

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division
Bureau of Medicaid Policy and Health System Innovation

Project Number: 1718-MCC **Comments Due:** October 17, 2017 **Proposed Effective Date:** December 15, 2017

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Policy Subject: Elimination of the Paper Version of the Facility Admission Notice

Affected Programs: Medicaid, Healthy Michigan Plan, Children’s Special Health Care Services (CSHCS), MIChild

Distribution: Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders.

Policy Summary: Effective December 15, 2017, the Michigan Department of Health and Human Services (MDHHS) will no longer accept the Facility Admission Notice form (MSA-2565-C) for the processing of facility admissions. Hospitals may continue to submit a modified MSA-2565-C to establish Medicaid eligibility for newborns when a hospital is unable to submit notice of the birth through the State’s Electronic Birth Certificate (EBC) system.

Workers will no longer enter admissions into Bridges for admissions received on paper MSA-2565-C forms after December 29, 2017.

Effective January 2, 2018, hospice, hospital, nursing facility, MI Choice Waiver and Program of All-Inclusive Care for the Elderly (PACE) providers will enter admissions/enrollments to their facility/program directly into the Community Health Automated Medicaid Processing System (CHAMPS).

Purpose: This policy streamlines the process of entering Medicaid coverage into the Bridges system and the Community Health Automated Medicaid Processing System (CHAMPS) when an applicant or beneficiary is admitted to a long term care facility, thereby eliminating many of the problems that occur because of the time lag using the current paper process.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders.

Issued: November 15, 2017 (Proposed)

Subject: Elimination of the Paper Version of the Facility Admission Notice

Effective: December 15, 2017 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), MICHild

Effective **December 15, 2017**, the Michigan Department of Health and Human Services (MDHHS) will no longer accept the Facility Admission Notice form (MSA-2565-C) for the processing of facility admissions. Hospitals may continue to submit the form to local MDHHS offices to obtain a Medicaid ID number and establish Medicaid eligibility for newborns only if the hospital is unable to submit notice of the birth through the State's Electronic Birth Certificate (EBC) system. The MSA-2565-C will be modified, and a draft of the revised form is attached to this bulletin.

With the exception of hospital submissions of the MSA-2565-C form for newborns, workers will no longer enter admissions into Bridges for admissions received on paper MSA-2565-C forms after **December 29, 2017**.

Effective **January 2, 2018**, hospice, hospital, nursing facility, MI Choice Waiver and Program of All-Inclusive Care for the Elderly (PACE) providers will enter **admissions/enrollments** to their facility or program directly into the Community Health Automated Medicaid Processing System (CHAMPS). In addition, effective **January 2, 2018**, these providers will be required to report the **discharge/disenrollment** of the individual into CHAMPS, regardless of whether the discharge is to another facility, program, or to the home.

In order to prevent access to care issues, workers will continue to have the ability to add reported admissions in Bridges, but this data will not be added to CHAMPS. Workers will also be able to enter reported discharges in Bridges and this data will transfer to CHAMPS, which will discharge them in CHAMPS for the provider.

A separate bulletin is being issued to Medicaid Providers with new policy and procedures related to the process for reporting admissions/enrollment and discharge/disenrollment of Medicaid recipients.

HOSPITAL NEWBORN NOTICE

INSTRUCTIONS

The MSA-2565-C serves as notice of birth of a newborn for the purposes of obtaining a Medicaid ID number. It must be completed only if the hospital is unable to submit notice of the birth through the Michigan Electronic Birth Certificate system.

- The hospital must retain **THE ORIGINAL** of the Hospital Newborn Notice in the beneficiary's file. A copy **MUST** be sent to the local MDHHS office.
- A copy of the MSA-2565-C will be returned to the hospital, noting the eligibility status of the newborn.
- Item 6 must state the name of the mother.
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the county, district, unit, worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

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The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

COMPLETION: Is voluntary

HOSPITAL NEWBORN NOTICE

1. Newborn Name (Last, First, Middle)		2. Newborn Gender <input type="checkbox"/> M <input type="checkbox"/> F	3. Newborn Birth Date / /	4. Newborn Social Security No. (If Available) - -	
5. Home Address (No. & Street, including apartment number)		City		State	Zip Code
6. Name of Newborn's Mother (Last, First, Middle)		7. Phone No. () -			
8. Mother Social Security No. (If Available) - -		9. Mother Birth Date / /			
10. Home Address (No. & Street, including apartment number)		City		State	Zip Code
11. Name of Provider		12. National Provider ID Number			
13. Provider Address (No. & Street)		City		State	Zip Code
14. Attending Physician Name		15. Hospital Case No. (If Applicable)			
16. Present Status of Patient (Check ONE) <input type="checkbox"/> Still a Patient <input type="checkbox"/> Discharged (Date): / / <input type="checkbox"/> Deceased (Date): / /					
17. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable <input type="checkbox"/> Medicare <input type="checkbox"/> No Other Insurance Coverage Available <input type="checkbox"/> Private Health Insurance (Complete items 18 thru 23 below)					
18. Name of Policyholder (Private Health Ins.)			19. Policyholder's SS No. - -		
20. Name of Insurance Company					
21. Location (City)		State	Zip Code		
22. Group / Policy Number			23. Cert. / Contract No.		
PATIENT CERTIFICATION					
I certify that the information furnished by me in applying for hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section 9 above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.					
24. Signature of Patient's Representative		Date Signed / /		25. Signature of Person Completing This Form	
				Date Signed / /	

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STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is: <input type="checkbox"/> DENIED (Contact Patient Representative for Explanation) <input type="checkbox"/> APPROVED (see the Billing Information below)					
Eligible Person's Name		Program	Grantee Name		
Recipient ID No.	MA Eligibility Effective Date		Grantee Client ID No.		MDHHS Case No.
Patient Pay Amount \$	Patient Pay Amt. Effective Date		County	District	Section
Insurance, Medicare, Third Party Name			Unit	Worker Name	
			Signature of Worker		