after the transition, assuming the beneficiary continues to qualify for transition services.
15	Question	During a warm transfer from the transition navigator to the new case manager or supports coordinator, will both entities be paid for case management during this month?
	Answer	Yes, if both entities are working with the individual to make sure the individual's needs are met, both entities will be paid. During this time the transition navigator should be assuring that all transition services have been provided. The other supports coordinator should be working to make sure home and community-based services are started and to understand the individual's wishes in rebuilding a life away from the nursing facility. This may require collaboration between the transition navigator and the supports coordinator. Warm transfers should generally last no longer than 30 days. However, there may be legitimate reasons to extend this period. This is true for transitions to MI Choice, PACE and Home Help. Transitions to MI Health Link may vary since the Integrated Care Organization is responsible for those transitions and payment for transition services.
16	Question	I thought we can provide transition navigation services for as long as the individual requires them. Why are warm transfers limited?
	Answer	When an individual does not enroll in another home and community-based services program after transition, transition navigation services may continue while the individual meets criteria for receipt of the services. That said, all other home and community-based services have a case management component. Continuing transition navigation services to individuals beyond a limited period to assure the individual has successfully transitioned as planned becomes a duplication of Medicaid-funded services.

DIFFERENCES BETWEEN THE OLD AND THE NEW		
17	Question	Can transition services be provided to beneficiaries who are in the hospital?
	Answer	Yes. A beneficiary who has been in the hospital for at least 30 days is eligible for Transition Services.
17	Question	If the transition navigator works for a CIL, and the individual enrolls in MI Choice after transition, will the CIL be paid for purchases made during the transition.
	Answer	Yes, the CIL will be paid for purchases made to facilitate the transition of the individual if the items are included in the Person-Centered Service Plan and meet the service definitions and standards for a community transition service. Transition services are no longer a part of the MI Choice program.
18	Question	What reports are required for the new program?
	Answer	Monthly Reports (due by the 15th of each month): • Referral Tracking • Expenditure Report Quarterly Reports • Work Plan Report in EGrAMS

MEDICAID ELIGIBLITY AND SPEND DOWN ISSUES		
1	Question	To verify Medicaid eligibility AFTER transition we need to call MDHHS or our local field office?
	Answer	MDHHS reviews Medicaid eligibility monthly when reviewing expenditure reports. If any changes to Medicaid eligibility are found, MDHHS will notify transition agencies.
2	Question	For the Medicaid eligibility piece: If we are working with someone who we know will be ineligible for MI Choice upon discharge due to over income, then we should be closing them currently to transition services?
	Answer	No, the transition navigator's role is to inform the individual of their options and services for which they may be eligible in the community. It is up to the individual to determine if they still want to transition knowing that they are over income for certain programs. It may be possible for some individuals to privately pay for the services they need in the community.
3	Question	Only individuals who do not have Medicaid after transition are not eligible for transition services, correct?
	Answer	MDHHS will continue allowing transition agencies to work with nursing facility residents who have active Medicaid or a Medicaid application pending. When the individual loses Medicaid eligibility after transition, the individual is no longer eligible for transition services.
4	Question	If a person does not meet Criteria I, but needs housing assistance, maybe first month's rent and security deposit, does that mean the individual would not be eligible for transition services and have to be assisted by nursing home social worker?

MEDICAID ELIGIBLITY AND SPEND DOWN ISSUES		
	Answer	For an individual to qualify for transition services, they must meet all three needs-based criteria.
5	Question	If an individual loses Medicaid after discharge, will we have to close them from follow along?
	Answer	Yes, only individuals who are Medicaid eligible are eligible for transition services. However, if the individual is willing to privately pay for services, or has some other funding source, you may continue furnishing services to them. In this case, the services would not be reimbursable by Medicaid.
6	Question	If an individual is Medicaid eligible while in the nursing facility but will most likely lose Medicaid eligibility in the community, can the transition navigator work with the individual until they transition while in the nursing facility and bill?
	Answer	Yes, if the individual is Medicaid eligible, transition navigators may bill MDHHS for the services provided to facilitate the transition.
7	Question	If a person has $75,000 in a MI Able account do we pay for services?
	Answer	Individuals with MI ABLE accounts maintain Medicaid eligibility and are therefore entitled to Medicaid services for which they qualify. The person-centered planning process should determine what expenses the individual is willing to pay for using their ABLE account. There are laws related to what constitutes a qualified purchase from an ABLE account and consequences for purchasing things that are not deemed eligible expenses. It is important to assure any expenses paid for through an ABLE account are eligible expenses and will not result in a penalty for the beneficiary. Generally, eligible expenses are those not otherwise covered by Medicare or Medicaid.
8	Question	How long do we have to purchase additional items for beneficiaries who transition home and their Medicaid reverts to Spend down?
	Answer	This time will vary based upon several factors. Medicaid usually converts from a patient pay amount in the nursing facility to a spend down community-based case at the beginning of the month. Therefore, the beneficiary will usually have full Medicaid coverage through the end of the month of transition.
9	Question	Will a list of community programs or groups that offer services that do not require Medicaid be provided to transition agencies?
	Answer	No. MDHHS does not have a comprehensive listing of non-Medicaid services available in each county. Transition agencies need to collaborate with other community-based organizations to compile this information.

SENDING ACTION NOTICES		
1	Question	Do we need to do a notice for those who are on spend down?
	Answer	Yes, if you are terminating, reducing or suspending transition services for any beneficiary, regardless of their spend-down status, you must provide the appropriate notice.
2	Question	Do we need to provide an adequate action notice for residents who transition and enroll in the MI Choice Waiver?

SENDING ACTION NOTICES		
	Answer	Yes, if you are terminating, reducing or suspending transition services for any beneficiary, regardless of the reason for doing so, you must provide the appropriate notice.
3	Question	If a transition agency does not have the capacity to meet all transition requests and has not made initial contact or CTA with participant is notice required and if so, what would be the code that would be listed? In this scenario we would always provide them with information on other potential transition agency options, if other options are available for the individual's county.
	Answer	Transition agencies are required to follow up on all referrals received. When a transition agency is unable to schedule an appointment for the Community Transition Assessment within one week of receiving the referral, the transition agency must provide Adequate notice to the beneficiary. This notice should include the toll-free number for transition services so that the individual can seek another transition agency if they choose. Most counties within the state have at least two transition agencies willing to serve them. MDHHS has not yet established requirements for the time from referral to the initial in-person visit with the individual. MDHHS is monitoring this time as a performance measure and may establish requirements in the future.
4	Question	Should we provide an advanced action notice when we refuse a transition service because the individual has resources to pay for that service?
	Answer	In general, transition agencies need to provide the beneficiary the proper action notice (either advanced or adequate) when the agency refuses to provide a Medicaid-funded service to an individual. That said, it remains important to seek all other forms of payment before authorizing Medicaid to pay 15or services. Thoughtful and diligent person-centered planning that includes properly documenting ALL transition services on the person-centered service plan and may relieve transition agencies from having to send an excessive number of notices. When the person-centered service plan indicates that "Aunt Betty will provide a couch" AND the beneficiary and Aunt Betty both sign the person-centered service plan in agreement, then all parties acknowledge that Aunt Betty will provide the couch. Therefore, the transition agency is not refusing to provide a service. Aunt Betty is providing the service. Should the beneficiary later state that they still need a couch, you can point to the signed person-centered service plan to remind the beneficiary of the plan. If they state that Aunt Betty's couch isn't good enough or the wrong color, then you may refuse the service and send an adequate action notice – or change the plan if warranted. Please note that the State General Fund services (code S9986) of rent, debt, groceries, appliances and court fees are not considered Medicaid-funded services since these services are not eligible for Federal matching funds.
5	Question	Are we required to provide notice when the individual discharges prior to the transition agency contacting them?

SENDING ACTION NOTICES		
	Answer	Yes, you must send an adequate action notice to let the individual know that you could not conduct an assessment because they were no longer in the nursing facility.
6	Question	Are we required to provide notice when we go to the initial in-person meeting and the participant changes their mind and does not wish to continue with transition program assessment?
	Answer	Yes, you must send an adequate action notice to let the individual know that you are not providing transition services because they indicated they did not wish to receive them.
7	Question	Do transition agencies need to send an Advanced Action notice to the beneficiary when we are terminating transition services at our agency so that the case can be transferred to another transition agency?
	Answer	The answer to this question depends upon the circumstances of the case. If the person-centered service plan includes a planned transfer to the other agency on a specific date, notice may not be required. In this case, there would be an identified end date on the transition services provided by the original agency. When services end on a planned end date, advanced notice is not required. Adequate notice is still required in this case. If the beneficiary signs a clearly written statement that says they understand that for this reason (specify the reason in the statement) they understand the case will be closed at one agency and opened at another, the original transition agency can supply an adequate action notice to the beneficiary. If neither of the above cases or any other exception to advance notice apply, then you are required to provide the beneficiary with advanced notice of the termination of services.

TRANSITION SERVICES		
1	Question	If someone plans to enroll in Home Help but cannot set up their worker until the participant gets out of nursing home, can an exception be used to provide HCBS Personal Care services?
	Answer	Yes, this is exactly the type of situation where we would expect HCBS Personal Care services to be used. In 2020, the agency rate for Home Help services was raised to $16.08 per hour. To find the most recent county rates, click here.
2	Question	If a ramp is approved as a Home Modification in Compass and the participant decides to leave the nursing facility before the ramp is completed, can we still provide the ramp.
	Answer	Yes. There is no reason to not complete the ramp, assuming the participant has left the nursing facility and moved to the home where the ramp is being built.
3	Question	For a Home Modification exception request, are we required to obtain multiple bids from providers?

TRANSITION SERVICES		
	Answer	MDHHS does not require transition agencies to obtain multiple bids from providers. MDHHS does require that we have enough information to assure that the home modification meets the service standards, including being medically necessary and a prudent purchase.
4	Question	If you find out after transition that in-home services cannot start as quickly as originally planned, may we ask for an exception for HCBS Personal Care?
	Answer	Yes, there is not a time limit on when an exception for HCBS Personal Care may be requested.
5	Question	How long should a transition navigator provide the housing sustainability functions of transition navigation after transition when the individual enrolls in a home and community-based program?
	Answer	This will always depend upon the unique situation. Generally, most other home and community-based programs can assist their clients with sustaining housing. However, some programs may have limited ability to do this. At all times, individuals will need to meet the needs-based criteria for receipt of transition services. Before providing transition navigation services to someone already using other home and community-based services programs, a discussion between MDHHS and the transition navigator of the unique circumstances of the individual would be welcomed.

FSR Correction Instructions

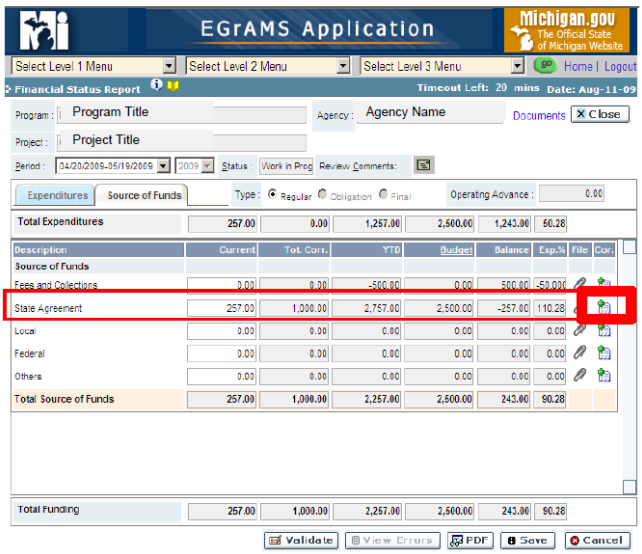
Quick Links

Expenditures Correction to a Prior Period FSR

- After clicking on the 'Save' button, the system will re-generate and now reflects the corrected amount in the Total Corrections Column.
- Click on the **Source of Funds** tab 'Corrections' icon to correct the funds category. System displays correction screen.

Note: Any corrections made in the Expenditures tab for a reporting period also needs to be corrected on the Source of Funds tab, for the same reporting period.

- Click the 'OK' button to save changes.
- **Click the 'Validate' button to check for errors (refer to page 89).**
- Upon Validation, you will receive an error message, if you have not made the corrections to the Source of Funds tab.



NOTE: The Financial Officer is the **only** Permission Code that will have the Submit checkbox available to submit an FSR.

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Quick Links

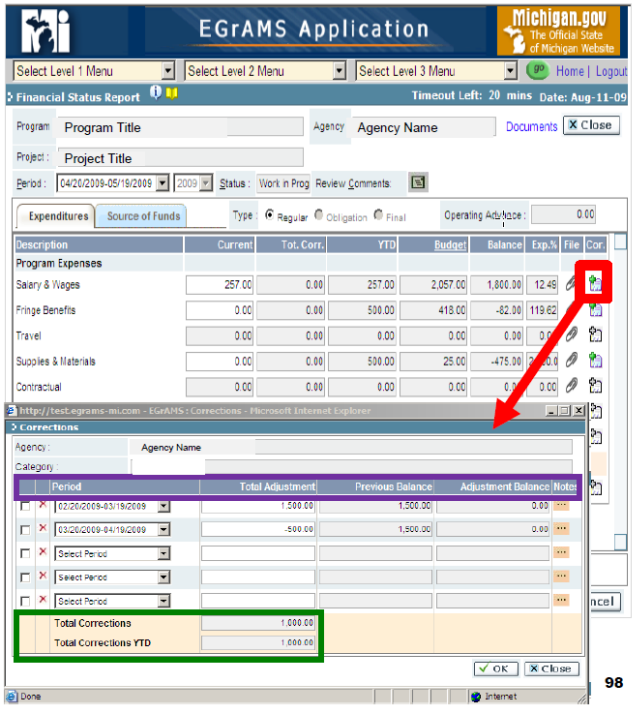
Expenditures Correction to a Prior Period FSR

On the Current FSR:

- Click on the 'Corrections' icon for the expense category to correct on the Expenditures tab. System displays correction screen.

The Correction Screen displays:

- **Period** – Select the reporting period of correction.
- **Total Adjustment** – Enter the amount to be corrected.
- **Previous Balance** – View previous balance adjusted.
- **Adjustment Balance** – View adjusted balance.
- **Total Corrections** – View the total correction amount for that period.
- **Total Corrections YTD** – View the total correction amount Year-To-Date.
- Click the 'OK' button to close pop-up and 'Save' to save changes.
- Click the 'Close' button to discard the selections.



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