MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Amanda Farley

Phone Number:

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The Centers for Medicare & Medicaid Services (CMS) renewed and approved changes to the 1915(i) State Plan Amendment (SPA) for Community Transition Services (CTS) on October 1, 2023. This policy updates the CTS chapter of the Medicaid Provider Manual to reflect changes in the approved 1915(i) SPA.

Reason for policy (problem being addressed):

To align the renewed 1915(i) SPA for CTS and the CTS chapter of the Medicaid Provider Manual.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

Yes.

Does policy have operational implications on other parts of MDHHS?

No.

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☒ Yes ☐ No If Yes, please provide status: ☒ Approved ☐ Pending ☐ Denied Date: 10/1/23 Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2421-HCBS	**Date:** August 7, 2024

Comments Due: September 11, 2024
Proposed Effective Date: November 1, 2024
Direct Comments To: Amanda Farley
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Policy Subject: Update to the Community Transition Services Chapter of the Michigan Department of Health and Human Services Medicaid Provider Manual

Affected Programs: Community Transition Services

Distribution: Transition Agencies, MI Choice Waiver Agencies, Nursing Facilities

Summary: On October 1, 2023, the Centers for Medicare & Medicaid Services (CMS) renewed and approved changes to the 1915(i) State Plan Amendment (SPA) for Community Transition Services (CTS). This policy updates the applicable portions of the CTS chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual to reflect changes in the approved 1915(i) SPA.

Purpose: The purpose of this policy is to comply with CMS approved changes to Community Transition Services.

Cost Implications: None

Potential Hearings & Appeal Issues: Potential Hearings or Appeals

State Plan Amendment Required: Yes ☒ **No** ☐ **If yes, date submitted:**	**Public Notice Required: Yes** ☒ **No** ☐ **Submitted date:**

Tribal Notification: Yes ☒ **No** ☐ **- Date:** January 20, 2023

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Transition Agencies, MI Choice Waiver Agencies, Nursing Facilities

Issued: October 1, 2024 (Proposed)

Subject: Update to the Community Transition Services Chapter of the Michigan Department of Health and Human Services Medicaid Provider Manual

Effective: November 1, 2024 (Proposed)

Programs Affected: Community Transition Services

On October 1, 2023, the Centers for Medicare & Medicaid Services (CMS) renewed and approved changes to the 1915(i) State Plan Amendment (SPA) for Community Transition Services (CTS). This policy updates the applicable portions of the CTS chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual to reflect changes in the approved 1915(i) SPA.

Summary of Changes

Updates to the CTS chapter of the MDHHS Medicaid Provider Manual to incorporate changes in the approved 1915(i) SPA include:

- Added the option of "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 CTS" to the criteria for beneficiary eligibility for transition services.
- Clarified the requirement to receive monthly monitoring through Transition Navigation Case Management and at least one covered service every three months.
- Modified the service and items available as a CTS according to the approved 1915(i) SPA application and clarified that prior authorization of each item is required.
- Added "fees for community living" as an item not included in the CTS definition.
- Clarified that only transportation services provided after transition are covered as Medicaid-reimbursable services and clarified that these services require prior authorization.
- Clarified that only HCBS Personal Care Services provided after transition are covered as a Medicaid-reimbursable service.
- Added a new section to clarify services that are 100% State-Funded
- Clarified that Transition Services Expenditure Reports are required for services provided to participants for whom Medicaid eligibility was presumed, but not obtained before services provided to these individuals will be reimbursed.
- Clarified that all services except Transition Navigation require prior authorization.

Beneficiary Eligibility for Transition Services

To be eligible for transition services, beneficiaries must:

- have expressed a preference to live at home or in a community-based setting;
- be eligible for Medicaid or have all the following:
  - a completed Michigan Medicaid application with all necessary verifications submitted to the MDHHS Local Office awaiting review,
  - reasonable assurance that MDHHS Local Office will likely approve the submitted application,
  - 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; or
  - 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 CTS.
- meet Needs-Based Criteria identified within the Community Transition Services chapter of the MDHHS Medicaid Provider Manual; or
- have at least one risk factor, as identified within the CTS chapter of the MDHHS Medicaid Provider Manual, that cannot be addressed by standard institutional discharge procedures.

Covered Services

To qualify for CTS, beneficiaries must minimally receive monthly monitoring through Transition Navigation Case Management and at least one covered service every three months in addition to monthly monitoring. CTS are not available through a self-directed arrangement.

Transition Navigation Case Management

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 eligibility for CTS.
- 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 person-centered service plan (PCSP) with the beneficiary using the PCP process, including revisions to the plan at the beneficiary's request or as changes in the beneficiary's circumstances may warrant.

Community Transition Services

CTS includes the following:

- Security deposits;
- 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.

Items and services under CTS may require prior authorization from MDHHS. (Refer to the Transition Services Coding Structure document on the MDHHS website for additional information.)

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, fees for community living, or household appliances or items that are intended for purely diversional or recreational purposes.

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.

The fee schedule established by MDHHS for the Non-Emergency Medical Transportation (NEMT) service must be utilized for this NMNET service. All NMNET services require prior authorization from MDHHS. Transition agencies may request reimbursement rates that are higher than the NEMT rates through the prior authorization process. (Refer to the Transition Services Coding Structure document on the MDHHS website for additional information.)

Home and Community-Based Services Personal Care

The following text will be removed from the Home and Community-Based Services Personal Care subsection:

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.

100% State Funded Services

MDHHS allows the following services to be provided to beneficiaries when they are necessary to facilitate a transition to the community. These services are not eligible for Federal Financial Participation.

- First month's rent
- Payment of delinquent debt that interferes with securing a home in the community.
- A limited quantity of groceries.
- Fees necessary 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.
- Non-Emergency, non-medical transportation while in the institution which is limited to visiting potential community-based residences and travel to businesses or agencies to address barriers to community-based living. Examples include going to the bank to open an account or the local Secretary of State office to obtain a State Identification Card.
- Appliances necessary for community-based living.
- Court costs for adding or removing guardianship or conservatorship.
- Personal Care Services provided while the beneficiary is in the institution. These are limited to a one to three day trial period in the community-based residence.

Billing Process

Expenditure Reports

Transition Services Expenditure Reports for CTS provided to individuals for whom Medicaid eligibility was not established must be submitted to MDHHS by the 15th day of the month following the month the transition agency knew about the Medicaid application denial.

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 before any expenditures will be reimbursed. All expenditures must comply with the established coding structure for CTS. (Refer to the Transition Services Coding Structure document on the MDHHS website for additional information). 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.

CHAMPS Billing

Claims for all Medicaid-eligible beneficiaries must be submitted in CHAMPS. Providers will use the Professional Invoice claim.

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.

Prior Authorization

The Prior Authorization subsection will be revised to read:

All CTS except Transition Navigation services require prior authorization by MDHHS. The prior authorization request must be entered and submitted into CHAMPS and include procedure codes for the requested services.

Examples of Non-Billable Services or Tasks

Some tasks performed by transition agencies are not billable as a claim.