MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 05-09

Distribution: Hospice
Hospitals
Medicaid Health Plans
Mental Health/Substance Abuse (Prepaid Inpatient Health Plans)
Nursing Facilities
Program of All Inclusive Care for the Elderly (PACE)
MI Choice Waiver

Issued: March 1, 2005

Subject: Second Clarification to Policy Bulletin MSA 04-15

Effective: Upon Receipt

Programs Affected: Medicaid

The purpose of this bulletin is to update eligibility and admission policy for the Michigan Medicaid Nursing Facility Level of Care Determination and related attachments as contained in policy bulletin MSA 04-15. The information in this bulletin has been incorporated into the related documents available on the MDCH website at www.michigan.gov/mdch; select "Providers", select "Information for Medicaid Providers" and select "Michigan Medicaid Nursing Facility Level of Care Determination".

The following summarizes the policy clarifications. The updates have been incorporated into the attached documents: Attachment 1 - Nursing Facility Eligibility and Admission Process; Attachment 2 – PACE Eligibility and Enrollment Process; and Attachment 3 – MI Choice Eligibility and Enrollment Process.

- Applicants must be evaluated prior to the start of Medicaid reimbursable services. Providers must submit the information via the on-line Michigan Medicaid Nursing Facility Level of Care Determination no later than 14 calendar days following the start of service.
- For continuing beneficiaries receiving nursing facility, MI Choice, or PACE services prior to November 1, 2004, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied no earlier than the next admission anniversary date. Continuing beneficiaries must be evaluated no later than October 31, 2005. MDCH understands that some evaluations may have been completed prior to the admission anniversary date. Continuing beneficiaries who were evaluated early and qualified as eligible will be processed. Please contact MDCH at (517) 241-4293 for persons evaluated prior to their admission anniversary date and determined to be ineligible.
- Emergency nursing facility transfers must be entered in the Michigan Medicaid Nursing Facility Level of Care Determination tool. Facilities do not need to complete the entire tool, but must submit the information request via the on-line Emergency/Involuntary Transfer form by selecting the Emergency/Involuntary Transfer option from the bottom of the LOC Determination Welcome Screen. Once admitted to the new facility, residents must meet the functional/medical criteria on an ongoing basis.
- The on-line Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once per admission to an individual provider/program.

- In evaluating continuing beneficiaries under Door 7, it is assumed that current services provided are necessary to maintain participant function.
- Current beneficiaries must be issued an adverse action notice as soon as the provider identifies that the beneficiary no longer meets functional/medical eligibility requirements.

Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines; MSA 04-15, Attachment B

Section II – Freedom of Choice (pg. 19)

- The following paragraph should be added immediately after the section heading "Section II – Freedom of Choice":

  "The eligible applicant acknowledges that they have received information regarding MI Choice, Nursing Facility care, or the PACE program. The program must supply information on the program(s) the applicant selects."

- Changes in language have been made regarding Fields 105 through 108 to clarify referral information reuqirements as noted above.

Manual Maintenance

Discard Attachment 1, Attachment 2, and Attachment 3 included with bulletin MSA 04-15 and replace with Attachment 1 (rev. March 2005), Attachment 2 (rev. March 2005), and Attachment 3 (rev. March 2005) included with this bulletin. This cover bulletin may be discarded after review and after the attachments have been retained. The attachments, in addition to policy bulletins MSA 04-15 and MSA 04-17, should be retained until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Michigan Department of Community Health, 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 phone number so you may be contacted if necessary. Providers may telephone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
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Michigan Department of Community Health

NURSING FACILITY ELIGIBILITY AND ADMISSION PROCESS

NOTE: The following changes replace current policy published in Section 4 of the Coverages and Limitations Chapter of the Michigan Medicaid Nursing Facilities Provider Manual.

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 Nursing Facility Eligibility

There are five necessary components for determining eligibility for Medicaid nursing facility reimbursement.

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility by the Family Independence Agency (FIA). When a Medicaid-eligible or potentially eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local FIA office to establish/confirm eligibility for Medicaid benefits. (Refer to the Forms Appendix of the Michigan Medicaid Provider Manual for a sample form.)

A facility is considered officially notified of an individual's Medicaid eligibility when they have received the completed MSA-2565-C.

In order for Medicaid to reimburse nursing facility services, the beneficiary must be in a Medicaid-certified bed.

4.1.B. Correct/Timely Pre-admission Screening/Annual Resident Review (PASARR)

The Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Pre-admission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form [Preadmission Screening (PAS)/Annual Resident Review (ARR); DCH-3877] may be found at the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.1.D. Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination

4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination

The nursing facility must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form. The Michigan Medicaid Nursing Facility Level of Care Determination is accessed through Michigan's Single Sign-on System located at https://sso.state.mi.us. The nursing facility may not bill Medicaid for services provided when the beneficiary does not meet the established criteria identified through the Michigan Medicaid Nursing Facility Level of Care Determination or Nursing Facility Level of Care Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will only be reimbursed when the determination demonstrates functional/medical eligibility through the electronic web-based tool. Applicants must be evaluated prior to the start of Medicaid reimbursable services. In addition, providers must submit the information via the web no later than 14 calendar days following start of service.

A copy of the Michigan Medicaid Nursing Facility Level of Care Determination form and the Field Definition Guidelines are on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," and " Michigan Medicaid Nursing Facility Level of Care Determination."

The Michigan Medicaid Nursing Facility Level of Care Determination must be used by a health professional [physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant] representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a professional. The nursing facility will be held responsible for billing Medicaid for only those residents who meet the criteria.

For residents currently in the facility and admitted prior to November 1, 2004, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied no earlier than the next anniversary date of their admission to the facility. All residents admitted prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Residents who are assessed at their admission anniversary date, and who qualify under Door 7 only, must be offered the opportunity and assistance to transition to the community, but may not be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to residents are necessary to maintain function.

When the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool for:

- **all new admissions of Medicaid-eligible applicants**, regardless of primary payer source, if Medicaid reimbursement beyond Medicare co-insurance and deductible amounts will be requested.

- **non-emergency transfers of Medicaid-eligible residents to** another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure.

- **disenrollment of a beneficiary from a Medicaid Health Plan** which has been paying for nursing facility services.

- **private-pay residents already residing in a nursing facility** who are applying for Medicaid as the payer for nursing facility services.

- **dually eligible** beneficiaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

- **any transfer of a Medicaid-eligible resident from a nursing facility that is undergoing an involuntary facility closure due to Federal or State regulatory enforcement action**; situations for retrospective review of transferred residents will still apply. Nursing facilities do not need to apply the Michigan Medicaid Nursing Facility Level of Care Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form. This form is located by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination Welcome Screen.

  Once admitted into the facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid Fee-For-Service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice should be issued if appropriate.

- **emergency transfer of a Medicaid-eligible resident** from a nursing facility experiencing a hazardous condition (i.e., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency. Nursing facilities do not need to apply the Michigan Medicaid Nursing Facility Level of Care Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form. This form is located by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination Welcome Screen.

  Once admitted into the new facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid Fee-For-Service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice should be issued if appropriate.

Completion of the Michigan Medicaid Nursing Facility Level of Care Determination is not required in the following situations:

- **hospice beneficiaries who are being admitted** to the nursing facility for any services.
- **nursing facility readmissions** when the resident level of care code determined by FIA has not changed, as long as the beneficiary was previously determined eligible using the Michigan Medicaid Nursing Facility Level of Care Determination process.

Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

The functional/medical criteria include seven domains of need:

- Activities of Daily Living,
- Cognitive Performance,
- Physician Involvement,
- Treatments and Conditions,
- Skilled Rehabilitation Therapies,
- Behavior, and
- Service Dependency.

For residents who qualify only under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission per individual provider.

4.1.D.2. Nursing Facility Level of Care Exception Process (NF LOC Exception Process)

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria. The NF LOC Exception Process is initiated when the prospective provider telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The NF LOC Exception Criteria is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.1.D.3. Telephone Intake Guidelines

The Telephone Intake Guidelines are questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. This document is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.1.D.4. Annual Re-certification

Federal regulations require annual re-certification that residents meet Medicaid financial eligibility requirements. The annual re-certification process is performed by the Family Independence Agency. In addition, nursing facility providers must ensure that residents meet the Michigan

Medicaid Nursing Facility Level of Care Determination criteria on an ongoing basis for services to be reimbursed. Quarterly Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis. The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission per individual provider.

4.1.D.5. Retrospective Review and Medicaid Recovery

At random and whenever indicated, the MDCH designee will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

4.1.D.6. Adverse Action Notice

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must immediately issue an adverse action notice to the beneficiary or their authorized representative. The provider must also offer the beneficiary referral information about services that may help meet his/her needs. The action notice must include all of the language of the sample letters for long term care. These letters may be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for contact information for the Administrative Tribunal.)

When a beneficiary appeals an adverse action notice to the MDCH Administrative Tribunal, the facility must notify MDCH LTC Services of the hearing by calling 517-241-4293. Both a facility representative and an MDCH LTC Services Representative must be present at the hearing.

Immediate Review-Adverse Action Notices

The MDCH designee will review all pre-admission or continued stay adverse action notices upon request by a beneficiary (or representative). When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- The MDCH designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.

- The MDCH designee will review the records, obtain information from the beneficiary (or representative) and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

- The beneficiary (or representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. Contact information can be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.1.E. Freedom of Choice

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant (or representative) must be informed of the following:

- services available through Medicaid-reimbursed nursing facilities.
- services available through the MI Choice Program.
- services available through the PACE program, where available.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination." Applicants who prefer a community long-term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-admissions must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive nursing facility services.

A copy of this form is included with the Michigan Medicaid Nursing Facility Level of Care Determination. This document is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.2 Appeals

4.2.A. Individual Appeals

Financial Eligibility: A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to the Family Independence Agency (FIA).

Functional/Medical Eligibility: A determination that a beneficiary is not functionally/medically eligible for nursing facility services is an adverse action. If the beneficiary (or representative) disagrees with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for MDCH website information.)

4.2.B. Provider Appeals

A retrospective determination that a beneficiary is not eligible for nursing facility services based on review of the functional/medical screening is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual.)

4.3 Admission Requirements

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with an asterisk (*****).

- Rights as defined by federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *****
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know Your Rights" booklet; *****
- Non-covered items and services, as well as the costs, for which the beneficiary may be charged (admission to the facility cannot be denied because the beneficiary is unable to pay in advance for non-covered services); *****
- Facility policies regarding protection and maintenance of personal funds; *****
- A description of the facility's policies to implement advanced directives; *****
- Facility policies regarding the availability of hospice care; *****
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; ***** and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

4.4 Preadmission Contracts

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).

Michigan Department of Community Health

PACE ELIGIBILITY AND ENROLLMENT PROCESS

BENEFICIARY ELIGIBILITY AND ENROLLMENT PROCESS

There are seven necessary components of the PACE eligibility and enrollment process:

- **Determination of Medicaid Eligibility**
  Medicaid payment for PACE services requires a determination of Medicaid eligibility by MDCH for Wayne County. The Family Independence Agency is responsible for determinations in all other Michigan counties.

- **Applicants Age 55 Years or Older**
  The specific aim of PACE is to provide services for the older population. This age restriction is mandated by federal PACE requirements.

- **Residence in the Service Area of a PACE Organization**

- **Ability to live safely in the community**
  At time of enrollment, a PACE participant must be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.

- **Assessment by an Interdisciplinary Team**
  Program enrollment requires a comprehensive assessment of participant needs by an interdisciplinary team.

- **Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination**
  The PACE organization must verify applicant appropriateness for services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form. The Michigan Medicaid Nursing Facility Level of Care Determination is accessed through Michigan's Single Sign-on System located at https://sso.state.mi.us. Applicants must be evaluated prior to enrollment in the PACE program.

  Services will only be reimbursed when the determination demonstrates functional/medical eligibility through the electronic web-based tool or the Nursing Facility Level of Care Exception Process. In addition, providers must submit the information via the web no later than 14 calendar days following start of service.

  Refer to the MDCH website to access the Michigan Medicaid Nursing Facility Level of Care Determination form and the Field Definition Guidelines.

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional [physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant] representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a professional. The PACE organization will be held responsible for enrolling only those participants who meet the criteria.

  For continuing participants enrolled in PACE prior to November 1, 2004, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied no later than the next anniversary date of their enrollment into the program. All participants enrolled prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Continuing participants who are assessed at their next anniversary date, and who qualify under Door 7 only, must be offered the opportunity and assistance to transition to other community programs, but cannot be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to participants are necessary to maintain function.

PACE organizations will not be reimbursed for participants who do not demonstrate eligibility through the electronic web-based tool. In addition, providers must submit participant information via the web no later than 14 calendar days following the start of service.

The PACE organization must provide an adverse action notice to participants who are found to be not eligible and who have been enrolled in the program for less than 12 months, and must refer the participant to appropriate service programs. When the PACE organization anticipates that the participant may become eligible again within the next six months, the PACE participant may continue to qualify for the program, when approved by MDCH.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based form in the following situations:

- all new enrollments of Medicaid beneficiaries
- re-enrollment of Medicaid beneficiaries

- **Provision of Timely and Accurate Information to Support Informed Choice for all Appropriate Medicaid Options for Long Term Care**
  The Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website at www.michigan.gov/mdch; select "Providers", "Information for Medicaid Providers", "Michigan Medicaid Nursing Facility Level of Care Determination".

  The functional/medical criteria include seven domains of need:

  - Activities of Daily Living,
  - Cognitive Performance,
  - Physician Involvement,
  - Treatments and Conditions,
  - Skilled Rehabilitation Therapies,
  - Behavior, and
  - Service Dependency.

  For participants who qualify only under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

  The electronic web-based tool must be completed only once for each enrollment to the program.

NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS (NF LOC EXCEPTION PROCESS)

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The Nursing Facility Level of Care Exception Process is initiated when the prospective provider telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The NF LOC Exception criteria is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination." To request a NF LOC Exception review, providers may view contact information on the above website.

TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines are questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. The guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

ANNUAL RE-CERTIFICATION

MDCH must annually certify that PACE financial eligibility requirements continue to be met by the participant. In addition, PACE organizations must ensure that participants meet the Michigan Medicaid Nursing Facility Level of Care criteria on an ongoing basis, as demonstrated in the medical record. The electronic web-based tool must be completed only once for each enrollment. Initial comprehensive assessments, reassessments and progress notes must demonstrate that the participant has met the criteria on an ongoing basis.

The PACE federal regulation allows for continuing eligibility of those individuals who are determined through the annual re-certification process to no longer meet the nursing facility level of care requirement if, in the absence of continued coverage under PACE, the individual would reasonably be expected to again meet the nursing facility level of care in the next six months.

RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination. If the participant is found to be ineligible for PACE services, MDCH will recover all Medicaid payments made for PACE services rendered during the period of ineligibility.

ADVERSE ACTION NOTICE

When the PACE organization determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the organization must immediately issue an adverse action notice to the beneficiary or their authorized representative. The action notice must include all of the language of the sample letters for long term care. These letters may be found at www.michigan.gov/mdch, select "Providers", "Information for Providers", "Michigan Medicaid Nursing Facility Level of Care Determination". The organization must also offer the beneficiary referral information about services that may help meet their needs.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for Administrative Tribunal contact and website information.)

IMMEDIATE REVIEW-ADVERSE ACTION NOTICES

The MDCH designee will review all pre-admission or continued stay adverse action notices upon request by an beneficiary or their representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- The MDCH designee will request that the PACE organization provide pertinent information by close of business the first working day after the date the beneficiary requests an immediate review.
- The MDCH designee will review the records, obtain information from the beneficiary (or representative) and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

- The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. Contact information can be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

FREEDOM OF CHOICE

When an applicant has qualified to receive services under the nursing facility level of care criteria, he must be informed of his benefit options and elect to receive services in a specific program. This election must take place prior to initiating PACE services.

The applicant (or legal representative) must be informed of the following:

- services available under PACE;
- services available through the MI Choice Program;
- services available through Medicaid-reimbursed nursing facilities.

If applicants are interested in nursing facility or MI Choice Program care, the PACE organization must provide appropriate referral information using the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-participants must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive PACE services.

A copy of this form is included with the Michigan Medicaid Nursing Facility Level of Care Determination. This document is available on the MDCH website at www.michigan.gov/mdch; select “Providers”, “Information for Medicaid Providers”, “Michigan Medicaid Nursing Facility Level of Care Determination”.

APPLICANT APPEALS

Financial Eligibility

A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to the Michigan Department of Community Health.

Functional/Medical Eligibility

A determination that a beneficiary is not functionally/medically eligible for PACE services is an adverse action. If the beneficiary and/or representative disagrees with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the Administrative Tribunal portion of the MDCH website. Beneficiaries may appeal such an action to MDCH for Wayne County determinations and to FIA for determinations in all other counties. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for website information.)

PROVIDER APPEALS

A retrospective determination that a beneficiary is ineligible for PACE services, based on review of the functional/medical screening, is an adverse action for the PACE organization if MDCH proposes to recover payments made. If the PACE organization disagrees with this determination, they should refer to the Contract Dispute Section included in the organization’s contract with MDCH.

Michigan Department of Community Health

MI CHOICE ELIGIBILITY AND ENROLLMENT PROCESS

BENEFICIARY ELIGIBILITY AND ENROLLMENT PROCESS

These are the required components of the MI Choice Program eligibility and enrollment process:

- **Determination of Medicaid Eligibility**
  Medicaid payment for MI Choice Program services requires a determination of Medicaid eligibility by the Family Independence Agency (FIA). When a Medicaid or Medicaid-eligible applicant is enrolled in the MI Choice Program, the MI Choice Program agent must submit the FIA Assistance Application form (FIA-1171) to the local FIA office to establish/confirm eligibility for Medicaid benefits. (The FIA-1171 may be obtained through the local FIA office.)

- **Appropriate Placement Based on the Michigan Medicaid Nursing Facility Level of Care Determination**
  The MI Choice Program agent must verify applicant appropriateness for services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination. The Michigan Medicaid Nursing Facility Level of Care Determination is accessed through Michigan's Single Sign-on System located at https://sso.state.mi.us. Providers of Long Term Care must complete a one-time registration process to access the Single Sign-on System.

  Applicants must be evaluated prior to the start of Medicaid reimbursable services. The MI Choice Program agent may not bill Medicaid for services provided when the applicant does not meet the established criteria identified through the tool or the Nursing Facility Level of Care Exception Process, and may not bill the applicant unless the applicant has been advised of the denial and elects, in advance, to pay privately for services.

  Services will only be reimbursed when the determination demonstrates functional/medical eligibility through the electronic web-based tool or the Nursing Facility Level of Care Exception Process. In addition, providers must submit the information via the web no later than 14 calendar days following start of service.

  A copy of the Michigan Medicaid Nursing Facility Level of Care Determination and the Field Definition Guidelines are available on the MDCH website at www.michigan.gov/mdch; select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional [physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant] representing the proposed provider. Staff who have met experience requirements for care management may complete the determination. The MI Choice Program agent will be held responsible for billing Medicaid for only those participants who meet the criteria.

  For continuing participants enrolled in the MI Choice Program prior to November 1, 2004, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied no earlier than the next anniversary date of the participant's enrollment into the program. All participants enrolled prior to November 1, 2004 must be evaluated no later than October 31, 2005.

  Continuing participants who are assessed at that time, and qualify under Door 7 only, must be offered the opportunity and assistance to transition to other programs, but may not be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to participants are necessary to maintain participant function.

When the MI Choice Program agent determines that the participant who has been receiving services for less than 12 months is not eligible based on functional/medical criteria, the participant must be provided an adverse action notice and referred to appropriate service programs.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool in the following situations:

- all new enrollments of Medicaid-eligible applicants.
- transfers of Medicaid-eligible participants from another MI Choice Program agency.

- **Provision of Timely and Accurate Information to Support Informed Choice for all Appropriate Medicaid Options for Long Term Care**
  The Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website at www.michigan.gov/mdch; select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

  The functional/medical criteria include seven domains of need:

  - Activities of Daily Living,
  - Cognitive Performance,
  - Physician Involvement,
  - Treatments and Conditions,
  - Skilled Rehabilitation Therapies,
  - Behavior, and
  - Service Dependency.

  For participants who qualify only under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

  In addition, applicants must require at least one waiver service on an ongoing basis to qualify for the MI Choice Program.

  The electronic web-based tool must be completed only once for each admission to the program.

NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS (NF LOC EXCEPTION PROCESS)

An exception process is available for those applicants who have demonstrated a significant level of long term care need, but do not meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The Nursing Facility Level of Care Exception Process is initiated when the prospective provider telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The NF LOC Exception Criteria is available on the MDCH website at www.michigan.gov/mdch; select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination". To request a NF LOC exception review, providers may obtain contact information at the above website.

TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines are questions that identify potential MI Choice Program participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the MI Choice Program agent. The guidelines are available on the MDCH website.

The Telephone Intake Guidelines are the only acceptable structured tool for telephonic pre-screening.

ANNUAL RE-CERTIFICATION

MI Choice Program participants must meet Medicaid Program requirements on an ongoing basis. The Family Independence Agency (FIA) must annually certify that financial eligibility requirements continue to be met by the participant. In addition, MI Choice Program agents must ensure that participants meet the Michigan Medicaid Nursing Facility Level of Care Criteria on an ongoing basis. Quarterly Minimum Data Set – Home Care (MDS-HC) assessments and progress notes must demonstrate that the participant continues to meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each MI Choice enrollment.

RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination and the quality of Medicaid MDS-HC data overall. If the participant is found to be ineligible for MI Choice Program services, MDCH will recover all payments made for services rendered during the period of ineligibility by making an adjustment during annual cost settlement.

ADVERSE ACTION NOTICE

When the MI Choice Program agent determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the program agent must issue an adverse action notice to the beneficiary (or authorized representative). For continuing beneficiaries, this notice must be issued as soon as the program agent identifies that the beneficiary no longer meets the functional/medical eligibility requirements. The program agent must also offer the beneficiary referral information about services that may help meet his/her needs. The adverse action notice must include all of the language of the sample letters for long term care. The letters may be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available on the Administrative Tribunal portion of the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for Administrative Tribunal contact and website information.)

IMMEDIATE REVIEW-ADVERSE ACTION NOTICES

The MDCH designee will review all pre-admission or continued stay adverse action notices upon request by a beneficiary (or his representative). When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- The MDCH designee will request that the MI Choice Program agent provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.
- The MDCH designee will review the records, obtain information from the beneficiary (or representative) and notify the beneficiary and the program agent of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.
- The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. Contact information can be found at www.michigan.gov/mdch; select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

FREEDOM OF CHOICE

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating MI Choice Program services.

The applicant (or legal representative) must be informed of the following:

- services available through the MI Choice Program;
- services available through Medicaid-reimbursed nursing facilities;
- services available through the PACE program, where available.

If applicants are interested in nursing facility or PACE Program care, the MI Choice Program agent must provide appropriate referral information using the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs.

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-participants must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive MI Choice Program services.

A copy of this form is included with the Michigan Medicaid Nursing Facility Level of Care Determination. This document is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

APPLICANT APPEALS

Financial Eligibility

A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to the Family Independence Agency (FIA).

Functional/Medical Eligibility

A determination that a beneficiary is not functionally/medically eligible for MI Choice Program services is an adverse action. If the beneficiary and/or representative disagree with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for website information.)

PROVIDER APPEALS

A retrospective determination that a beneficiary is ineligible for MI Choice Program services based on review of the functional/medical screening is an adverse action for the MI Choice Program agent if MDCH proposes to recover payments made. If the MI Choice Program agent disagrees with this determination, an appeal may be filed with MDCH. (Refer to the Directory Appendix of the Michigan Medicaid Provider Manual for Administrative Tribunal contact and website information.)