Community Transition Services Frequently Asked Questions

Last revised 04/22/2022

CONFLICT OF INTEREST		
1	Question	What conflict of interest protections are required for community transition services (CTS)?
	Answer	The conflict of interest protections 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	Yes, as long as the individual is enrolled in CHAMPS as a personal care services provider. Enrollment in CHAMPS includes the necessary background checks for the individual and helps assure the individual meets provider qualifications.
5	Question	What are the fee and frequency screens for each of the service codes for transition services?
	Answer	The CTS Services Grid dated February 14, 2022, contains this information. This information is also available on the transition services website. Click here for the CTS website: **CTS 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 agencies will need to obtain an NPI to enroll in CHAMPS. Taxonomy codes agencies have used: 251B00000X Case management; 251X00000X supports brokerage; 253Z00000X in home supportive care. It is up to each agency to determine the proper taxonomy code to use for their agency. Transition navigators are required to have an NPI. Transition Navigators are not required to have a license to enroll in CHAMPS. When enrolling you will need to choose a taxonomy code. Codes that may be appropriate include: 171M00000X case

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		manager/care coordinator; 104100000X social worker; 1041C0700X clinical social worker; 363LF0000X nurse practitioner; 163W00000X registered nurse.
7	Question	There has been mention of prior authorization for some transition services. What does this mean?
	Answer	Until all CTS providers are enrolled in CHAMPS, continue using the Exceptions Process in the CTS Portal to request an exception to the fee and frequency screens. Once MDHHS requires billing through CHAMPS, you will need to request prior authorization for all CTS services, except transition navigation. MDHHS will provide training on how to make a prior authorization request before you are required to use the prior authorization function in CHAMPS. The prior authorization process is used to approve CTS services for the individual, or to approve a specific reimbursement rate for the services received. The prior authorization process will be used to authorize these services and to assure that they are the most prudent use of Medicaid funding.
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 February 14, 2022, for instructions on how to bill for these services.
9	Question	Can CTS pay for transportation to medical appointments?
	Answer	No, CTS can only pay for non-medical non-emergency transportation that is necessary for transition such as going to look at apartments, going to Secretary of State or the move to their new home.
10	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, back to your agency, etc.
11	Question	What is the anticipated time from submission of billing to payment to the provider?
	Answer	While using the Expenditure Report method, MDHHS anticipates being able to reimburse providers within 30 days of submitting the Expenditure Report form. This will depend upon the accuracy and completeness of the information submitted. Once billing is conducted electronically through CHAMPS, the process should be much quicker. Typically, CHAMPS will generate payment weekly.
12	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). Home evaluations fall under the Transition Navigation service. Therefore, anyone performing home evaluations must meet the transition navigator

BILLING FOR TRANSITION SERVICES		
		provider qualifications. The transition agency would bill this evaluation as Transition Navigation. This service must also be included in the Person-Centered Service Plan. If the person performing the home evaluation is not an employee of the transition agency, the person would need to submit a bill to the transition agency, the transition agency would pay the provider, then submit a transition navigation claim on their Expenditure Report, or through CHAMPS to be paid by MDHHS.
13	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 approval). 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.
14	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.
15	Question	Will we receive reimbursement for individuals who are on a spend down after transition?
	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.
16	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.
17	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.

BILLING FOR TRANSITION SERVICES		
18	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.
19	Question	What are the requirements for the State plan DME per the Medicaid Provider Manual?
	Answer	According to the Medicaid Provider Manual, Medical Supplier Chapter (Section 1), ▫ Each item must be medically necessary ▫ Documentation must include: • Diagnosis • Medical condition • Other information (not limited to the following) • Duration of condition • Clinical course prognosis • Nature and extent of functional limitations • Other therapeutic interventions and results • Past experience with related items • DME Companies May Request Prior Authorization
20	Question	Can a DME provider refuse to install items or charge installation fees?
	Answer	Per the Medicaid Provider Manual any DME provider enrolled in CHAMPS cannot charge installation and is to provide installation of DME. However, if an item requires a contractor to install, CTS can cover the installation (i.e. a grab bar needs to be mounted to studs in the bathroom). It is standard business practice for Medicaid per the Medicaid Provider Manual, Medical Supplier Chapter reimbursement to include the following: ▫ Payment for items in full ▫ Delivery of item to participant home ▫ Installation of item ▫ Repair/maintenance of item

BILLING FOR TRANSITION SERVICES		
21	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 Kevin Koenigsknecht are working with the CILs, Dorothy Yonchewski is working with the waiver agencies. If you have a question about your reimbursement, please contact your MDHHS liaison directly from the identified individuals above.

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, the Transition Navigator should make a referral to the chosen MI Choice waiver agency to have them screened and placed on the MI Choice waiting list. The chosen waiver agency should work closely with the transition navigator to assure there is a MI Choice assessment completed BEFORE the transition date and MI Choice enrollment can occur and MI Choice services can start on the day of transition.
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 the waiver agency uses the NFT-WOS indicator in status tables.
4	Question	What if an individual intends to enroll in Waiver but then closes (dies/changes 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 transition agencies by going to http://www.hpclearinghouse.org. Once there, click on “Order Here”, then “Transition Services” and you can order directly from the website. A CTS handbook has been developed and sent out for printing. We hope to have this available in the next couple of months. You will be able to order copies of this handbook from the clearing house website mentioned above.
3	Question	Can MDHHS provide an Action Notice example?
	Answer	Yes, examples of action notices, both advanced and adequate are available on the transition services website.
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	With the Compass October 5, 2020, release, the Transition Services Eligibility worksheet is no longer a separate document. As the CTA is completed in Compass it auto-populates the eligibility criteria questions and indicates if the individual qualifies for CTS.
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.

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
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.
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. Transition agencies are paid for indirect expenses each month. This reimbursement is meant to cover indirect costs such as quality assurance activities.

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
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). • 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, if the rental agreement does not specify that the proprietor is responsible for the modification. The proprietor must also agree to have the modification completed.

TRANSITION NAVIGATOR BILLABLE ACTIVITIES		
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. This information is contained within the electronic CTA in Compass. For a listing of CTA fields that lead to this eligibility calculation, please **click here.**
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.
3	Question	Should we be filling out the 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 MDHHS freedom of choice form? Or can we just use the facility's 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. The transition navigator should assist the individual with accessing whichever program they choose whether it is Home Help, MI Choice, MI Health Link, PACE or a non-Medicaid program.

FREEDOM OF CHOICE FORM AND NURSING FACILITY LEVEL OF CARE		
6	Question	Can a CTS case be closed when we think the member is making unsafe choices?
	Answer	No. It is important to remember that we encourage CTS participants to make their own choices and decisions. The only exception to this is when someone has a legal guardian or other decision maker in place. Transition Navigators do not need to agree with the decisions participants choose to make about their own lives. It is the Transition Navigators job to keep the participant informed if there are risks to their decisions and educate them on potential consequences. It is important these conversations are documented and allow for the participant to be given the dignity of their decision process and allowing them to assume the level of risk that they feel comfortable assuming.

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. To do this for an individual whose case has been closed after transition, the Transition Navigator will need to complete the CTA with the individual and submit a NFT Notice to MDHHS in Compass.
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 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?
	Answer	Following the release of Compass 3.20, agencies will need to submit a “Close Notice” record, the new terminology for case closure. If the individual transitioned, do not submit a close notice record until the transition results have been entered. Within the close notice MDHHS has added two more reasons to close a transition record: No longer need Transition Services Reevaluation Close Notices **do not** need to be immediately submitted when: Someone transitions and enrolls in another program Someone leaves the nursing facility against medical advice The search for housing is taking a long time

DIFFERENCES BETWEEN THE OLD AND THE NEW		
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. When someone transitions to their home, this is considered a change in condition and requires 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?
	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

DIFFERENCES BETWEEN THE OLD AND THE NEW		
		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. If the CTA is completed in Compass using plain language, and the appropriate fields are completed, you may generate a Person-Centered Service Plan report in Compass and provide a copy of that report to the participant to meet this requirement.
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 can work on determining if there is a less manual way to track this? how/when will we report this out?

DIFFERENCES BETWEEN THE OLD AND THE NEW		
	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 All CTS referrals must have a referral record created in Compass. The referral information needs to be in Compass by the 15th of the following month to ensure that CIM will include the data during the monthly exchange to MDHHS.
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 meet with the individual, update the CTA and submit a new NFT 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 and meets the CTS eligibility requirements may receive CTS.
18	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.
19	Question	What reports are required for the new program?
	Answer	Monthly Reports (due by the 15th of each month): • Referral Tracking a. Provided by CIM, but agencies must have data entered by the 15th of the following month. • 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	Now that agencies are enrolled in CHAMPS, they can look up the individual's Medicaid eligibility. MDHHS will continue to monitor 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.

MEDICAID ELIGIBLITY AND SPEND DOWN ISSUES		
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?
	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. As long as the individual is Medicaid eligible, and qualifies for CTS, CTS are covered by Medicaid.
8	Question	Does community Transition Services have an income limit?
	Answer	The CTS program does not have an income limit or cap for beneficiaries.
9	Question	Does Community Transition Services have an Individual Expense Cap?
	Answer	CTS **DOES NOT** have a cap on per participant/per transition expenditures ▫ The old cap of $3000/transition went away with approval of the 1915(i)SPA ▫ There are still caps on some transition services, which can be found on the CTS services grid ▫ If you anticipate that you will need to go over the fee screen for a particular service, submit an exception request or request prior authorization.
10	Question	How long do we have to purchase additional items for beneficiaries who transition home and their Medicaid reverts to Spend down?
	Answer	MDHHS does not place a time limit on purchasing additional items after transition if the individual remains eligible for CTS. This time will vary based upon several factors including enrolling in another Medicaid program after transition, Medicaid eligibility after transition, and switching from a patient pay amount to spend down Medicaid

MEDICAID ELIGIBLITY AND SPEND DOWN ISSUES		
		after transition. 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.
11	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?
	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 a participant, do we need to send the individual a notice? If so, what 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. The reason indicated on the notice would be that you cannot timely assess the individual for this service. 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.

SENDING ACTION NOTICES		
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	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. Because all CTS participants are Medicaid eligible, they are entitled to Medicaid-covered services. Therefore, the individual should not be asked to pay for a service that is covered by CTS. That said, it remains important to seek all other forms of payment before authorizing Medicaid to pay for 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 to indicate that CTS will cover the couch if no other options are available. 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?
	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?

SENDING ACTION NOTICES		
	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.
8.	Question	When do I send an Adequate Notice vs an Action Notice?
	Answer	On the CTS website you can find a decision guide for action notices: **Click here**

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. 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?
	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. The bid should include a cost breakdown.
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.

TRANSITION SERVICES		
5	Question	How can HCBS Personal Care be used for a "trial run" at home?
	Answer	The individual must have a home to go to for the duration of the trial run. 1. The individual or their informal supports expressed doubts about being at home – even with additional services 2. You secure a service provider for a few days 3. The individual takes a therapeutic leave from the nursing home (see Section 11.2.B of NF coverages chapter of Medicaid Provider Manual) a) Must be approved by a physician b) NF can hold bed up to 18 days c) Medicaid will reimburse the facility for the leave days if the individual returns to the NF 4. The individual goes home for a few days to see how things go
6	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.
7	Question	Is a new CTA to be performed post transition?
	Answer	Yes, a new CTA needs to be conducted within 30 days after the transition to determine whether the new living arrangement and services provided will meet the individual's needs **AND** if additional CTS services are needed.
8	Question	Can CTS assist an individual who wants to move out of state?
	Answer	Yes, CTS can assist if they meet the eligibility criteria. In these cases, a Prior Authorization needs to be submitted that includes where they will be moving, the transportation method, what medical equipment or supplies will be needed, if they will need someone with them during travel, and with whom the transition navigator will be coordinating the move to the other state.
9	Question	Can CTS assist an individual who lives in an out of state nursing facility and wants to move to Michigan?
	Answer	Yes, CTS can assist if they meet the eligibility criteria and have an active or pending **Michigan** Medicaid application. In most cases, this would mean that the person was a previous Michigan resident who is being served in an out of state facility.
10	Question	Can CTS provide assistance to an individual who was incarcerated after a transition plan was developed?
	Answer	No, if someone has been incarcerated, services should stop, and a Close Notice should be submitted in Compass. The transition agency also needs to send an

TRANSITION SERVICES		
		Adequate Action Notice to the beneficiary letting them know that transition services ended because of their incarceration.
11	Question	When community resource programs are reporting long waits for installing ramps, can CTS provide the ramp instead?
	Answer	CTS is considered a payor of last resort meaning all other resources must be exhausted before requesting CTS authorization of the services. When other sources are not readily available, CTS should be used so as not to delay the transition. When submitting an exception request or prior authorization for a ramp, the transition navigator should include details about other source researched and why they will not work for this individual. If you have doubts, discuss the situation with MDHHS staff.
12	Question	Will I need to help the individual come up with a contingency plan?
	Answer	Yes, as part of the person-centered planning process, transition navigators should have conversations with individuals about what they will do if their service providers (i.e., chore provider or direct care worker) do not show as planned after transition. Person-Centered planning also includes discussions about how the individual will evacuate their home in case of an emergency. These plans can be captured within the person-centered transition plan or the NFT notes and documented in the case record.

FSR Correction Instructions

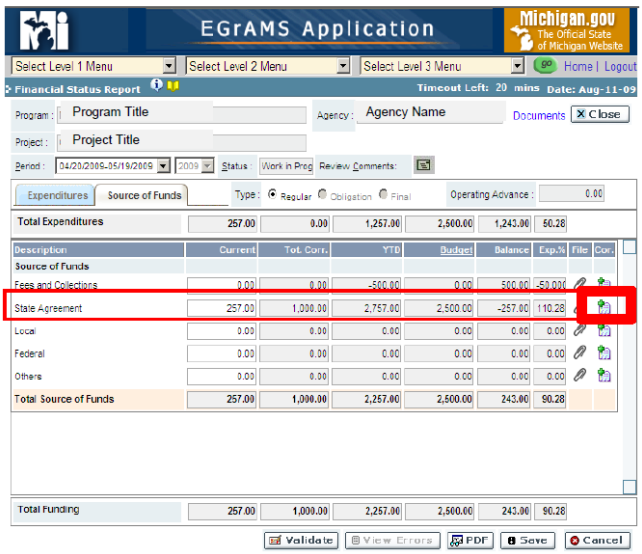
Quick Links

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

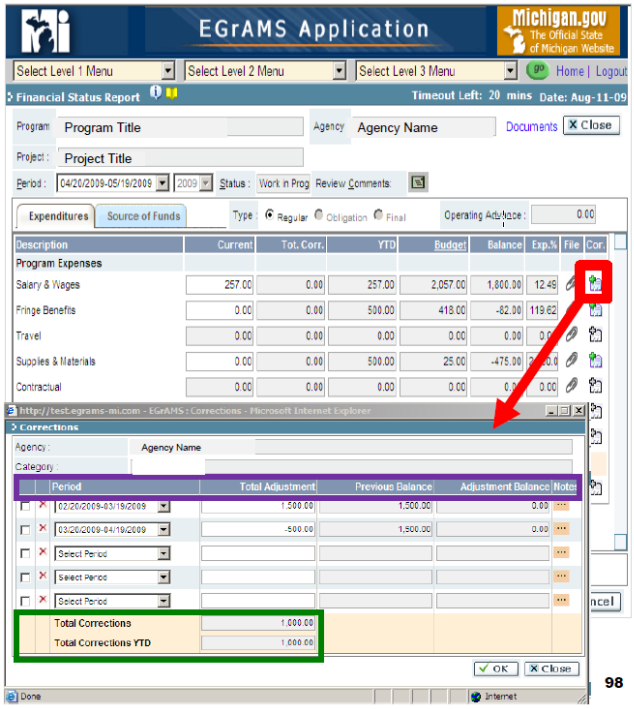
Expenditures Correction to a Prior Period FSR

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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Questions That Populate HCBS Eligibility

Community Transition Services: When is a CTA complete enough for approval?

The HCBS eligibility criteria is populated by 20 questions in the CTA. Once these questions are answered the CTA is considered eligible for Notice submission.

The CTA sections where these questions are located are:

- Your Move to the NF
- Functional Abilities
- Barriers → Cognitive Barriers
- Barriers → Harmful Behaviors
- Barriers → Identification
- Barriers → Housing

Questions that Populate the HCBS Eligibility Criteria: Your Move to the NF Section

- Current NFLOC Door (from NF Staff)
- How long does NF Staff expect individual to meet NFLOC criteria?
- The beneficiary does not currently reside in a nursing facility or other institution but is at risk of returning to the nursing facility without the provision of transition services
- Has the participant indicated they have changed their minds about where they choose to receive long-term services and supports by indicating they no longer choose to receive services in the institutional setting on a Freedom of Choice form?
- Were you homeless immediately prior to being admitted to the nursing facility?
- Do you need assistance finding housing?
- Before going to the nursing home, did you receive assistance in your home?
- Do you feel these services were meeting your needs prior to your NF stay?
- Has your health changed since before coming to the nursing facility?

Questions the Populate the HCBS Eligibility Criteria: Functional Abilities

- Bed Mobility
- Transfers
- Toilet Use
- Eating
- Dressing
- Personal Hygiene
- Bathing
- Locomotion
- Negotiating Stairs
- Incontinence Care
- Shopping
- Cooking
- Managing Medications
- Using the Phone
- Housework
- Laundry
- Public Transportation
- Managing Finances
- Night Time Care

Questions the Populate the HCBS Eligibility Criteria: Barriers → Cognitive Barriers

- Needs minimal assistance in making safe decisions in familiar situations, but experiences some difficulty in decision making when faced with new tasks or situations due to a short-term memory problem
- Is assessed with at least some difficulty making decisions in new situations or makes poor or unsafe decisions in recurring situations
- Is assessed to be usually understood and needs assistance (i.e. little or no prompting) finding the right words or finishing thoughts due to a short-term Memory problem

Questions the Populate the HCBS Eligibility Criteria: Barriers → Harmful Behaviors

- Have you or has anyone else observed you moving about with no discernible, rational purpose, seemingly oblivious to needs or safety?
- Do you curse or threaten others?
- Do you have concerns with harmful behaviors or actions towards yourself or others?
- Have you or has anyone else observed you demonstrating socially inappropriate or disruptive behaviors such as disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, or rummaging through other's belongings?
- Have you or have others told you that you resist care?

Questions the Populate the HCBS Eligibility Criteria: Barriers → Identification

- If no identification or missing identification, do you need assistance obtaining it?

Questions the Populate the HCBS Eligibility Criteria: Barriers → Housing

- Does your home need any of the following services before you can return?