MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Nursing Facilities 04-07

Issued: October 1, 2004

Subject: Nursing Facility Certification, Survey and Enforcement Chapter of the Medicaid Provider Manual

Effective: November 1, 2004

Programs Affected: Medicaid

PURPOSE

The purpose of this policy bulletin is to provide nursing facilities with a new chapter of the Medicaid Provider Manual pertaining to Certification, Survey and Enforcement. This new chapter has been created to incorporate previously published policy regarding Medicaid nursing facility bed certification, survey and enforcement. This chapter also includes new policy as outlined below, and information on certification requirements for nursing facility staff.

NEW AND CLARIFIED POLICY

New policy contained in this chapter includes the requirement of dual certification (Medicare and Medicaid) for all new Medicaid bed certifications; the requirement that Medicaid-only facilities must become dually certified within one year of a sale; criteria for evaluation of new Medicaid bed certification requests; a process for re-entry into the Medicaid program after de-certification; the recovery process for Civil Money Penalty fines if not paid; the recovery process for Medicaid funds paid for new residents admitted under a Denial of Payment for New Admission (DPNA); and a definition of "new admission" for DPNA purposes.

Clarified policy includes the Medicaid provider enrollment process for nursing facilities; nursing facility closure protocols; survey and enforcement processes; and enforcement remedies.

MANUAL MAINTENANCE

Replace existing Chapter V with the attached chapter. Providers may discard the following bulletins.

Bulletin Number	Subject
LTC 96-01	Upper Limit on LTC Beds Certified for Medicaid
LTC 98-01	OBRA Enforcement System
LTC 04-02	Medicaid Certification and De-certification of Nursing Facility Beds and Medicaid Provider Enrollment

Discard this bulletin upon completion of manual maintenance.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Support, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

Paul Reinhart, Director
Medical Services Administration

CERTIFICATION, SURVEY AND ENFORCEMENT

NURSING FACILITIES

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SECTION 1 - INTRODUCTION

Michigan Department of Community Health (MDCH), under an approved State Plan as required by the Social Security Act, is responsible for annual Medicaid certification of all nursing facilities (other than State-owned facilities). MDCH is also responsible to ensure all Medicaid-certified nursing facilities are in compliance with Health Survey and Life Safety Code Survey requirements.

As required by federal law, the State Medicaid Agency (MDCH, Medical Services Administration) has entered into an interagency agreement with the State Survey Agency (MDCH, Bureau of Health Systems) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts the State Survey Agency's (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.

For the purposes of this chapter, a Medicaid-certified nursing facility (NF) is defined as a nonstate-owned nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. This chapter includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies when facilities are not in compliance with applicable requirements.

SECTION 2 - MEDICAID CERTIFICATION AND DE-CERTIFICATION OF NURSING FACILITY BEDS AND MEDICAID PROVIDER ENROLLMENT

This Section describes Medicaid certification requirements for nursing facilities, certification and de-certification of nursing facility beds, and how nursing facility providers enroll in Medicaid.

The State Medicaid Agency (SMA) is responsible for initial certification and annual certification of beds for nursing facilities seeking Medicaid reimbursement. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The State Survey Agency (SSA) is responsible for conducting any required certification surveys for the SMA.

2.1 DUAL CERTIFICATION

MDCH requires all new Medicaid-certified nursing facility beds to also be certified for Medicare. Requests for certification of new Medicaid beds that are not Medicare-certified will be denied. Requests for initial Medicare certification may be made to the provider's SSA Licensing Officer. Facilities must meet state and federal regulations for certification.

Providers may seek annual certification of nursing facility beds currently certified as Medicaid-only. Beds that were certified as Medicaid-only as of August 1, 2004 are not required to become Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on August 1, 2004. However, MDCH strongly encourages Medicare and Medicaid (dual) certification of all nursing facility beds in order to maximize access for beneficiaries.

A nursing facility that has certified beds that were granted an exception under this policy, and that is subsequently involved in circumstances that would require it to enroll with Medicaid (such as a change in ownership), must secure Medicare certification for Medicaid beds within one year. A provider's failure to secure dual certification for all Medicaid-certified beds will result in denial of Medicaid certification and termination of the Medical Assistance Provider Enrollment and Trading Partner Agreement.

A provider that requests new Medicaid certification for some beds in a nursing facility must dually certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the existing Medicaid-certified beds were granted an exception under this policy. For example, a nursing facility has a distinct part or unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and requests Medicaid certification for the new beds. The new beds will be approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit.

A licensed nursing facility entity that becomes a provider as a result of the purchase of a previously closed or currently operating Medicaid-only nursing facility must receive Medicare certification for all Medicaid-certified beds in that nursing facility within one year from the date of purchase of an operating nursing facility or the date of reopening of a previously closed nursing facility. The provider will receive a provisional Medicaid provider agreement while pursuing Medicare certification of the Medicaid-certified beds. This provisional agreement is time limited and holds the provider to the loss of Medicaid certification and disenrollment without appeal if Medicare certification is denied. If warranted, the SMA may grant an additional grace period contingent upon evidence that substantial progress has been made toward Medicare certification. Failure to meet this requirement will result in de-certification of the

Medicaid beds and termination of the Medical Assistance Provider Enrollment and Trading Partner Agreement.

A nursing facility that currently has Medicare certification of its Medicaid beds must maintain the dual certification. A nursing facility that voluntarily disenrolls or decertifies beds from Medicare will lose Medicaid certification of those beds. A nursing facility that loses its Medicare certification through the Centers for Medicare and Medicaid Services (CMS) regulatory enforcement actions will automatically lose its Medicaid certification. An exception or exemption to this dual certification may be made pursuant to the provisions contained in Section 21718 of P.A. 368 of 1978 (MCLA 333.21718). Any exception or exemption granted to a nursing facility under Section 21718 of P.A. 368 of 1978 prior to August 1, 2004 will be recognized.

Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds, are also required to dually certify some types of special population beds (e.g., ventilator dependent care beds). ICF/MR or MI beds need not be dually certified.

A provider must request and receive dual Medicaid and Medicare certification for new Medicaid beds acquired through the CON process, e.g. new construction or the redistribution of certified beds.

2.2 Medicaid Bed Certification Limits

Individual facilities seeking to enroll in the Medicaid program or seeking to increase the number of Medicaid-certified beds must apply as outlined in the Medicaid Nursing Facility Bed Certification Process subsection. Requests to the SMA will be reviewed in date order and must be received 45 days before the first of the month beginning the next quarter of the provider's cost reporting year. MDCH will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit (set in 1996 at 47,542), based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection. Preference will be given to facilities that are requesting Medicaid certification in order to dually certify beds, to facilities that are creating innovative living environments for beneficiaries who choose nursing facility care, and to facilities in geographic areas with limited Medicaid accessibility. Changes in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

2.3 Criteria for Evaluation of Medicaid Bed Certification Requests

The SMA will collaborate with the SSA when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDCH for Medicaid bed certifications will be based on the following criteria:

- Verification from the SSA that the beds are also Medicare-certified.
- The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility has not been subject to one of the following actions or concerns within three years (or as noted) of the filing of an application for Medicaid bed certification:

- A state enforcement action involving license revocation, a limited or total Ban on Admissions, reduced license capacity, selective transfer of residents, receivership, or appointment of a clinical/administrative advisor or temporary manager.
- Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by MDCH.
- A state rule violation showing failure to comply with state minimum staffing requirements and/or a federal citation documenting potentially harmful resident care deficits resulting from insufficient staff.
- A state or federal finding of Immediate Jeopardy.
- Repeat citations at the harm or substandard quality of care level. "Repeat citation" is defined as two citations of the same federal deficiency, or two or more citations within the same regulatory grouping, at the substandard quality of care, harm, or Immediate Jeopardy levels, issued within the last three years or three standard survey cycles.
- A number of citations at Level Two or above on the scope and severity grid on three consecutive standard surveys that exceeds twice the statewide average number of citations. (NOTE: The time frame for this criterion may exceed three years.)
- A number of citations resulting from abbreviated surveys at Level Two or above on the scope and severity grid during any calendar year that exceeds twice the statewide average of abbreviated survey citations.
- A federal or state termination or decertification action.
- A federal or state action to deny payment for new or all admissions.
- A filing of bankruptcy or failure to meet financial obligations that threatens the ability of the nursing facility to achieve or maintain compliance with state and federal requirements.
- An outstanding debt to MDCH (i.e., cost settlement, civil money penalty [CMP] fine, provider bed tax, licensing fees). This does not include financial issues that are in the appeal process.
- Failure to comply with a state correction notice order.
- Enforcement action against the administrator's license in current or previously administered nursing facilities.
- Any other concerns reasonably related to the ability of the nursing facility to maintain compliance with Medicare and Medicaid Requirements for Long Term Care Facilities or to provide appropriate care to residents.

- If currently enrolled as a Medicaid provider, in addition to the criteria above, must be a provider in good standing, defined as:
  - The nursing facility, owner(s), administrator, or other staff are not sanctioned or excluded by Medicare or Medicaid;
  - The nursing facility is in compliance with the Medicare and Medicaid Requirements for Long Term Care Facilities.

Medicaid may enter into a provisional Medical Assistance Provider Enrollment and Trading Partner Agreement with a provider (or the owner or management company) that does not meet the above criteria if:

- The applicant and the owner or management company take actions acceptable to MDCH to correct, improve or remedy any conditions or concerns that would result in denial of the application; and
- The applicant and the owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medical Assistance Provider Enrollment and Trading Partner Agreement. Failure of the provider to comply with the terms of the conditional agreement will result in termination without appeal of the provisional Medical Assistance Provider Enrollment and Trading Partner Agreement.

2.4 Medicaid Nursing Facility Bed Certification Process

Current providers who wish to change their Medicaid-certified beds (increase, decrease, relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. A written request to change Medicaid-certified beds must contain the following:

- Number and location of facility beds
- Current certification designation of all facility beds by unit or wing
- Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds.

A provider may request a change in Medicaid bed certifications at the time of annual survey and any time throughout the year up to once per quarter.

The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Section 3202.

MDCH will respond to Medicaid bed certification requests with a determination within 45 days of receipt of all requested information.

2.4.A. Bed Certification Process for Medicaid Enrolled Providers

Nursing facilities that are currently enrolled with Medicaid and want to change their number of Medicaid-certified beds must file a written request with their SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of requests for additional Medicaid beds. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests and the Dual Certification subsections of this chapter.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the MDCH LTC Rate Setting Section will be notified, in writing, by the SMA. If the request is denied, the provider will be notified of their appeal rights in writing. If the request is approved, the SSA will be given approval to issue a new Notice of Licensure/Certification Action (LC-180) reflecting the change.

2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid

This subsection applies to providers operating existing facilities that have not previously participated in the Medicaid Program, or providers seeking to certify Medicaid beds following the loss of certification due to a regulatory action.

Non-Medicaid providers seeking to receive Medicaid certification for nursing facility beds and receive Medicaid payment must file a written request with their SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection of this chapter.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the MDCH Reimbursement and Rate Setting Section (RARSS) will be notified, in writing, by the SMA. If the request is denied, the SMA will notify the provider of their appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

The provider must also enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection of this chapter.

2.4.C. Bed Certification Process During a Change in Ownership (CHOW)

A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDCH. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA Licensing Officer, the SMA/LTC Services Section and the LTC Rate Setting Section. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The following are changes in ownership that must be reported to the SMA and SSA, regardless of whether a CON is required:

- A change from sole proprietorship to partnership or corporation,
- A change from partnership to sole proprietorship or corporation,
- A change from corporation to sole proprietorship, partnership or corporation,
- Sale or lease of a nursing facility,

- Transfer or sale of stock resulting in a change of the controlling interest in a privately held company,
- Consolidation or merger of two or more corporations that results in the creation of a new corporation.

If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were under the previous owner. However, if the facility has beds designated as Medicaid-only, the new owner must dually certify all Medicaid beds within one year as outlined in the Dual Certification subsection. As part of the CHOW approval process, the SMA may deny bed certifications and recommend against Medicaid enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection. In addition, dual certification requirements apply as outlined in the Dual Certification subsection.

If the new owner wants to change the bed certifications, a written request must be filed with the SSA Licensing Officer and with the SMA Long Term Care Services Section. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for additional Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the MDCH RARSS will be notified, in writing, by the SMA. If the request is denied, the SMA will notify the provider of appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

A new owner is considered a new provider and must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection, regardless of whether any bed certification changes are made.

2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds

A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license nursing facility beds must first receive approval through the CON process within MDCH.

Providers seeking to receive Medicaid certification for the new nursing facility beds and receive Medicaid payment must file written requests with the SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. Medicaid approval or denial of the application will be based on the Criteria for Evaluation of Medicaid Bed Certification Requests.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and MDCH RARSS will be notified in writing. If the request is denied, the SMA will notify the provider of appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

If not already enrolled, the provider must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection.

2.5 MEDICAID PROVIDER ENROLLMENT

To enroll with Medicaid, a nursing facility must:

- Receive written notice from the SMA approving the Medicaid bed certifications.
- Receive an LC-180 from the SSA authorizing the Medicaid bed certifications. This document must indicate Medicare certification of the new Medicaid certified beds.
- Complete a New Provider Information Packet to establish data with the MDCH RARSS. (Requests for a New Provider Information Packet may be made to the MDCH RARSS at 517-335-5356. New Provider information can also be found on the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Long Term Care Provider Forms.)
- Complete a Medical Assistance Provider Enrollment and Trading Partner Agreement. (Requests for an application may be made to MDCH Provider Enrollment. Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)
- Nursing facilities are required to enroll with the State of Michigan Vendor and Contractor Payment System. Providers can enroll on-line or call the Payee Registration Helpline. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

A provider will not be enrolled with Medicaid, which includes issuance of provider ID number for billing, until MDCH Provider Enrollment has received:

- A copy of the letter from MDCH authorizing the CON (for new providers and CHOW).
- Written notice from the SMA that the nursing facility has been approved for Medicaid bed certifications. This will include a copy of the LC-180 indicating dual certification (Medicare) for the new Medicaid-certified beds.
- Notice from the MDCH RARSS that the provider has the required data on file.
- A completed Medical Assistance Provider Enrollment and Trading Partner Agreement.
- A copy of the nursing facility license.

NOTE: The provider's Federal Employer ID number registered with the Vendor and Contractor Payment System must agree with the Federal Employer ID on file with the MDCH RARSS and in the nursing facility enrollment file with MDCH Provider Enrollment.

2.6 Notification Process for Regulatory Actions

MDCH or CMS may make decisions that result in the loss or reduction of a provider's Medicaid-certified beds. Loss of certification, or de-certification, means that Medicaid will no longer pay for any service in the nursing facility related to the de-certified beds.

MDCH or its designee notifies the following entities, in writing, of the loss of Medicaid certification at least 30 days prior to the effective date of payment termination:

- The affected nursing facility,
- The local Family Independence Agency (FIA) office, and
- The public by means of public notice in a local newspaper.

This notification of the nursing facility's loss of certification will state that residents must either:

- Make other arrangements for payment to the nursing facility; or
- Relocate to a setting that is Medicaid certified.

The provider may request assistance from FIA to coordinate relocation for those beneficiaries who wish to transfer. MDCH may choose to apply the Nursing Facility Closure Protocol described in the Nursing Facility Closure Protocol subsection to protect the best interests of residents faced with transfer.

2.7 Nursing Facility Closure Protocol

An interagency agreement exists, including the SMA, the Office of Services to the Aging (OSA), the SSA, and FIA, to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, the nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.

2.8 Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure

A provider may choose to close voluntarily, not as a result of regulatory action. A provider may also choose to continue operating as a nursing facility, but withdraw from participation in the Medicaid Program. In both situations, the nursing facility must follow established guidelines to assure safe and appropriate care of residents.

When a provider decides to close voluntarily, it must provide written notice at least 30 days in advance to residents and, if known, a family member or legal representative of the resident. In order to allow time for appropriate relocation, facilities are encouraged to provide residents with as much notice as possible in excess of the 30 days required by law. The provider is responsible for the safe and appropriate relocation of all residents.

Actual notice of closure must be given, which means that the notice must be given to the resident and a family member or legal representative in a form that they can understand and must be explained to them as needed. The notice must include contact information for the LTC Ombudsman. Facilities are encouraged to include the following information:

- The timeline for voluntary closure or withdrawal from Medicaid
- The process for relocation
- The long term care options available to residents, including community-based care
- Contact information for assistance, e.g. the Area Agency on Aging.

The provider must submit written notification of termination at least 60 calendar days prior to the termination to MDCH Provider Enrollment, the MDCH RARSS, the SSA Licensing Officer, the SMA/LTC Services section, and the local FIA office. (Refer to the Directory Appendix for contact information.)

In the event of a voluntary closure, the nursing facility remains Medicaid-certified until all residents are relocated.

If the nursing facility chooses to withdraw from Medicaid but remain open as a licensed nursing facility, residents who are Medicaid eligible at the time of facility disenrollment may remain in the facility and receive Medicaid payment. The nursing facility's Medicaid enrollment will continue for purposes of payment for state plan services as long as Medicaid residents remain in the facility.

The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this chapter addresses voluntary closures as well as regulatory closures, and outlines the responsibilities of the state agencies involved. The SSA monitors the withdrawal or closure of a nursing facility. The provider may request FIA assistance with resident relocation if needed.

If the provider does not fulfill their responsibilities for the safe and appropriate relocation of residents, as reported by the SSA, the State Closure Team may change the closure into a regulatory action. At that point, the closure becomes non-voluntary and the State Closure Team may request the assistance of a closure agent or take other measures to insure a safe and orderly transfer of residents. The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this chapter would apply.

2.9 Nursing Facility Filing of Bankruptcy

Medicaid-enrolled providers are required to notify the MDCH Long Term Care Services Section Manager and the MDCH RARSS Manager immediately upon filing for bankruptcy. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

2.10 Re-entry After De-certification

A nursing facility may re-enter the Medicaid Program after decertification (whether voluntary or involuntary) if the following conditions are met:

- Submission of a request to the SSA for re-entry, including documentation indicating that the factors leading to a regulatory termination no longer exist.
- Evidence that all of the applicable statutory and regulatory requirements have been met.

- There is reasonable assurance that the deficiencies that caused the regulatory termination will not reoccur.
- The facility is concurrently pursuing Medicare certification.
- The facility meets all enrollment criteria outlined in this section.

Upon re-entry into the Medicaid Program, all Medicaid beds must also be Medicare certified.

The process for re-entering the Medicaid Program includes:

ACTION	DESCRIPTION OF PROCESS
Application	The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and the SMA for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Bed Certification Requests apply as outlined in this section.
Departmental Review	The SMA makes a formal review of the nursing facility's financial status and requests confirmation of compliance with all civil rights requirements from the Office of Civil Rights (OCR). If financial responsibility and compliance with the civil rights requirements are confirmed, a reasonable assurance period (not subject to appeal) is set and the SSA is asked to conduct an initial survey.
Survey Activity	There will be at least two surveys during the reasonable assurance period. ▪ **Initial Survey** - A survey is conducted at the beginning of the reasonable assurance period to document compliance with previously cited deficiencies. The initial survey may be a partial or full survey at the discretion of MDCH. A finding of substantial compliance at this survey will allow the nursing facility to begin the reasonable assurance period. If the nursing facility is found to not be in substantial compliance, then it must re-apply. ▪ **Second Survey** - A full survey must be conducted and the nursing facility must be in substantial compliance in order for the reasonable assurance period to end. The SSA will schedule the survey to coincide with the end of the established reasonable assurance period. If the nursing facility has maintained compliance during the reasonable assurance period, it may be approved for Medicaid enrollment. If the nursing facility is not in substantial compliance at the second survey, it must enter another reasonable assurance period if it continues to seek re-entry into Medicaid.

ACTION	DESCRIPTION OF PROCESS
	▪ **General Survey Protocol** - Facilities are afforded the same rights for challenging survey results as in the standard certification process, which is through the administrative review process within the SSA. During the reasonable assurance period, the SSA may conduct as many surveys as approved by Medicaid to document compliance with state and federal requirements. Surveys are unannounced; therefore, the nursing facility will only receive acknowledgement of receipt of the approved application and that Medicaid enrollment is based on the outcomes of the surveys conducted. All survey reports (CMS-2567L) are forwarded to the SMA within 10 working days to determine the significance of any findings and the resultant action plan. The results of each survey are evaluated to ensure that the reasons for the termination no longer exist or are at the level of substantial compliance (Level One – Cells A, B or C). Facilities are notified of the determination, in writing, by the SMA. If the SSA determines that the conditions for re-entry are met, Medicaid enrollment will be approved. If the SSA determines that the conditions for re-entry have not been met, the SSA will send the provider a denial letter. The nursing facility may correct the deficiencies and re-apply for certification, resulting in another reasonable assurance period.
Reasonable Assurance Period	The reasonable assurance period is designed to assure that a nursing facility can operate for a certain period of time without the re-occurrence of the deficiencies that led to termination from participation in the program(s). The SMA contacts the SSA to conduct surveys during the reasonable assurance period. The reasonable assurance period begins when the initial survey is completed, which assures MDCH that the nursing facility is complying with requirements for which they were originally de-certified. The SMA will establish a reasonable assurance period, typically from one to six months duration. The length of the reasonable assurance period is not subject to appeal. The time frame for reasonable assurance is based upon criteria, which may include: ▪ A history of maintaining compliance ▪ Absence of a pattern of repeat citations ▪ Timely submission of plans of correction and implementation of approved plans of correction when needed ▪ Number of adverse actions initiated in the past three years ▪ History of termination and re-admission to the program ▪ Current compliance status ▪ Existence of other factors that may affect compliance, e.g., staffing concerns, turnover of key personnel, pay scale The SMA will not approve Medicaid enrollment until the reasonable assurance period has been satisfied. During the reasonable assurance period, the nursing facility must: ▪ Employ adequate management and care staff to provide care in accordance with all applicable federal, state and local regulations.

ACTION	DESCRIPTION OF PROCESS
	▪ Limit admissions to two residents per day or four residents in a seven-day period, regardless of payment source. ▪ Develop an admissions informed consent document that is acceptable to the SMA and that explains the re-entry process. The document should further explain to the resident (or authorized representative) that his residency in the nursing facility could be temporary and a transfer to another setting may be necessary if the nursing facility fails to meet all of the requirements for certification. This notice must be explained to, and signed by, the resident or his authorized representative. A signed copy of this document must be placed in the resident's record.
Appeals Procedure	An applicant may appeal a denial of Medicaid enrollment by submitting a written request within 60 days of the date of the denial decision. The appeal should be addressed to the MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The written appeal must include documentation to support the appeal. If the applicant fails to submit documentation within the 60 days, then the denial decision remains in effect.
Payment	Providers are eligible for Medicaid reimbursement when the nursing facility has been found to meet the conditions for re-entry and is an enrolled Medicaid provider. Under extraordinary circumstances, the SMA may elect to enter into a provisional Medicaid provider agreement during the reasonable assurance period. In most cases, Medicaid reimbursement is not available until the facility has met all required conditions.

2.11 NON-AVAILABLE BEDS

Any nursing facility bed is considered available for occupancy if the bed is licensed and Medicaid certified, unless it is removed from service due to a regulatory ban on admissions or removed voluntarily using the SMA's non-available bed policy.

The SMA allows nursing facilities to designate beds as non-available, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Nursing Facility Reimbursement Chapter.

SECTION 3 - STAFF CERTIFICATION

All health care professionals performing duties within Medicaid-certified nursing facilities must possess the licensure and certification credentials required for their individual disciplines.

3.1 NURSE AIDE CERTIFICATION AND TRAINING

A nurse aide employed in a Medicaid-certified nursing facility must be a Certified Nursing Assistant (CNA). Medicaid reimburses facilities through the annual cost settlement process for the Medicaid share of documented costs directly related to meeting the nurse aide training and testing requirements. Training programs and testing sites must be approved by the SSA in order for those costs to be reimbursed by Medicaid**.** A nursing facility may not charge its employed aides for training, testing, and registry costs related to meeting these requirements. (Refer to the Nursing Facility Reimbursement Chapter for additional information.)

The SSA is responsible for approval of programs that train and certify nurse aides for employment in all Medicaid-certified nursing facilities.

- For information about training requirements, programs or facilities, or concerns regarding the testing program or information placed on the Nurse Aide Registry, contact the MDCH, Bureau of Health Professionals.
- For testing registration information or assistance, or test site concerns, contact the Michigan Nurse Aide Customer Service.
- To inquire about a nurse aide's listing on the Registry, name and good standing, contact the Michigan Nurse Aide Registry.

(Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

3.2 EMPLOYEE SCREENING (CRIMINAL BACKGROUND CHECKS)

Nursing facilities are prohibited from employing, independently contracting with, or granting clinical privileges to any individual making application or being offered privileges who has been convicted of certain crimes. Public Act 303 of 2002 requires nursing facilities to facilitate and bear the cost of criminal background checks, either through the Michigan State Police or the Federal Bureau of Investigation (depending on defined criteria), on all individuals seeking to perform direct services to residents. The law also provides for the sharing of criminal background information with other member agencies of the provider community for the purpose of applicant screening.

An overview of Public Act 303 of 2002 and template forms for use by nursing facilities conducting criminal history checks on applicants are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

SECTION 4 - NURSING FACILITY SURVEY

The purpose of surveying nursing facilities in the State of Michigan is to ensure quality of life and quality of care for residents. In order to fully comply with the applicable federal and state statutes, the State Medicaid Agency has contracted with the State Survey Agency to conduct nursing facility certification surveys. This contract represents the intent and purpose of both agencies to promote high quality health care and services for beneficiaries under the Medicaid Program to:

- comply with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration of the Medicaid Program and certification of health care providers;
- assure that the services provided under Title XIX and Title V of the Social Security Act are consistent with the needs of beneficiaries and the programs' objectives and requirements.

Reports generated as a function of this process are used by MDCH to assure proper payment of claims submitted, to facilitate enforcement actions, and to assess continued certification under the current Medical Assistance Provider Enrollment and Trading Partner Agreement.

4.1 SURVEY PROCESS

The basic survey protocol, including criteria and procedures, is the same for participation in both the Medicaid and Medicare Programs. The State Survey Agency (SSA):

- At appropriate intervals as prescribed by federal and state regulations, conducts on-site surveys, re-surveys and other necessary monitoring of the providers applying to or already participating in the Medicaid Program to determine compliance with program requirements.
- Recommends to the SMA certification of those providers that meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification complies with applicable statutes, regulations, the provisions of the intraagency agreement and is subject to review and comment by the SMA.
- Notifies the SMA and the individual provider within five working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both agencies and shall include information sufficient in detail to allow Medicaid to carry out appropriate provider agreement action. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
- Annually provides to Medicaid a complete listing of all certifications in effect on January 1st of that year.
- Determines and authorizes any waiver of provider requirements granted, the conditions of the waiver, and the time period such waiver will be in effect.

4.2 Survey Review

The SSA sends all survey reports with enforcement recommendations to the SMA for review. Reports and subsequent enforcement recommendations include information sufficient in detail to allow the SMA to carry out appropriate provider agreement action. Following review and authorization by the SMA, the SSA may be designated to generate any or all of the necessary certification and enforcement documentation pertaining to a participating provider.

SECTION 5 - NURSING FACILITY ENFORCEMENT

This enforcement policy applies when the State Survey Agency (SSA) or the Centers for Medicare and Medicaid Services (CMS) determines, on the basis of a standard, abbreviated, extended, or partial extended survey, that a provider is or was out of compliance with the federal certification requirements as stated in 42 CFR Part 488, Survey, Certification and Enforcement Procedures. In Michigan, the Michigan Department of Community Health, Bureau of Health Systems functions as the State Survey Agency.

5.1 AUTHORITY

The Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended, incorporated specific provisions for nursing home reform into the Social Security Act, including revised requirements for survey, certification, and enforcement of providers participating in the Medicare and Medicaid programs. Applicable regulations are found at 42 CFR Part 488.

5.2 GUIDING PRINCIPLES OF ENFORCEMENT

5.2.A. PHILOSOPHY

- All long term care providers have the **responsibility** to provide person-centered quality care and services appropriate to the needs of the residents they serve.
- Long term care providers are an essential **resource** for communities, providing health care services, education, and employment.
- MDCH, as the licensing and certification authority, must insure that all Michigan long term care providers fulfill their responsibility to provide **quality** services.

5.2.B. PURPOSE

To develop, implement, and support an enforcement system that:

- **Promotes** continuous provision of quality care and the highest practicable physical, mental and psychosocial functioning of each resident.
- **Protects** the health, welfare, rights, and choices of long term care residents, as defined by law and regulation, without infringing upon the rights of the resident.
- **Promptly corrects** noncompliance through effective application of appropriate regulatory remedies.

5.3 ENFORCEMENT PRINCIPLES

- The enforcement system must reflect a philosophy of serving resident needs by providing quality care.
- The SSA and the SMA must both strive for consistency in identifying deficiencies and in decision-making for selection and application of remedies. This enforcement principle is consistent with the intent of federal enforcement regulations, the State Operations Manual, and the CMS evaluation process for State Survey Agency performance.

- The SMA's enforcement plan contains a range of remedies. This allows an appropriate remedy scheme tailored to the facility and the cited deficiencies.
- Repeat noncompliance or failure to obtain compliance will result in the application of progressively stronger remedies.
- Remedies that displace residents from their homes will only be used as a last resort; such remedies include facility closure, termination of Medicaid or Medicare provider agreements, or transfer of residents. These remedies will not be used unless the health, safety and/or welfare of the residents is seriously affected, other remedies have not resulted in the facility's ability to achieve and maintain substantial compliance, and/or the physical plant is not a viable setting for quality care and services.
- State enforcement remedies for nursing facilities must include, at a minimum, statutorily specified remedies for skilled nursing facilities and may include additional or alternative remedies approved by CMS.

5.4 Facility Compliance and Deficient Practice

The SSA or CMS, on the basis of a standard, abbreviated, extended or partial extended survey, will determine whether a participating provider is in compliance with the federal regulations governing Medicaid certification. Based on this determination, one or more remedies (corrective actions) may be selected based on the seriousness of the deficiency, facility history, welfare of the residents, and the likelihood that the remedy will promote prompt and sustained compliance. Enforcement remedies include both federal and state enforcement options. Criteria have been designed to minimize the time between identification of the deficiencies and application of remedies. Repeated or uncorrected deficiencies will be assessed progressively stronger remedies. If the SSA finds that a provider currently meets the requirements, but previously was noncompliant, the SSA may impose a remedy for the days it finds that the facility was not in compliance. Nothing in this paragraph shall be construed as restricting the remedies available to the MDCH to address a nursing facility's deficiencies.

5.5 Determining the Seriousness of Deficiencies

To determine the seriousness of deficiencies for the purpose of selecting enforcement remedies, MDCH will consider the factors of scope and severity. **Scope** represents how much of the facility, or how many residents, are or may be affected by a specific deficient practice. **Severity** represents the potential for harm, or the level of harm that has occurred. Scope and severity are assigned an alphabetic and numeric level on the remedy determination grid. The most serious deficiency cited (based on level of scope and severity) determines the category or categories of remedies to be applied. Other factors in the selection of remedies include:

- whether the deficiencies immediately jeopardize the health, safety, or welfare of the facility's residents;
- the relationship of one deficiency to other deficiencies;
- the facility's compliance history;

- the likelihood that the selected remedy will promote correction and continued compliance;
- the provider's culpability, i.e., whether noncompliance is the result of neglect, indifference or disregard;
- the relationship of one remedy to other remedies.

5.5.A. SEVERITY

LEVEL OF SEVERITY	DEFINITION
No actual harm with a potential for minimal harm	The deficiency has the potential for causing no more than a minor negative impact on the resident(s).
No actual harm with a potential for more than minimal harm, but not Immediate Jeopardy	Noncompliance that results in minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Actual harm that is not Immediate Jeopardy	Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental, and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Immediate jeopardy to resident health or safety	A situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility.

5.5.B. SCOPE

SCOPE OF IMPACT	DEFINITION
Isolated	Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
Pattern	Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) has been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.

SCOPE OF IMPACT	DEFINITION
Widespread	Scope is widespread when the problems causing the deficiencies are pervasive in the facility or represent systemic failure.

5.6 Enforcement Remedies

A remedy is a corrective action. Remedies available to MDCH are specified in federal and state law. When the scope and severity increase, the deficiencies repeat, or the facility fails to maintain substantial compliance, selected remedies may also increase.

5.6.A. Federal Enforcement Remedies

Each federal remedy listed below is described in rules as stated in 42 CFR Part 488 et. seq., and further discussed in the CMS State Operations Manual for Medicaid and/or Medicare certified facilities. Federal remedies available to MDCH or CMS include, but are not limited to:

- Denial of payment for new Medicare and/or Medicaid admissions
- State monitoring
- Temporary management
- Directed plan of correction
- Directed inservice training
- Civil money penalties
- Transfer of residents
- Closure of facility with transfer of residents
- Termination of Medical Assistance Provider Enrollment and Trading Partner Agreement
- Denial of payment for all Medicare and/or Medicaid residents imposed by CMS
- Alternative or specified state remedies approved by CMS
- Administrative/Clinical Advisor

5.6.B. State Enforcement Remedies

The SSA has the option of imposing any state or federal remedy based on the facility's failure to maintain compliance, deficiencies cited within the same regulatory grouping that repeat within the last 24 months (or two standard survey cycles), and the degree of culpability of the facility. In addition to federal remedies, the SMA may accept one or more of the following enforcement actions taken by the SSA under state licensure authority. Also see Michigan Enforcement Rules for Long Term Care Facilities at R 330.11001-330.11017.

- Emergency Order Limiting, Suspending or Revoking a License

- Notice of Intent to Revoke Licensure
- Correction Notice to Ban Admissions or Readmissions
- Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements
- Appointment of a Temporary Manager or Clinical/Administrative Advisor
- State Patient Rights Penalties, if applicable

5.7 Denial of Payment for New Admissions (DPNA)

Denial of payment for new admissions may be imposed at any time a provider is not in substantial compliance and must be imposed when a provider is not in substantial compliance within three months of being found out of compliance.

The DPNA enforcement remedy stops Medicaid payment for any new residents admitted to the facility after the effective date of the DPNA. The resident's status on the effective date of the denial of payment is the controlling factor in determining whether readmitted residents are subject to the denial of payment.

Guidelines for the definition of new admission are:

- Medicaid residents admitted to the facility on or after the effective date of the denial of payment for new admissions are considered new admissions. If Medicaid residents are discharged and readmitted to the facility, they continue to be considered new admissions, and are subject to the denial of payment.
- Medicaid residents admitted to the facility and discharged before the effective date of the DPNA are considered new admissions if they are readmitted to the facility on or after the effective date of the DPNA. Therefore, they are subject to the denial of payment.
- Medicaid residents admitted before the DPNA and discharged on or after the effective date of the DPNA are not considered new admissions if subsequently readmitted. Therefore, they are not subject to the denial of payment.
- Medicaid residents admitted before the effective date of the DPNA who take temporary leave before, on, or after the effective date of the DPNA are not considered new admissions upon return and, therefore, are not subject to the denial of payment.
- Medicaid residents admitted on or after the effective date of the DPNA who take temporary leave (e.g., hospital or therapeutic leave) are not considered new admissions when they return. If they were subject to the DPNA before their leave, they continue to be subject to it after their return.
- Private pay residents admitted to the facility after the effective date of the DPNA who then become eligible for Medicaid are subject to the denial of payment.
- Private pay residents in the facility prior to the effective date of the DPNA who then become eligible for Medicaid after the effective date of the DPNA are not subject to the denial of payment.

5.8 Recovery of Medicaid Funds for Admissions During DPNA

Under federal regulations, no federal funds will be paid to a nursing facility or to a state for any resident admitted when the facility is under a Denial of Payment for New Admissions sanction. Nursing facilities will be subject to Medicaid post-payment review to determine if any new residents were admitted during a period of time when the facility was under a DPNA sanction and, if so, Medicaid funds will be recovered from the facility. Facilities will be notified in advance of any recovery action and given the opportunity to produce documentation indicating that the admission was not a new resident and/or to appeal MDCH's determination.

5.9 Minimum Data Set - Resident Assessment Instrument

On a monthly basis, a nursing facility is required to electronically submit to the SSA resident assessments completed in the past month. Failure to comply will result in citations and imposition of remedies, including requirement of a plan of correction. Continued failure to comply will result in increasingly severe remedies up to and including termination of the Medical Assistance Provider Enrollment and Trading Partner Agreement.

An individual who willfully and knowingly certifies a material and false statement in a resident assessment will be subject to civil money penalty fines as outlined in 42 CFR § 483.20(f)(5)(j)(1).

5.10 Termination

This remedy may be imposed at any time when appropriate, but must be imposed when a provider has been out of substantial compliance for six months.

5.11 Purpose of Remedies

TYPE OF REMEDY	PURPOSE
Directed Plan of Correction	The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements. It is used when specific corrective action is required or the corrective action must be accomplished within a specified time, e.g., when a facility's heating system fails and specific repairs or replacement must be made within a specific period of time; when a provider has had difficulty attaining compliance after a revisit; or when assistance with a plan of correction is needed to ensure an effective revisit prior to imposition of a denial of payment or termination of provider status.
Directed In-Service Training	The purpose of directed in-service training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements. Directed in-service training is used when education is likely to correct deficiencies and help the provider achieve substantial compliance.

TYPE OF REMEDY	PURPOSE
State Monitoring	The purpose of state monitoring is to oversee correction of cited deficiencies as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring is appropriate if the provider has had three consecutive standard surveys with substandard quality of care; poor compliance history, pattern of poor quality of care, and/or many complaints; immediate jeopardy without a temporary manager appointment; concern that conditions in a facility have potential to worsen; the provider refuses to accept appointment of a temporary manager; the provider is unwilling or unable to take corrective action for cited substandard quality of care. MDCH may impose state monitoring without notice.
Denial of Payment for New Admissions	The purpose of Denial of Payment for New Admissions (DPNA) is to encourage prompt and sustained compliance. DPNA may be imposed any time the provider is found out of substantial compliance and must be imposed when a provider is out of compliance three months after a determination of noncompliance. DPNA may be imposed alone or in combination with other remedies.
Denial of Payment for All Medicare and Medicaid Residents	The purpose of Denial of Payment for All Medicare and Medicaid Residents is to encourage prompt and sustained compliance. This remedy may be imposed any time the provider is out of substantial compliance, but only by CMS. Factors considered in imposing this remedy include the seriousness of current survey findings, noncompliance history of the facility, and failure of other remedies to achieve or sustain compliance.
Temporary Management	The purpose of a temporary manager is to oversee correction of deficiencies and ensure the health and safety of the facility's residents while corrections are being made. A temporary manager may be imposed as a federal remedy any time a provider is not in substantial compliance; when a facility's deficiencies constitute immediate jeopardy or widespread actual harm and is imposed as an alternative to termination; or to oversee the orderly closure of a facility. The authority and qualifications of the temporary manager are described in the State Operations Manual at Section 7550.
Temporary Administrative and/or Clinical Advisor	The purpose of a Temporary Administrative and/or Clinical Advisor is to monitor and mentor the facility administrative and/or clinical staff through the period of corrective action. This is an additional federal Category 2 enforcement remedy defined in the State Plan and Michigan Department of Community Health Rule 330.11007(6). Authority for this remedy is found at §488.303(e) and §488.406(a)(8)&(9).

5.12 REVISIT POLICY

Revisits are not assured and, depending on the circumstances of any given situation, termination can occur any time for any level of facility noncompliance without regard to revisits. Facilities have the responsibility to correct their deficiencies and notify the SSA when corrections will be completed. It is expected that revisit requests will be made prudently so that the likelihood of additional revisits is reduced. If correction is not achieved at the expected time, the facility should notify the SSA that correction has been delayed so that the revisit can be delayed. MDCH's expectation is that the facility has achieved compliance status as alleged in the Plan of Correction. Revisits may be conducted for any

level of noncompliance. Remedies may be imposed for any level of noncompliance. Revisits are not assured before imposition of denial of payment for new admissions or termination.

The SSA is authorized, at its discretion, to perform up to three revisits to verify compliance. A fourth revisit may be conducted by the SSA only with the authorization of the SMA. An approved Plan of Correction must be received by the SSA with each revisit request. A fourth revisit requires justification.

5.13 Choosing the Compliance Date

MDCH follows CMS policy related to revisits. On a first revisit, the compliance date is the accepted Plan of Correction completion date if it is determined at the time of the revisit that the deficiencies were corrected and the facility is in substantial compliance. If a revisit survey identifies that the facility had a deficiency after the completion date that was corrected before the revisit date, the actual correction date is used.

On the second revisit, the compliance date is the revisit date, unless there is specific evidence of earlier compliance. In this case, observation of compliance is relevant, as is evidence indicating a specific date of correction.

On third or subsequent revisits, the compliance date is the revisit date, without exception.

5.14 Evidence of Compliance in Lieu of a Revisit

Revisits may be conducted at any time for any level of noncompliance. Revisits are required whenever a survey finds noncompliance at Level F (Substandard Quality of Care), Harm, or Immediate Jeopardy (IJ) and must continue for all citations at that level until compliance is achieved with F (SQC), Harm, or IJ citations. In other cases, appropriate to the type of deficiency, acceptable evidence of compliance may be allowed in lieu of a revisit at the SSA's discretion. Evidence of compliance is not acceptable after a second revisit has been conducted within an enforcement cycle. When a facility is allowed to present acceptable evidence in lieu of a revisit, the compliance date is the date the evidence indicates the facility was in substantial compliance.

5.15 Setting the Mandatory Three- and Six-Month Remedy Time Frames

The three-month mandatory denial of payment for new admissions and the six-month mandatory termination dates will be set based on full months rather than on a number of days. With few exceptions, these dates will coincide with the same numerical date of the month of survey exit that identified the noncompliance. For example, if a survey ended on 1/15, the three-month effective date for mandatory denial of payment for new admissions is 4/15, and the six-month termination date is 7/15. Exceptions involve those cases for which a three-month or six-month numerical date is not on the calendar. In these cases, the effective date of the remedy will be the next calendar day.

NOTE: Immediate Jeopardy situations generally have 23-day termination cycles.

5.16 Failure to Readmit a Qualified Medicaid Resident

A daily civil money penalty (CMP) of $400 will be imposed when an enrolled Medicaid facility refuses to readmit a qualified Medicaid resident (as defined by CMS) following hospitalization. An opportunity to correct will not be provided. This daily CMP will start on the date validated by MDCH that nursing home readmission should have occurred. The daily $400 CMP continues until the resident is offered the next qualifying available Medicaid bed at the refusing facility, or the resident is placed in another suitable facility. The refusing facility will be notified by the SSA when an allegation of failure to readmit a qualified Medicaid resident is being investigated.

5.17 Definitions

TERM	DEFINITION
Administrative and/or Clinical Advisor	An alternative federal Category 2 remedy imposed upon a facility for the purpose of mentoring facility administrative and/or clinical staff through the period of corrective action.
Ban on Admissions	Admissions to the facility are suspended on the date specified in the MDCH Correction Notice Order. Includes readmissions if stated in the order.
CMS	The Centers for Medicare and Medicaid Services.
Culpability	The extent to which the facility is responsible for the cited deficient practice. This is often related to occasions when the noncompliance is determined by the State Survey Agency to be intentional, or a product of neglect, indifference, or disregard.
Deficiency	A facility's failure to meet any participation requirement specified in the Social Security Act or in 42 CFR, Subpart B, 483.5 - 485.75.
Failure to Maintain Compliance	Inability of the facility to maintain substantial compliance for at least three months, or a facility having three or more survey cycles in a 12-consecutive month period.
Immediate Jeopardy	Immediate Jeopardy to resident health or safety means a situation in which immediate corrective action is necessary because the nursing facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility. Such a finding is made in accordance with the criteria and definitions in the CMS State Operations Manual Appendix Q - Guidelines For Determining Immediate Jeopardy.
Noncompliance	Any deficiency that causes a facility to not be in substantial compliance.
No Opportunity to Correct	The facility will have remedies imposed immediately after a determination of noncompliance has been made.

TERM	DEFINITION
Opportunity to Correct	The facility is allowed an opportunity to correct identified deficiencies before remedies are imposed.
Past Noncompliance	Past noncompliance is noncompliance that occurred between two certifications of compliance, against which a civil money penalty is imposed. If past noncompliance is cited, a civil money penalty must be imposed.
Plan of Correction (POC)	Mandatory for all deficiencies of scope and severity levels B through L on the remedy determination grid. A POC must be provided to the SSA within 10 days of the receipt of the survey report (CMS-2567). The POC must be approved by the SSA; if disapproved, remedies may be imposed immediately.
Remedy	A corrective action. Some remedies are specified in federal law, others are specified in state law.
Repeat Deficiency	When deficiencies in the same regulatory grouping of requirements are found more than once within 24 months or two standard survey cycles.
Repeated Noncompliance	For purposes of enforcement action, this term refers to findings of Substandard Quality of Care on three (3) consecutive standard surveys, but does not refer to citations in which the substance of a deficiency or the exact tag number of a deficiency is repeated.
Substandard Quality of Care	Deficiencies at 42 CFR 483.13 (Resident Behavior and Facility Practices, F tags 221-226); 483.15 (Quality of Life, F tags 240-258); or 483.25 (Quality of Care, F tags 309-333) on the remedy determination grid in cells F, H, I, J, K, or L.
Substantial Compliance	Survey findings or acceptable evidence of compliance in lieu of revisit indicate that no actual harm has occurred and there is a potential for no more than minimal harm.

5.18 SUBSTANDARD QUALITY OF CARE (SQC)

When a standard or abbreviated survey identifies substandard quality of care (SQC), an extended or partial extended survey is conducted. In addition to the imposition of remedies, the SSA takes the following actions:

- Notifies the attending physicians of residents identified during the survey process as having been affected by the substandard quality of care.
- Notifies the state licensure board responsible for licensing the facility's administrator of all findings of substandard quality of care.
- Prohibits the facility from providing nurse aide training and competency evaluation programs for two years.

If a facility has been found to have provided SQC on the last three (3) consecutive standard surveys, along with other remedies, the MDCH will impose:

- Mandatory denial of payment for new admissions;
- State monitoring.

5.19 Immediate Jeopardy

When the SSA identifies that Immediate Jeopardy to resident health or safety exists, the provider is notified and directed to submit as soon as possible an allegation that the Immediate Jeopardy has been removed. Within two calendar days of the last day of the survey during which Immediate Jeopardy was identified, the SSA will notify the provider that the SMA must terminate the Medical Assistance Provider Enrollment and Trading Partner Agreement within 23 calendar days of the last day of survey if the Immediate Jeopardy has not been removed. At its discretion, the SMA may appoint a temporary manager who must remove the Immediate Jeopardy within 23 days to avoid termination.

In order for a 23-day termination timeclock to be stopped, the provider must submit an acceptable Plan of Correction to the SSA. A subsequent revisit must then be conducted to verify removal of the Immediate Jeopardy, even if the underlying deficiencies have not been fully corrected.

Civil Money Penalties (CMP) of $3,050 to $10,000 per day will be imposed for each day an Immediate Jeopardy was identified before removal. Following removal of the Immediate Jeopardy, CMPs will continue until the facility is found to be in substantial compliance, but will be selected from a lower fine range of $50 to $3,000 per day. The upper range of CMPs will apply for a minimum of one day, even if the Immediate Jeopardy is removed immediately after identification and notification. No CMP will apply on the day the facility is determined to be in substantial compliance.

The SSA may consider using a Per Instance Civil Money Penalty of $1,000 to $10,000 when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g., a discretionary denial of payment for new admissions, directed plan of correction, or directed in-service training.

5.20 No Opportunity to Correct

Providers will not be given an opportunity to correct deficiencies before remedies are imposed when they have deficiencies of actual harm (or higher) on the current survey event, as well as on the previous standard survey or any intervening survey. The previous harm (or higher) level deficiency must have been in a completed survey cycle with compliance verified. The MDCH will impose either a Civil Money Penalty or Denial of Payment for New Admissions, or both. The MDCH may impose other optional federal remedies.

5.21 Opportunity to Correct

An opportunity to correct deficiencies before remedies are imposed is not assured. The SSA has no obligation to give a provider an opportunity to correct deficiencies prior to imposing remedies and must only meet the minimum notice requirements that are applicable to the imposition of remedies. At the SSA's discretion, it may provide facilities an opportunity to correct deficiencies before remedies are imposed when they do not meet the criteria for "No Opportunity to Correct."

When an opportunity to correct deficiencies before remedies are imposed is offered, the SSA will request an acceptable plan of correction, provide initial notice of possible enforcement action, conduct a revisit (if applicable), and provide formal notice of other remedies if noncompliance continues at revisit. While formal notice of denial of payment for new admissions is generally provided in the first revisit letter, the SSA may provide it to the facility in the initial deficiency notice.

The MDCH must impose DPNA no later than three months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

The MDCH may impose either a per day or per instance Civil Money Penalty for past noncompliance, for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by the MDCH based on facility history, repeating deficiencies, high numbers of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance, and for increasing noncompliance.

5.22 Prohibition of Approval of Nurse Aide Training and Competency Evaluation Programs

Federal law, as specified in the Social Security Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. Exceptions to this, as specified in Public Law 105-15, Permitting Waiver of Prohibition of Offering Nurse Aide Training and Competency Evaluation Programs in Certain Facilities, will apply.

5.23 New Owner

A new owner may apply to the SSA to have approval of the facility's nurse aide training and competency evaluation program restored before a two-year lockout period has expired.

5.24 Notice of CMP Assessment

Prior notice is not required before the imposition of CMPs. A penalty equivalent to a one-day penalty will apply in all circumstances even if the violation(s) is immediately corrected. The daily penalty will end on the day prior to the determination of substantial compliance, or on the day prior to the determination that a civil money penalty is no longer warranted. The SSA determines compliance. CMP amounts may be increased to reflect changes in levels of noncompliance at revisit. CMP amounts may increase for repeat deficiencies.

The SSA has developed a CMP schedule for Immediate Jeopardy and Harm or Potential Harm occurrences to promote a consistent application of penalties. The CMP schedule conforms to 42 CFR 488.408 and is intended to cover the majority of cases of CMP imposition. Situations may occur that justify exception to the guidelines. The CMP schedule is subject to change without notice. For further information, contact the Enforcement Unit, Division of Operations, Bureau of Health Systems. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

Accrual of CMPs ceases when one of the following situations occurs:

- the facility is determined by the SSA to have achieved substantial compliance
- the appointment of a receiver by a circuit court
- closure of a facility
- appointment of a temporary manager for the purpose of overseeing the orderly closure of the facility
- termination of a provider agreement

5.25 Use of CMP Funds

Money collected by the SMA as a result of civil money penalties is held in a special fund to be applied to the protection of the health or property of residents of any nursing facility that MDCH finds deficient. Money recovered by the SMA from funds due a facility (because of lack of payment of civil money penalties by the facility) is also deposited into this fund.

5.26 Cost Reporting for Remediation Expenses

Temporary manager and (limited) other remediation expenses incurred by the provider as a result of an enforcement action are a Medicaid allowable routine nursing care cost as part of the owner/administrator cost classification. Total owner/administrator compensation is subject to established program cost limitations and allowable cost principles. Civil money penalties are not allowable Medicaid costs. (Refer to the Nursing Facility Reimbursement Chapter for additional information.)

5.27 Appeal Rights

The provider is notified of appeal rights at the time of remedy imposition. Providers may only appeal the existence of a deficiency and/or the number of days considered in violation. The established daily amount of the CMP is not subject to appeal. Appeals are through MDCH. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

MDCH has developed an informal review process for resolution of disputes regarding deficiencies cited by surveyors. Information regarding this process can be found on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information).

The provider is also notified of waiver rights at the time of remedy imposition. Within 60 calendar days of the notice of appeal rights, the provider may elect to waive the right to appeal. The waiver must be in writing and be received by the SSA Enforcement Unit and by the MDCH Administrative Tribunal and Appeals Division within 60 days of the notice of appeal rights. Waiver of the right to appeal will reduce the total CMP amount by 35%.

5.28 Penalty Collection

Collection of civil money penalties will be made by voluntary transmittal, in a check payable to the State of Michigan, within 30 calendar days of notice of penalty amount due or within 15 days of issuance of appeal results. If voluntary transmittal does not occur, the CMP will be recovered by gross adjustment against the next available Medicaid warrant or as a component of final cost settlement in a change of ownership. No repayment schedules will be allowed for any penalty assessments. Civil money penalties are not allowable Medicaid costs.