PROVIDER PROCEDURE MANUAL

COMMUNITY TRANSITION SERVICE

December 2017

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CTS PROVIDER PROCEDURE MANUAL

I) General

The purpose of this manual is to set forth the minimum requirements for providers of Community Transition Service (CTS) through the Elderly and Disabled Waiver transitional services. Community Transition Service participants may receive transitional services for 30 days upon discharge from a qualified Long Term Care Facility (LTCF). Transition Care Management, for the purpose of planning a discharge, is the only CTS service for which the provider may bill while an individual is still residing in a qualified institution.

This manual also provides maximum annual service limits and the maximum limits for one-time allowable expenditures for supporting participants in transitioning to the community.

This manual has been prepared for the information and guidance of providers of services participating in the Mississippi Division of Medicaid CTS. Community Transition Service is an available service to participants that will enroll into the Elderly and Disabled Waiver.

It is the provider's responsibility to assure that the business's employees at all locations are knowledgeable of the requirements for CTS and have access to Medicaid and other information pertinent to the performance of their duties.

This manual provides information for the implementation of CTS. As the program evolves and automated systems are put in place, updates will be provided.

II) Staff Training

1) A minimum of 20 hours of initial in-service training (excluding orientation) is required the first year. Additionally, a minimum of 10 hours of in-service training is required annually thereafter.

2) Training areas include, but are not limited to:

    a) Person Centered Planning (PCP)

    b) Person Centered Thinking

c) Home and Community Based Services

III) Referrals and Eligibility Criteria

1) Referrals are identified in two (2) ways

   a) Individuals residing in a LTCF and their caregivers may self-refer at any time

   b) Individuals residing in a LTCF will be identified by answering "yes" to Question 500 B of the Minimum Data Set (MDS). A Transition to Community Referral (TCR) form must be completed and submitted to the secure fax 601-359-6294. DOM will contact the LTCF via phone for options counseling.

2) Referrals are received by phone or secure fax (601) 359-6294 using the Initial Referral Form (DOM CTS.1).

3) Eligibility Criteria:

   a) Reside in a LTCF for at least 90 consecutive days, less any short term rehabilitative days (including skilled nursing)

   b) At least one of the required 90 days must be funded by Medicaid

   c) Qualify for the Medicaid Elderly and Disabled Waiver

4) Services:

   a) Providers must bill services according to approved procedure codes. See attached Procedure Code and Fee Schedule

IV) Initial Referral Process

1) The CTS DOM staff receives Initial Referrals by fax or phone

2) **Initial Referral (DOM Form CTS.1)** must be

   a) Completed with agreement and input from the individual and/or personal representative/guardian. Referrals received from other sources, such as advocates, will be followed up with a call to the individual and/or personal representative/guardian

   b) Submitted to DOM CTS via the secure fax server (601) 359-6294

   c) Retained in the individual's record

3) DOM staff contacts the individual and/or personal representative/guardian to discuss providers, informed choice, and consent to participate. DOM staff obtains permission to send provider information through LTCF social worker.

4) DOM staff sends information on all possible providers and Freedom of Choice (DOM Form CTS.3) to LTCF social worker asking him/her to:

   a) Review options with potential participant

   b) Indicate provider choice and sign Freedom of Choice

   c) Return to DOM via secure fax ATTN: CTS or mail ATTN: CBS to 550 High Street Jackson, MS 39202

5) DOM staff will enter all referral information into the online web based system Long Term Services and Supports (LTSS) which will be used for all form uploads

   a) The website for LTSS is https://sso.ltssmississippi.org

   b) LTSS will be utilized by all providers for CTS as the method for uploading documents such as the Discovery Profile, Risk and Transition Worksheet, PCP Forms

   c) The module in LTSS for CTS is also where providers will be able to see assigned participants and will complete all phases once the paper forms have been signed

   d) Training on LTSS is available as needed by contacting DOM staff

6) **Freedom of Choice Selection Form (DOM Form CTS.3)**

   a) DOM staff will create the Freedom of Choice Selection form in LTSS and will send form to the LTCF social worker (or designee)

   b) The LTCF social worker (or designee), is responsible for discussing the provider options and obtaining individual's and/or personal representative/guardian's signature(s) indicating choice

   c) The LTCF social worker, or designee, will complete and fax form to DOM within five (5) business days

   d) The form is reviewed at DOM and entered into the LTSS module, as well as uploaded as an attachment to the participants profile by DOM. The chosen provider will be selected in LTSS, which will send a notification to the provider that a new referral has been received

e) The form is retained in the individual's record

f) Forms not received by DOM within ten (10) business days will be considered closed referrals

7) The CTS provider has ten (10) business days from the date of assignment in LTSS to conduct a face-to-face meeting to discuss CTS and program options with potential participant and/or personal representative/guardian.

8) The CTS provider is responsible for reviewing records of legal representation in the participant's file in LTSS and obtaining signature of personal representative/guardian where appropriate on all CTS forms.

9) Consent to Participate Phase I (DOM Form CTS.7) is signed at the initial face-to-face meeting. Potential participant and/or personal representative/guardian has seven (7) business days from date Phase I is signed to make a decision to pursue or decline CTS. Once Phase I is signed, the provider has five (5) business days to complete Phase I documentation in LTSS.

   a) Consent to Participate Phase II (DOM Form CTS.7) is signed indicating decision

   b) Phase II can be signed at the initial meeting if the seven (7) business days are not needed to make decision

10) **Consent to Participate (DOM Form CTS.7)**

   a) The CTS provider is responsible for discussing the program and obtaining individual's and/or personal representative/guardian's signature(s) on Phase I, II and III of the form

   b) The three (3) phase form must be completed and signed by the individual and/or personal representative/guardian

   c) Phase I (Exploring Your Options)

      1. Community Navigator explains CTS in full to the individual and/or personal representative/guardian. It does not obligate the potential participant

      2. The individual has seven (7) business days from date signed to make decision to pursue or decline CTS. Once Phase I is signed, it must be completed in LTSS within five (5) business days

   d) Phase II (Transition to Community Planning)

      1. Potential participant has made an informed decision regarding CTS participation

2. Must be signed within seven (7) business days after initial meeting with Community Navigator

3. Once Phase II is signed, it must be completed in LTSS within five (5) business days

e) Phase III (Transitioning to the Community)

1. Signed at least fifteen (15) days before transitioning to the community

2. Participant understands that they will be moving from LTCF to a qualified home in the community

3. Once Phase III is signed, it must be completed in LTSS within two (2) business days

f) The form is retained in the individual's record and a copy is provided to the individual and/or personal representative/guardian

11) Once potential participant consents to participate in Phase II of CTS, the following form must be completed

a) **Bill of Rights (DOM Form CTS.4)**

1. The CTS provider is responsible for explaining the individual's rights and responsibilities if they choose to participate, and for obtaining appropriate signatures

2. The form is retained in the individual's record and a copy is provided to the individual and/or personal representative/guardian

3. Bill of Rights form must be uploaded as an attachment in LTSS within five (5) business days of signature

The DOM-CTS staff

1. Reviews the Initial Referral Form within three (3) working days of receipt

2. Determines if the initial screening requirements have been met

3. Notifies referral source and/or resident if initial eligibility requirements are not met

4. Enters information, creating the CTS referral and profile in LTSS

5. Contacts the referral source/resident/personal representative/guardian for additional information in order to determine appropriateness for the program

6. Determines appropriate provider options

7. Contacts facility and ensure provider options are explored fully

8. Ensures Freedom of Choice is signed

9. Signs and forwards the Initial Referral Form and Freedom of Choice via LTSS to the CTS provider

The CTS Provider

1. Contacts the individual and/or personal representative/guardian within ten (10) business days of receipt of referral to conduct face-to-face visit

2. Provides individual with information needed to make a decision regarding participation in CTSs. The individual has seven (7) business days to make a decision to pursue or decline CTS

3. Notifies DOM of referral status via LTSS and Consent to Participate Form (DOM Form CTS.7) within five (5) business days of signature. These forms are retained in the individual's record

V) Discovery Profile

1) The Discovery Profile (DOM Form CTS.10) must be completed prior to the first Person Centered Planning Meeting and submitted via LTSS within five (5) business days after the initial Person Centered Planning meeting

2) Updates to the Discovery profile are required after each PCP meeting and prior to discharge after the participant has transitioned back into the community

    a. Each update must be uploaded to LTSS within five (5) business days after the PCP meeting has been conducted

3) A copy of the Discovery profile must be given to the participant as well as to the Waiver Case Management team

VI) Risk and Transition Worksheet (RTW) (DOM Form CTS.5)

1) Implementation timelines

a) RTW must be submitted to DOM for review via LTSS at least 15 days prior to participant's proposed enrollment (discharge from facility) into CTS

1. RTW must be retained in participant's record and contain the following:

   a. CTS services, amounts, provider, and beginning and ending dates

   b. Other services received (regardless of payer source) including provider, amounts, and beginning and ending dates

   c. Narrative of service supports, needs, and outcomes

b) DOM will notify CTS provider of approval, denial, or changes of RTW via LTSS

2) Provider monitoring of participant's RTW

a) Continuous: The RTW is continuously monitored by the Community Navigator through phone and face-to-face contacts with the participant and/or family

b) Monthly: The RTW is reviewed monthly by the Community Navigator during a face-to-face visit. The Community Navigator completes a progress note that is placed in the participant's record

c) 30 days: The RTW is reviewed within thirty (30) days post transition through a person-centered planning team meeting

d) As needed/requested: RTW can be reviewed at any time when needs or circumstances have changed and/or the individual and/or personal representative/guardian requests review

VII) Risk Mitigation included in the Plan of Services and Supports (PSS)

A comprehensive and pro-active risk mitigation plan, which is a part of the RTW, must be developed to address any risk that has been identified through discovery and planning. Implementation timelines:

a) The Risk Mitigation Plan (RMP) must be submitted for review via LTSS and approval at least 15 days prior to participant's proposed enrollment (discharge from facility) into CTS

b) The RMP must address any risks in the following categories and include a detailed mitigation plan for any cited areas of concern including, but not limited to:

1. Medical and physiological
2. Behavioral and psychiatric

3. Environmental (i.e., living conditions)
4. Financial
5. Activities of daily living (i.e., loss of a home/loss of natural supports)
6. Service disruption
7. Legal (i.e. prior convictions, recidivism risk)
8. Natural disaster plan (i.e., flooding and/or hurricane evacuation plan, including emergency contact information)
9. Other

c) The RMP also must include and address:

1. Twenty-four seven (24/7) contact number for CTS provider staff

2. Emergency contact numbers including 911, local sheriff's office, local hospital, and regional Community Mental Health Center, etc.

3. A written and oral explanation of appropriate response to emergencies (i.e. health or mental health emergency) versus situations in need of immediate attention (i.e. broken medical equipment or failure of a service provider to make an appointment)

d) A copy of the RMP must be provided to anyone providing services to the participant including waiver case managers. The RMP must be reviewed by the Community Navigator as needed and at a minimum, within 30 days post transition during face-to-face contact. This review must be recorded in the participant's record.

e) DOM will notify CTS provider of approval, denial, or changes of RMP via LTSS

VIII) <u>Services</u>

1) **Transition Care Management (Community Navigation)**
<u>Pre-discharge planning should occur within 90 days (with the possibility of an extension in 30 day increments), and Transition Care Management for 30 days after discharge from facility.</u>

a) One CTS provider staff is assigned to a participant as the Community Navigator (CN). (Services are billed as one unit per 15 minutes for any care management service provided.)

b) All contact made by Community Navigators, about and/or on behalf of a participant, must be documented in narrative form in a Notes Section of the file and include:

1. Reason for the contact including content
2. All follow-up activities
3. Calls from third parties
4. The Community Navigators' activities in helping people get what they need
5. Calls to providers, resources, etc., to ask questions or discuss services or supports
6. Calls from service providers or natural supports including:
    a) Name
    b) Service agency
    c) Issue(s) discussed
    d) Any necessary follow-up actions needed as a result of the call
7. When, why, and what type of information is received regarding a person
8. When, why, and what type of information is sent to another party regarding a person
9. Any changes in services
10. Other situations based on individual circumstances

c) Documentation of services provided must include:

1. Date of the service
2. Time of the service (beginning and ending)
3. Type of contact (face-to-face, phone, e-mail, PCP activities, and meetings, etc.)
4. Who was contacted (participant, family member, community resource, housing location, housing client participation, housing partners)
5. Summary of contact must address:
    a. Health and welfare needs
    b. Community needs
    c. Risk mitigation
6. Community Navigator's signature
7. Content of the documentation must be commensurate with the time billed

d) Minimum service contact requirements include:

1. Face-to-face meeting with participant and interested parties must occur within ten (10) business days of CTS provider receiving referral
2. At least one contact per week with family and/or participant
    a. Pre-Transition (up to 90 days)
    b. Post-Transition (30 days)
3. At least one (1) face-to-face visit every two weeks with participant (Pre- and Post- Transition)
4. After Consent to Participate Phase II is signed, initial PCP meeting must be held within the first 21 days
5. At least one (1) person-centered planning team meeting must be conducted every 45 days Pre-Transition, and within 30 days Post-Transition
6. At least one (1) contact with assigned Waiver Services Case Management per month to ensure service coordination

e) In situations where a participant does not have a qualified residence identified, providers can bill for housing location under Transition Care Management.

   1. When possible, participants should be provided and shown at least three (3) housing options prior to making a selection

   2. Medicaid encourages Transition Care Management providers to work closely with local housing partners and designated DOM CTS housing designees to identify housing options for participants

f) A Community Navigator's case load is not to exceed 20 total participants or 10 in each of the categories listed below:

   1. ***Active*** status refers to clients for whom a Community Navigator is providing Transition Care Management services on an ongoing basis, as prescribed in the timeline above, prior to transition
   2. ***Post Transition*** refers to participants for whom a Community Navigator is continuing to provide ongoing Transition Care Management services for 30 days post transition, but whose primary health care oversight and management responsibilities have been turned over to appropriate waiver case managers

g) CTS extension requests

   1. For a period greater than ninety (90) days pre-transition may be approved on an individual basis

   2. Will only be granted in 30 day increments with a maximum of three (3) extensions given for any particular participant

   3. Must be requested fifteen (15) days prior to reaching 90 days via LTSS and must include the following:

      a. The Discovery Profile must be complete and up to date in LTSS
      b. Risk and Transition Worksheet must be completed and up to date in LTSS
      c. Waiver Referral must be made
      d. Written justification uploaded into LTSS must be complete with date of transition along with residence information complete in LTSS
      e. Phase III signature must be complete and signed in LTSS

h) Qualifications for Transition Care Management (Community Navigation) must meet one of the following criteria listed below. **<u>No one individual can serve as a participant's Community Navigator and traditional case manager.</u>**

   1. Social workers must be licensed to practice in Mississippi with a bachelor's

degree in social work and have at least (1) one year of full-time experience in direct care service to older adults and persons with physical, intellectual and developmental disabilities, or serious mental illness.

2. Case managers must have at least (1) one year of relevant work experience AND be certified by the Department of Mental Health after a thorough program review indicates the program has met all case management standards for mental health providers as specified in the DMH Minimum Standards OR case managers must possess a bachelor's or master's degree in Rehabilitation Counseling or a related field.
3. Others with relevant experience and training and at least a bachelor's degree and one (1) year of work experience in a social or health service setting or comparable technical and human service training will be considered.

2) **Security and Utility Deposits**

Participants are eligible for **<u>ONE-TIME</u>** security and utility deposits when moving into a dwelling that is not already leased by a caregiver

a) Services must be billed at reimbursement for cost, with detailed receipts, and submitted via the CMS 1500 to DOM

b) Detailed receipts must be retained in the participant's files

3) **Household Furnishing and Goods**

Participants are eligible for a **<u>ONE-TIME</u>** household furnishing and goods cost when moving into a dwelling and are in need of essentials to assist with startup costs

a) Services must be billed at reimbursement for cost, with detailed receipts, and submitted via the CMS 1500 to DOM

b) Detailed receipts must be retained in the participant's files

c) Household Furnishing and Goods Worksheet (DOM Form CTS.6) is used to assess essential items needed for transition and must have prior authorization from DOM CTS staff

4) **Moving Expenses**

Participants are eligible for **<u>ONE-TIME</u>** moving expenses for items that need to be transported from the facility to their new community residence. Moving expenses may also cover delivery of household furnishings from a store to the participant's residence. This may include one-time cleaning and/or pest eradication if needed.

a) Services must be billed at reimbursement for cost, with detailed receipts, and submitted via the CMS 1500 to DOM

b) Detailed receipts must be retained in the participant's files

5) **Home Adaptation**

Home adaptations/structural changes such as wheelchair ramps, widened doorways, lowered cabinets and other accessibility modifications through CTS are based on a needs assessment.

a) Services must be billed at reimbursement for cost, with detailed receipts, and submitted via the CMS 1500 to DOM

b) Adaptations must be performed by a licensed and bonded contractor

c) Assessment of needs and detailed receipts must be retained in the participant's files

6) **Durable Medical Equipment**

a) Durable medical equipment must be obtained and billed through traditional DME suppliers

b) A prescription and/or Medical Supply Certificate for Medical Necessity (CMN) must be completed and signed by the ordering physician, nurse practitioner, or physician assistant. CMN must indicate CTS at the top of form

c) Notify DOM CTS staff via email (CTS@medicaid.ms.gov) of request made for DME, including Community navigator name and agency, transition date, requested items, and justification

d) Any facilitation of this process will be documented in the CN contact note, including offering and selection of DME provider

IX) Person-Centered Planning

1) Implementation timelines

a) Within 21 days of participant enrolling into CTS

b) Held at a **minimum** of every 45 days (pre-transition)

c) Held within 30 days (post-transition)

d) As circumstances change, and/or the needs of the participant require that the team meet on a more frequent basis to best coordinate care

e) The individual and/or personal representative/guardian requests a meeting

2) Required documentation

a) Interviews including notes, dates, and names of all persons present

b) Activities and observations including location, notes, and dates

c) Discovery Profile (as developed)

d) Dated Action Plans from each PCP meeting (see PCP form)

e) Sign-in sheets of all meetings and dates

f) Notes from all PCP meetings

g) Action Plan and PCP write up must be submitted to DOM via LTSS 5 days after each PCP meeting

X) Discharge

1) When a CTS participant is discharged, the provider must complete a CTS discharge in LTSS within two (2) business days

2) Complete the Discharge (DOM Form CTS.8) indicating end dates and reason for discharge

3) Submit forms to DOM CTS via LTSS system

XI) Status Category

Active status refers to participants for whom a Community Navigator is providing Transition Care Management services on an ongoing basis prior to transition up to 90 days (with the possibility of extensions granted in 30 day increments), and in the first 30 days after transition.

XII) Grievances, Appeals & Fair Hearing Rights

1) Grievance process: A grievance is a complaint filed about unfair treatment and the grievance process provides for prompt resolution of issues not relating to appeals. Grievance procedures cannot interfere with a participant's freedom to make a request for a fair hearing or direct access to a fair hearing.

   a) CTS providers must establish a grievance system that includes written policies and procedures that assure participants and families:

      1. Reasonable assistance in completing forms and other procedural steps
      2. Interpreter services, if needed

3. Toll free numbers to file oral grievances
4. Acknowledgement of receipt of a grievance
5. Receive information regarding the right to file grievances, and requirements and timeframes for filing
6. Documentation is required with participant signature stating they received grievance procedure documents

2) Appeals and Fair Hearing Rights

a) An appeal is a formal request to change a decision

b) The right to appeal is an essential component of the CTS program. As such, the State provides individuals an opportunity to appeal a decision and request a Fair Hearing

c) The appeal and fair hearing process may be requested or initiated when a participant or family

1. Are denied the services of choice or the provider of choice
2. Has services denied, suspended, reduced or terminated that are already authorized Medicaid-covered services

d) CTS providers must establish an appeal and fair hearing process that include written policies and procedures that assure participants and families

1. Reasonable assistance in completing forms and other procedural steps
2. Interpreter services, if needed
3. Acknowledgement of receipt of an appeal
4. Provide information regarding the right to file appeals, and their requirements and timeframes for filing including
   a. How to obtain a hearing
   b. Right to representation at a hearing
   c. Right to continuation of benefits during a Fair Hearing appeal. If the CTS provider's Action in a Fair Hearing is upheld, the participant or family may be liable for the cost of any continued benefits

e) Notice of Action

1. CTS providers must provide appropriate and timely Notice of Action of any decision to:

   a. Deny a service authorization request, or
   b. Authorize a service in an amount, duration, or scope that is less than requested or agreed upon

2. The Notice of Action must be:

a. Written in language that is easily understood
b. Available in alternative formats
c. Written in a manner that takes into consideration those with special needs

3. Contents of the Notice of Action

a. Description of the action the provider has taken or intends to take
b. Explanation for the action
c. Notification that the participant or family has the right to file an appeal
d. Procedures for filing an appeal
e. Notification of participant or family's right to request a Fair Hearing
f. Notice that the participant and family have the right to have benefits continued pending the resolution of the appeal

4. Timeframes for the Notice of Action

a. CTS providers must give notice of at least ten (10) calendar days before the date of any action to terminate, suspend or reduce services
b. In the event of fraud or abuse, the notice may be reduced to five (5) days
c. The period of advance notice may be shortened to one (1) day:

(1) In the event of the death of the participant
(2) By written request of the participant or family to terminate services
(3) When the participant's admission to an institution makes her/him ineligible for further services (i.e., after 30 consecutive days)
(4) When the participant's whereabouts are unknown and contact information is invalid
(5) When the participant moves out of the jurisdiction of CTS services (out of state)
(6) When a physician prescribes a change to the level of care

5. The Fair Hearing Appeals Process must incorporate the following provisions

a. Appeals must be filed within a reasonable timeframe, not to exceed thirty (30) calendar days from the date on the Notice of Action
b. Appeals may be either oral or in writing; however, any oral request to appeal must be followed by a written and signed appeal
c. The CTS provider may be required by DOM to participate in any review, appeal, fair hearing or litigation involving issues related to CTS
d. The CTS provider must continue the benefits/services to the participant and family if the Fair Hearing process requirements are met, until one of the following occurs:

(1) The appeal is withdrawn
(2) Fair Hearing decision is made
(3) Authorization expires or authorization service limits are met

6. CTS providers must provide the grievance, appeals and fair hearing rights information to all subcontractors at the time they enter into a subcontract

7. The CTS provider must provide the family with a copy of the signed and completed form used to describe and document that the participant and family are offered the opportunity to request a fair hearing

XIII) Serious Incident Reports

1) Serious incidents are defined as any occurrence that results in injury, neglect, exploitation or death of the CTS Participant. A serious incident report can be either witnessed or reported to the navigator and must be reported to DOM

2) Serious incidents must be reported in writing within twenty-four (24) hours or the next business day to DOM CTS. Written reports must include the following:

    a) Provider name and address

    b) Date, time and place of event

    c) Date and time staff notified of event

    d) Name of CTS participant

    e) Name of any staff involved if abuse, neglect, or misconduct are alleged

    f) A written description of events and actions

    g) All written reports including outcomes

XIV) Quality Management

All CTS providers will be monitored for compliance with state and federal requirements via the On Site Compliance Review (OSCR) process.

a) OSCRs will be conducted to evaluate assurances concerning the protection of the participant health and welfare, financial accountability, and other elements

b) The OSCR process will monitor a CTS provider in three domains

    1. Administration: This area comprises the organizational structure and management of the CTS program. Administrative functioning is evaluated through the review of such information as staff credentials and training, utilization review documents and incident reports, etc.

2. Program: This area comprises the philosophy and structure of the CTS provider's approach to treatment (what they believe constitutes good treatment and how they plan to carry it out). The program is evaluated through the review of program policy and procedure manuals, staff training schedules, and staff interviews.

3. Services: This area comprises the manner in which a CTS provider translates into services provided to participants. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each participant. Special emphasis is placed on the Plan of Care and Community Navigation.

XV) Timeline

1) Initial Referral Form received at DOM. DOM has three (3) business days to contact potential participant and/or personal representative/guardian.

2) DOM staff contacts facility to provide potential participant and/or personal representative/guardian provider information for Freedom of Choice (FOC) Provider Selection.

3) Facility returns FOC to DOM within five (5) business days of receipt.

4) DOM forwards Initial Referral and FOC to selected provider within three (3) business days of receipt.

5) The CTS provider schedules and conducts a face-to-face visit within ten (10) business days of receiving referral and FOC from DOM.

6) The Community Navigator provides information about CTS to potential participant and family and has Phase I of Consent to Participate signed. If declined, process stops. Consent to Participate completed in LTSS. **NOTE: No billing can take place if individual does not sign Phase One (1) AND Phase Two (2).**

7) The potential participant/family has seven (7) business days to make decision to pursue CTS services. Community Navigator must initiate contact after seven (7) business days for a decision regarding Phase II of Consent to Participate and must be signed. If declined, process stops. Consent to Participate must be completed in LTSS.

8) The Provider enters Consent to Participate (Phase I and II completed) to DOM indicating status via LTSS.

9) Discovery Begins. The discovery process and profile must be completed before the initial Person Centered Plan meeting and uploaded to DOM via LTSS within five (5) business

days. The discovery profile must be updated as necessary and reviewed throughout the process with documentation of review.

10) Once participant consents to participate, Community Navigation begins. Community Navigator must schedule the first person-centered planning meeting within 21 days of signature on Phase II. The Person Centered Planning meeting must include at least three (3) individuals. It should always include the participant and the navigator, and must be scheduled ahead of time to give all interested parties the opportunity to attend.

11) Once a Qualified Residence is determined, the Community Navigator will initiate the HCBS referral (E&D).

12) The provider uploads information and Consent to Participate (Phase I, II, and III completed) to LTSS and informs DOM indicating CTS status. This occurs approximately fifteen (15) days before facility discharge. This allows for coordination of facility discharge date, HCBS and CTS enrollment date to ensure no gaps in service. This also allows CTS providers to bill for all CTS services that an individual qualifies for after discharge from the facility.

13) **Transition to Community. DOM Form 317 must be sent to DOM CTS staff the day of transition**. The Community Navigator will assist the participant with application for SNAP benefits as well as assisting with ensuring that participant goes to the Social Security office.

14) Continued minimum contact required for participants (CN contacts and PCP requirements.) See section VIII.1.d for details

15) Fifteen (15) days prior to CTS discharge, discharge planning begins

16) Provider uploads CTS Discharge Form and Completes Discharge in LTSS. This occurs within two (2) business days of CTS discharge

17) DOM will notify provider when CTS status has been processed in system

XVI) Attachments:

CTS Procedure Codes and Fee Schedule

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