MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

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Distribution: MI Choice Waiver Agencies, Centers for Independent Living, Nursing Facilities, Program of All Inclusive Care for the Elderly (PACE) Organizations

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Subject: Medicaid Provider Manual Chapter for Community Transition Services

Effective: July 1, 2021

Programs Affected: Medicaid, Community Transition Services, MI Choice Waiver, PACE

This bulletin establishes a new MDHHS Medicaid Provider Manual chapter for Community Transition Services. The Community Transition Services program offers Home and Community-Based Services (HCBS) and supports for individuals in an institution who desire to move to a community residence. Community Transition Services was added as part of the Medicaid State Plan under the §1915(i) authority effective October 1, 2018, and are available to all beneficiaries who qualify and choose to leave or avoid readmission to an institution and choose to live in a community setting.

Community Transition Services available to assist beneficiaries with transitioning from an institution to community include:

- transition navigation/case management;
- locating and securing a community residence;
- items and supplies needed immediately upon transition from the institution;
- transportation;
- temporary personal care services until more permanent arrangements are made; and
- home modifications.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-969-4662.

Approved

Kate Massey, Director
Medical Services Administration

COMMUNITY TRANSITION SERVICES

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SECTION 1 – GENERAL INFORMATION

Community Transition Services (CTS) are Home and Community-Based Services (HCBS) for Medicaid beneficiaries who meet eligibility criteria. The benefit is administered by the Michigan Department of Health and Human Services (MDHHS) on a fee-for-service (FFS) basis through transition agencies including Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations.

Beneficiaries eligible for CTS include nursing facility and institutional residents who meet needs-based criteria and have at least one risk factor as described in this chapter. Provision of CTS does not relieve institutions of required discharge planning activities.

1.1 DEFINITION OF TERMS

Community Health Automated Medicaid Processing System (CHAMPS)	The MDHHS web-based Medicaid claims and enrollment processing system.
Compass	Web-based information system utilized for tracking beneficiary data.
Michigan Department of Licensing and Regulatory Affairs (LARA)	The State of Michigan agency responsible for professional licensing.

SECTION 2 – BENEFICIARY ELIGIBILITY FOR COMMUNITY TRANSITION SERVICES

To be eligible for CTS, beneficiaries must:

- be eligible for Medicaid or have **all** the following:
  - a completed Michigan Medicaid application with all necessary verifications submitted to the local MDHHS office awaiting review;
  - reasonable assurance that local MDHHS office will likely approve the submitted application; and
  - application registration on Bridges as verified by MDHHS.
- be age 65 or older;
- be age 18 through 64 with a physical disability;
- meet one of the following:
  - be at risk of inappropriate institutionalization due to being served in an institution but do not meet the level of care for that institution; or
  - indicate on the Freedom of Choice form that they no longer choose to receive long term services and supports in an institutional setting;
- meet Needs-Based Criteria identified within this chapter; and
- have at least one risk factor, as identified within this chapter, that cannot be addressed by standard institutional discharge procedures.

2.1 NEEDS-BASED CRITERIA

Beneficiaries must be assessed to minimally meet Needs-Based Criteria under Door A, B, or C.

Door A: Activities of Daily Living (ADLs)	The beneficiary requires assistance to perform at least one ADL or instrumental activity of daily living (IADLs). ADLs include bed mobility, transfers, toilet use, eating, dressing, personal hygiene, bathing, and locomotion. IADLs include shopping, cooking, managing medications, using the phone, housework, laundry, public transportation, or managing finances.
Door B: Cognitive Performance	The beneficiary: ▪ 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 some difficulty making decisions in new situations or makes poor or unsafe decisions in recurring situations; or ▪ 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.
Door C: Behavior	The beneficiary is assessed to have required assistance managing one of the following challenging behaviors in the last seven (7) days: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, or resisted care.

2.2 Risk Factors

Beneficiaries must have at least one of the following risk factors:

- history or at risk of inability to secure or retain housing in the community;
- history or at risk of inability to secure HCBS without assistance;
- history or at risk of inability to secure documentation needed for independent living without assistance, including identification cards, health insurance cards, birth certificate, etc.; or
- history of an unsafe or inaccessible living environment.

2.3 Re-Evaluation of Eligibility

Individuals who have been approved to receive CTS must have an annual re-evaluation of their eligibility. This includes a re-evaluation of eligibility criteria mentioned above as well as a re-assessment using the community transition assessment.

SECTION 3 – COVERED SERVICES

To qualify for CTS, beneficiaries must receive at least one of the transition services outlined in the Transition Navigation Case Management subsection of this chapter. Transition services are not available through a self-directed arrangement.

3.1 TRANSITION NAVIGATION CASE MANAGEMENT

Transition Navigator (TN) services are provided to ensure the delivery of supports and services needed to meet the beneficiary's goals for living in the community after an institutionalization. The TN functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's person-centered service plan (PCSP). The frequency and scope of TN contacts must take into consideration the health and welfare needs of the beneficiary. TN services may include the direct provision of CTS as specified in the PCSP.

Functions performed by the TN include:

- Conducting the initial and subsequent needs-based criteria evaluation and community transition assessment, and providing that evaluation to MDHHS for approval.
- Annual reassessment and re-evaluation of Medicaid eligibility.
- Gathering, reviewing, documenting, and updating information relating to the assessment and beneficiary's history (i.e., medical, social, etc.).
- Supporting a person-centered planning (PCP) process that:
  - focuses on the beneficiary's preferences;
  - includes family and other allies as determined by the beneficiary;
  - identifies the beneficiary's goals, preferences and needs;
  - provides information about options; and
  - focuses on engaging the beneficiary in monitoring and evaluating services and supports.
- Developing a PCSP using the PCP process, including revisions to the plan at the beneficiary's request or as changes in the beneficiary's circumstances may warrant.
- Conducting the PCP meeting.
- Completing the PCSP.
- Referral to and coordination with providers of home and community-based services and supports, including non-Medicaid services and informal supports. This may include helping with access to entitlements or legal representation.
- Monitoring of the services and supports identified in the PCSP for achievement of the beneficiary's goals. Monitoring includes opportunities for the beneficiary to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the beneficiary and other key sources of information as determined by the beneficiary.

- Providing social and emotional support to the beneficiary and allies to facilitate life adjustments and reinforce the beneficiary's sources of support. This may include arranging services to meet those needs.
- Providing advocacy in support of the beneficiary's access to benefits, ensuring the beneficiary's rights as a Medicaid beneficiary, and supporting the beneficiary's decisions.
- Monitoring the beneficiary after the community transition to ensure a successful adjustment to community life, including ensuring access to and enrollment in needed HCBS programs.
- Maintaining documentation of the above listed activities to ensure successful support of the beneficiary, compliance with Medicaid and other relevant policies, and meeting quality assurance and quality improvement requirements.
- Conducting a tenant screening and housing assessment that identifies the beneficiary's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
- Assisting with the housing search and application process.
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses.
- Completing documentation needed to secure services.
- Ensuring that the living environment is safe and ready for move-in.
- Assisting in, arranging for, and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Education and training on the roles, rights, and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords and property managers with a goal of fostering successful tenancy.
- Assistance in resolving disputes with landlords and neighbors to reduce risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
- Assistance with the housing recertification process.
- Coordinating with the beneficiary to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
- If risks are identified during the PCP process, discuss with the beneficiary any strategies to mitigate those risks.

3.1.A. Transition Navigator Provider Qualifications

Provider Type	License or Other Standard	Verification (Annual)
Registered Nurse (RN)	RN, licensed in Michigan	LARA, CHAMPS
Social Worker	Limited or full license: Limited License Bachelor of Social Work (LLBSW), Limited License Master of Social Work (LLMSW), Licensed Baccalaureate Social Worker (LBSW), or Licensed Master Social Worker (LMSW), licensed in Michigan	LARA, CHAMPS
Other Transition Navigator	Non-licensed or other licensed health care professional with the following qualifications: ▪ a bachelor's degree in a health or human services field or Community Health Worker certification, and ▪ at least three years of experience in the provision of health or social services. If licensed, must be licensed in Michigan.	CHAMPS

3.2 Community Transition Services

CTS are non-reoccurring expenses necessary to enable a beneficiary who is transitioning from a nursing facility or other institutional setting to the community to establish a basic household and do not constitute room and board. This service is available while in the institution to prepare the beneficiary's chosen home and to accommodate a successful discharge to the community. This service may be available in the community when additional needs that were not accounted for prior to discharge are identified.

CTS includes the following:

- Security deposits and fees for community living, including fees for a birth certificate, credit checks, or housing application fees required to obtain a lease on an apartment or home,
- Set-up fees for utilities or service access, including telephone, electricity, heating and water,
- Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens, and
- Services necessary for the beneficiary's health and safety, such as pest eradication, allergen control, and one-time cleaning prior to occupancy.

Some items or services under CTS may require prior authorization from MDHHS. (Refer to the Directory Appendix for website information related to the Transition Services Coding Structure.)

3.2.A. Limitations

CTS are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP and only when the beneficiary is unable to meet such expense, or when the services cannot be obtained from other sources. CTS do not include monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely diversional or recreational purposes.

Personal emergency response systems provided as a transition service are limited to those that do not have ongoing monthly fees and are a one-time purchase.

3.2.B. Provider Qualifications

Provider Type	License or Other Standard	Verification	Frequency of Verification
Center for Independent Living	Enrolled as Medicaid Provider in CHAMPS	LARA, CHAMPS	Annually
Area Agency on Aging	Enrolled as Medicaid Provider in CHAMPS	LARA, CHAMPS	Annually
Community Based Organization	Enrolled as Medicaid Provider in CHAMPS	CHAMPS	Annually
Retail Stores	Items purchased from retail stores must meet the CTS definition.	Transition Agency	Prior to furnishing services and annually thereafter.
Contractor, Builder	Licensed Contractor or Builder. Licensed in Michigan	LARA	Annually

3.3 Non-Medical (Non-Emergency) Transportation

Non-Medical (Non-Emergency) Transportation (NMNET) is offered to enable beneficiaries to gain access to community services, activities and resources specified by the beneficiary's PCSP.

NMNET services may be provided while in the community to address issues identified on the PCSP. This may include, but is not limited to, going to the grocery store, religious services, volunteering, or work.

This service is available while in the institution, though limited to visiting potential community-based residences and travel to businesses or agencies to address barriers to community-based living. Examples of transportation to a business or agency to address a barrier would be to go to the bank to open an account, or the local Secretary of State office to obtain a State Identification Card.

The fee schedule established by MDHHS for the Non-Emergency Medical Transportation (NEMT) service must be utilized for this NMNET service. Transition agencies may request prior authorization for reimbursement rates that are higher than the NEMT rates.

3.3.A. LIMITATIONS

Whenever possible, family, neighbors, friends or community agencies that can provide transportation without charge must be utilized before authorizing this transition service. NMNET services offered are not available through the State Plan and are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a). This service does not include purchasing, leasing, repair or maintenance of vehicles.

This service may not be authorized to reimburse caregivers to run errands for beneficiaries when the beneficiary does not accompany the driver of the vehicle. The purpose of this service is to enable the beneficiary to gain access to their community services, activities, and resources.

Reimbursement does not include expenses for meals or lodging incurred while traveling.

3.3.B. PROVIDER QUALIFICATIONS

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual (paid or volunteer, no familial relationship)	Must have Michigan Driver's License and be enrolled in CHAMPS. All drivers must have vehicle insurance as required by the State of Michigan. All drivers must follow all motor vehicle laws. All passengers must comply with seat belt laws.	Transition Agency	Annually
		Secretary of State	Every 4 years (renewal of Driver's License)
Public Transit	Must have Michigan Driver's License. Must follow all applicable laws, including licensure, inspections, vehicle maintenance, etc.	Secretary of State	Annually
Private/Commercial/Non-Profit Transportation Company	Must have Michigan Driver's License and be enrolled in CHAMPS. Must follow all applicable laws, including licensure, inspections, insurance, vehicle maintenance, etc. Must include passenger assistance in the provision of service when needed by passenger.	Secretary of State	Annually

3.4 Home Modifications

Home modifications include physical adaptations to the home that, according to the PCSP, are necessary to ensure the health and welfare of the beneficiary or that enable the beneficiary to function with greater independence in the home. Assessments and specialized training needed in conjunction with the home modifications are included as part of the cost of the service.

This service is available while in the institution to prepare the beneficiary's chosen home and to accommodate a successful discharge to the community. This service may be available in the community when additional needs that were not accounted for prior to discharge are identified. Claims for this service will not be billed until the beneficiary is discharged from the institution.

Home modifications may include:

- installation of ramps and grab bars;
- widening of doorways to accommodate medical equipment such as a wheelchair or walker;
- modification of bathroom facilities to make them accessible to the beneficiary;
- modification of kitchen facilities to make them accessible to the beneficiary;
- installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and
- environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers or locks.

The case record must document that the home modification is the most cost-effective and reasonable alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home (e.g., converting a dining room on the main floor to a bedroom) or finding alternative housing.

The provider must comply with all local building codes, as applicable. The infrastructure of the home involved in the funded modification must comply with all applicable local codes and have the capability to accept and support the changes.

All home modifications require prior authorization from MDHHS.

3.4.A. Limitations

The services under the home modification service are limited to additional services not otherwise covered under the State Plan, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Home modifications required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home.

Home modifications will not be approved for rental properties without a close examination of the rental agreement and the proprietor's responsibility to furnish the modification.

Home modifications are not available for condemned structures and must not result in valuation of the structure significantly above comparable neighborhood real estate values.

Home modifications cannot increase the square footage of the home.

Other exclusions are those modifications that:

- are of general utility;
- are considered standard housing obligations of the beneficiary or homeowner; and
- are not of direct medical or remedial benefit to the beneficiary.

Examples of exclusions are:

- carpeting
- roof repair
- sidewalks and driveways
- heating
- central air conditioning
- garages and raised garage doors
- storage and organizers
- hot tubs, whirlpool tubs, and swimming pools
- landscaping
- general home repairs or maintenance

Some exceptions may be considered on a case-by-case basis.

Home modifications exclude costs for improvements exclusively required to meet local building codes.

Home modifications exclude general construction costs in a new home or additions to a home purchased by the beneficiary. If a beneficiary or the beneficiary's family purchases or builds a home while in the process of transitioning, it is the beneficiary's or family's responsibility to ensure the home will meet basic needs (such as having a ground floor bath or bedroom when the beneficiary has mobility limitations). However, home modifications may include assistance with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a recently purchased home.

If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the home modification service may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need.

Billing for home modifications must not be done until the service is completed.

3.4.B. Provider Qualifications

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual	Licensed builder or licensed contractor Michigan license under: MCL 339.601(1), MCL 339.601.2401(1), MCL 339.601.2403(3)	Transition Agency	Prior to provision of services and annually thereafter
		LARA	Annually
Retail Store	Items purchased from retail stores must meet the home modifications service definition.	Transition Agency	Prior to furnishing services and annually thereafter.
Agency/Business	Licensed builder or licensed contractor Michigan license under: MCL 339.601(1), MCL 339.601.2401(1), MCL 339.601.2403(3)	Transition Agency	Prior to provision of services and annually thereafter
		LARA	Annually

3.5 Home and Community-Based Services Personal Care

Home and Community-Based (HCBS) Personal Care Services enable beneficiaries with functional limitations resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive setting preferred by the beneficiary. HCBS Personal Care Services include the provision of assistance with ADLs (eating, toileting, bathing, grooming, dressing, transferring, and mobility) and IADLs (taking medication, meal preparation, shopping for food or other necessities, laundry, and housekeeping).

HCBS Personal Care Services provided while in the community are limited to beneficiaries who are not eligible for State Plan Personal Care Services (Adult Home Help) or who require personal care services to begin before State Plan Personal Care Services or other HCBS services (e.g., Program of All-Inclusive Care for the Elderly [PACE], MI Health Link, MI Choice) can be authorized. Beneficiaries must not receive both State Plan Personal Care Services and HCBS Personal Care Services at the same time. HCBS Personal Care Services may also be authorized when a beneficiary's needs change and they are unable to

quickly secure other personal care services available through the State Plan or a waiver. Services cannot duplicate, replace or supplant other available State Plan services. Beneficiaries enrolled in another HCBS program offering similar services must receive personal care services through that program.

HCBS Personal Care Services provided while the beneficiary is in the institution are limited to a one- to three-day trial period in the community-based residence. Claims for this service will not be billed until the beneficiary has transitioned to the community.

MDHHS utilizes the reimbursement structures established for State Plan Personal Care Services. The State-developed fee schedule rates depend on the beneficiary's county of residence and whether the provider is an individual or agency. State-developed rates are published on the MDHHS website. (Refer to the Directory Appendix for website information.)

HCBS Personal Care Services require prior authorization based upon a review of the PCSP and the beneficiary's assessed needs.

3.5.A. Provider Qualifications

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual	Must be enrolled in CHAMPS. Must not have any excludable convictions based upon a background check. Must be able to meet the needs of the beneficiary as specified in the PCSP.	Transition Agency	Prior to provision of services and annually thereafter
Agency/Business	Must be enrolled in CHAMPS. Employees and other key staff must not have any excludable convictions based upon a background check. Employees must be able to meet the needs of the beneficiary as specified in the PCSP.	Transition Agency	Prior to provision of services and annually thereafter

3.6 Conflict of Interest Standards

The conflict of interest standards for CTS ensure, at a minimum, that persons performing evaluations, assessments, and PCSP functions are not:

- related by blood or marriage to the beneficiary, or any paid caregiver of the beneficiary;
- financially responsible for the beneficiary;
- empowered to make financial or health-related decisions on behalf of the beneficiary; or

- providers of State Plan HCBS for the beneficiary, 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 PCSPs because such individuals are the only willing and qualified entity in a geographic area, and the State devises conflict of interest protections.
- TNs who provide 1915(i) services cannot also be supports coordinators for MI Choice Waiver services.

SECTION 4 – PERSON-CENTERED PLANNING

MDHHS requires that transition agencies and TNs use a person-centered approach in working with beneficiaries.

PCP is a process for planning and supporting a beneficiary that builds on the beneficiary's desire to engage in activities that promote community life and that honor that beneficiary's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the beneficiary desires. TNs must utilize a PCP process that includes assessing the needs and desires of the beneficiary, developing the PCSP, and continuously updating and revising those plans as the beneficiary's needs and desires change. The beneficiary and his/her chosen representative(s) must be provided with written information from the transition agency explaining their right to participate in the PCP process. Transition agencies must implement the PCP process in accordance with MDHHS guidelines.

PCP meetings are conducted when the beneficiary is not in crisis and at a time of the beneficiary's choice. The beneficiary has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process.

A pre-planning session may occur prior to the first PCP meeting. During the pre-planning session, the beneficiary chooses desires, goals and other topics he/she would like to discuss, who to invite to the PCP meetings, who will facilitate and record the meeting, and a time and location that meets the needs of everyone involved in the process. The beneficiary and chosen allies design the agenda for the PCP meeting.

The PCP process results in development of the PCSP. The PCSP may otherwise be referred to as a person-centered transition plan (PCTP). Both terms may be used interchangeably for the same plan.

4.1 PERSON-CENTERED SERVICE PLAN

The PCSP is an individualized, comprehensive document developed by the beneficiary, his/her chosen representatives, and TN. The TN must establish a written PCSP that is based on the beneficiary's expressed needs and desires. The PCSP identifies the beneficiary's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. The document includes all services provided to, or needed by, the beneficiary regardless of funding source. The PCSP includes the amount, frequency, and duration of each service. If risks were discussed during the PCP meeting, beneficiary-approved strategies to mitigate those potential risks are documented in the PCSP.

The beneficiary must approve all services and interventions before implementation, and the TN must document the beneficiary's approval. Regular updates to the PCSP occur when the need for services or circumstances change, or otherwise upon the request of the beneficiary, but at least once every year.

The PCSP must reflect the services and supports that are important for the beneficiary to meet the needs identified through an assessment of functional need, as well as what is important to the beneficiary regarding preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, and the scope of services and supports available, the PCSP must:

- Reflect that the setting in which the beneficiary resides is chosen by the beneficiary. The setting chosen by the beneficiary must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work

in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

- Reflect the beneficiary's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect the services and supports (paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the beneficiary in lieu of other services.
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Be understandable to the beneficiary receiving services and supports, and the individuals important in supporting him/her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Identify the individual or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the beneficiary in writing, and signed by all individuals and providers responsible for its implementation.
- Be distributed to the beneficiary and other individuals involved in the plan.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Document that any modifications of the additional conditions specified in the Home and Community Based Services chapter of this manual must be supported by a specific assessed need and justified in the PCSP. The following requirements are documented in the PCSP:
  - identify a specific and individualized assessed need;
  - document the positive interventions and supports used prior to any modifications to the PCSP;
  - document less intrusive methods of meeting the need that have been tried but did not work;
  - include a clear description of the condition that is directly proportionate to the specific assessed need;
  - include a regular collection and review of data to measure the ongoing effectiveness of the modification;
  - include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
  - include informed consent of the beneficiary; and
  - include an assurance that the interventions and supports will cause no harm to the beneficiary.

SECTION 5 – ASSESSMENT AND REASSESSMENT

TNs will obtain information from applicants using a community transition assessment approved by MDHHS. The assessment tool contains information about the beneficiary's ability to perform ADLs and IADLs, informal support network, goals for community living, available resources, identification of barriers to transition, how the beneficiary would like to overcome those barriers, and need for CTS. The assessment information will be submitted to MDHHS via the Nursing Facility Transition (NFT) Portal in Compass. MDHHS will review the documentation submitted to verify the beneficiary has Medicaid eligibility and meets the needs-based criteria.

If MDHHS does not have enough information to make an eligibility determination, MDHHS will request additional information from the TN. The TN must provide the additional information if it can be obtained. MDHHS reserves the right to evaluate the applicant in person to confirm that he/she meets all eligibility requirements for CTS.

During the re-evaluation, the TN will update the community transition assessment tool, including the PCSP. This updated information will be added to the NFT Portal for MDHHS review. MDHHS will review the documentation to ensure the beneficiary still meets criteria for continued receipt of CTS. Beneficiaries must receive at least one of the CTS every three months, and the TN must conduct monthly monitoring.

MDHHS requires TNs to report the initial assessment date and the transition date to MDHHS within the NFT Portal.

Needs-based eligibility re-evaluations are conducted at least every 12 months.

Claims for services will include the actual date of service provision.

SECTION 6 – HOME AND COMMUNITY-BASED SETTINGS

Settings in which a beneficiary resides or receives services must comply with the federal HCBS settings rules, the Home and Community-Based Services policy chapter of this manual, and the Statewide Transition Plan. Transition agencies must ensure that settings to which beneficiaries transition meet federal HCBS settings rules.

Transition agencies must educate beneficiaries that if they choose to live in a setting that does not meet the HCBS settings criteria, Medicaid cannot pay for CTS after the transition date. Medicaid will not pay room and board.

SECTION 7 – BILLING PROCESS

7.1 EXPENDITURE REPORTS

Transition Services Expenditure Reports for CTS provided must be submitted to MDHHS by the 15th day of the month following the month the service was provided. For example, the expenditure report for services provided in January must be submitted to MDHHS by February 15.

The community transition assessment must be updated prior to or upon submission of the Expenditure Report so documentation supports billed services. The NFT Notice must be approved by MDHHS. All expenditures must comply with the established coding structure for CTS (refer to Directory Appendix). Services or items requiring prior authorization will not be payable until approved by MDHHS. Expenditure Reports must be signed by the transition agency prior to submission to MDHHS.

7.2 CHAMPS BILLING

When available, claims must be submitted in CHAMPS. The Professional Invoice claim will be used. Claims may be submitted into CHAMPS via direct data entry or 837P files. Refer to the General Information for Providers and the Billing & Reimbursement for Providers chapters of this manual for claim submission instructions.

The transition agency is the billing provider and will need to have a National Provider Identifier (NPI).

The rendering provider is whomever is providing the service. This provider must have either an NPI or CHAMPS Provider ID. The rendering provider will be included in the header or line on the claim in CHAMPS.

If prior authorization is required for the item or service, the approved prior authorization number must be included on the claim in the "Prior Authorization Number" field.

7.3 PRIOR AUTHORIZATION

The nature of some CTS makes them inappropriate for fee or frequency screens. There may be instances when a beneficiary has a legitimate need for an item or service that is more expensive than the fee or frequency screen allows. In these situations, the prior authorization process is used to approve a specific reimbursement rate for items/services received by a beneficiary. Procedure codes must be submitted along with the prior authorization request. Until CHAMPS is programmed to accept prior authorizations for CTS, the Exceptions Process in the NFT Portal must be used.

Once functionality exists in CHAMPS, the prior authorization request will be entered and submitted into CHAMPS.

7.4 EXAMPLES OF NON-BILLABLE SERVICES OR TASKS

Some tasks performed by transition agencies are not billable. Some examples of these tasks are:

- TN travel time
- TN time off (sick leave, vacation)

- Unsuccessful attempts to contact the beneficiary or others on their behalf
- Staff meetings and trainings
- Contact with support staff within the agency
- Filing
- Reviewing case files for quality assurance
- Activities provided by anyone who does not qualify as a TN

SECTION 8 – CRITICAL INCIDENT RESPONSE AND REPORTING

TNs are required to track and to report certain events that may indicate exceptional risk to the beneficiary.

8.1 TYPES OF CRITICAL INCIDENTS AND SERIOUS EVENTS

The following are specific critical incidents or serious events that must be reported to MDHHS:

- Provider No Show, particularly when the beneficiary is bed-bound all day or there is a critical need for the service to be provided
- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Medication error
- Neglect
- Physical abuse
- Sexual abuse
- Suicide attempts
- Unexpected/unexplained death related to providing services, supports, or care
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Restraints, seclusion or restrictive interventions

8.2 CRITICAL INCIDENT RESPONSE

TNs have the initial responsibility for identifying, investigating, evaluating, and responding to critical incidents that occur with beneficiaries as listed above. All suspected incidents of abuse, neglect, and exploitation require reporting to MDHHS Adult Protective Services (APS) for investigation and follow-up. TNs must begin investigating and evaluating critical incidents within two business days of the date it was noted that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

Each transition agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with MDHHS-APS to determine the result of the reported incident and the steps to be taken if the results are unsatisfactory. All reports to MDHHS-APS must be maintained in the beneficiary's case record.

8.3 Critical Incident Reporting

TNs are responsible for tracking and responding to critical incidents using the Critical Incident Reporting web-based system. TNs are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of knowledge of the incident. The critical incident system allows MDHHS to review the reports in real time and ask questions or address concerns with the transition agencies. MDHHS must receive notification from transition agencies of suspicious deaths within two business days.

SECTION 9 – ENROLLMENT IN OTHER PROGRAMS

Some beneficiaries may choose to enroll in other Medicaid programs such as the MI Choice Waiver, MI Health Link, PACE, or Home Help after the discharge from the nursing facility. TNs may follow these beneficiaries for up to 30 days to ensure previously planned services are completed. Once the beneficiary is enrolled in these other programs, the transition agency must not bill for any new CTS for which there are similar services offered through the other program.

If a beneficiary is enrolled in Medicaid managed care with a Medicaid Health Plan, the TN must keep the health plan informed that transition work is occurring and when the transition from the institution to a community setting occurs.

If the beneficiary is enrolled in the MI Health Link program when the CTS referral is made to the transition agency, the transition agency must refer that beneficiary back to the MI Health Link Integrated Care Organization with which the beneficiary is enrolled.

SECTION 10 – PROVISION OF NOTICES

Transition agencies must provide each beneficiary the appropriate Adverse Action Notice when the agency terminates, suspends, or reduces previously authorized services, or denies a request for enrollment or additional services. The types of Adverse Action Notices are: 1) Adequate Action Notice, and 2) Advance Action Notice.

10.1 ADEQUATE ACTION NOTICE

The Adequate Action Notice is a written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. This notice is provided on the same date the action takes effect.

An Adequate Action Notice is also sent to the beneficiary in the following circumstances:

- when the transition agency is unable to schedule an appointment for the community transition assessment within one week of receiving the referral;
- the beneficiary discharges from an institution prior to the transition agency contacting the beneficiary and the assessment could not be conducted;
- the transition agency has information confirming the death of the beneficiary;
- the transition agency receives a clearly written statement signed by a beneficiary who no longer wishes to receive services;
- the beneficiary gives information that requires the termination of services and indicates that they understand termination is the result of supplying this information;
- the beneficiary's whereabouts are unknown and mail is returned without a forwarding address;
- the transition agency determines the beneficiary has eligibility for Medicaid in a different jurisdiction; and
- the date of the action will occur in less than 10 days.

The Adequate Action Notice must contain:

- a statement of the action being taken;
- the reason for the action;
- the regulation(s) that supports the action;
- an explanation of the beneficiary's right to request a State Fair Hearing and instructions for doing so; and
- an explanation that the beneficiary may have self-representation or use legal counsel or another spokesperson.

10.2 ADVANCE ACTION NOTICE

The Advance Action Notice is a written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided. This notice is provided at least 10 days prior to the effective date of the action.

The Advance Action Notice must include:

- all Adequate Action Notice requirements;
- the circumstance under which services will be continued pending resolution of the appeal;
- how to request that benefits be continued; and
- the circumstances under which the beneficiary may be required to pay the costs of these services.

10.3 Continuation of Services

The transition agency must continue services after the Advance Action Notice when the following are true:

- the beneficiary specifically requests services to continue and files the appeal within 10 days of the date of the notice;
- the appeal involves termination, suspension, or reduction of a previously authorized service; and
- the period covered by the original authorization has not expired.

10.4 Exceptions to Adverse Action Notices

There are some exceptions to sending Adverse Action Notices. No notice is necessary if the services were for a clearly defined length of time and that length of time has expired according to the PCSP as approved by the beneficiary or their chosen representative, or the service was offered on a one-time only basis.

An Adverse Action Notice is also not required when the determination is a result of a State Fair Hearing decision.

10.5 Exceptions to Advance Action Notice

There are exceptions to sending an Advance Action Notice. According to 42 CFR §431.213, the transition agency may send an Adequate Action Notice in lieu of an Advance Action Notice no later than the date of action if:

- the transition agency has information confirming the death of the beneficiary;
- the transition agency receives a signed, written statement by the beneficiary that:
  - indicates the choice to no longer receive services; or
  - gives information that requires termination or reduction in services and indicates that he understands that this must be the result of sharing that information;
- the beneficiary has been admitted to a penal institution (jail or prison), making the beneficiary ineligible for CTS;
- the beneficiary's whereabouts are unknown and mail is returned with no forwarding address;
- the beneficiary has been accepted for Medicaid services in another locality, state, territory, or commonwealth; or

- there is a change in the level of medical care needed according to the beneficiary's physician.

SECTION 11 – QUALITY ASSURANCE REVIEWS

To ensure the highest quality of services and supports, MDHHS operates a comprehensive quality management system that incorporates evaluations of various aspects of the CTS program. The quality assurance process evaluates beneficiary satisfaction, service provision, service plan development and maintenance, beneficiary records, responses to critical incidents, and other topics. Transition agencies are required to comply with MDHHS requests and requirements for the quality assurance process.

SECTION 12 – CASE CLOSURE

There is no set time limit on how long an individual may use CTS. In general, individuals who transition from the nursing facility are linked to HCBS programs. Once the individual begins receiving services from another program, the need for CTS may end.

- MDHHS allows up to 30 days to facilitate a transfer from CTS to a HCBS program.
- If all is going well with the individual, the transition navigator should close the individual's case at the end of 30 days.
- Reasons for keeping the case open longer than 30 days after starting HCBS must be clearly documented in the case record and approved by MDHHS Home and Community-Based Services Section.
- Not all individuals who transition will qualify for or choose HCBS programs. These individuals may remain open to CTS if they continue to meet eligibility criteria, including the demonstrated and documented need for at least one community transition service on a monthly basis.
- A case may also be closed if the beneficiary is deceased or otherwise not eligible, or has refused services or moved out of the service area and chosen to work with another transition agency.