MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Nursing Facilities 04-02
Nursing Homes (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)

Issued: June 1, 2004

Subject: Medicaid Certification and De-certification of Nursing Facility Beds and Medicaid Provider Enrollment

Effective: August 1, 2004

Programs Affected: Medicaid

This policy describes how Medicaid certifies and de-certifies nursing facility beds and how nursing facility providers enroll in Medicaid. This policy also requires Medicare certification of all new Medicaid-certified beds.

The State Medicaid Agency (SMA) is responsible for the initial certification and annual re-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.

Section 1: Dual Certification

Medicaid strongly encourages Medicare and Medicaid (dual) certification of all nursing facility beds in order to maximize access for beneficiaries. State law requires that any nursing facility participating in the Medicaid (Title XIX) program must also be certified for, and give evidence of, participation in the Medicare (Title XVIII) program, pursuant to Section 21718 of Public Act 368 of 1978. With the effective date of this bulletin, Medicaid requires that all new Medicaid-certified nursing facility beds also be certified for Medicare. Requests for new Medicaid bed certification of nursing facility beds that are not Medicare certified will be denied. Medicaid beds that are not Medicare-certified on the effective date of this bulletin will automatically be granted an exception to this requirement. Requests for initial Medicare certification may be made to the provider's Licensing Officer. Facilities must meet state and federal regulations for certification.

Providers may seek annual certification of nursing facility beds currently designated Medicaid-only under that designation. Beds that are certified as Medicaid-only on the effective date of this bulletin will be grandfathered in; they are not required to become Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on the effective date of this bulletin.

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 re-certification and termination of the Medicaid provider 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 would 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 recently closed or current 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 Medicaid Provider 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 de-certifies 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 the effective date of this policy 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 all bed increases acquired through the CON process, such as new construction or the redistribution of certified beds.

Section 2: Medicaid Nursing Facility Bed Certification

2.1 Medicaid Bed Certification Limits

Medicaid policy bulletin Long Term Care 96-01, Upper Bed Limit on Long Term Care Beds Certified for Medicaid in Nursing Facilities, County Medical Care Facilities, and Hospital Long Term Care Units, set a statewide aggregate limit on the number of Medicaid beds, as well as a Medicaid-certified bed limit for individual facilities. The result has been that facilities built since 1996 or facilities that now want to participate in the Medicaid program are excluded. This has caused residents who change their payer source to Medicaid to move in order to use their Medicaid benefit. Therefore, effective with the date of this bulletin, Medicaid-certified bed limits set for individual facilities will be removed. The statewide aggregate limit of Medicaid bed certification as set in 1996 will remain in place.

Individual facilities who wish to enroll in the Medicaid program or who wish to increase the number of Medicaid-certified beds must apply as outlined below. Requests to the SMA will be reviewed in the order in which they are received. MDCH will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit, based on the criteria outlined below. 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.

2.2 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 certified for Medicare.
- The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility must not have been the subject of one of the following actions or concerns, within three years (or as noted below) 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 advisor or temporary manager.
    - Termination of a Medicaid Provider 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 a 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 de-certification 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 monetary 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 a provider where:
  - 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 Medicaid provider agreement with a provider (or their owner or management company) that does not meet the above criteria if:

- The applicant and their 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 their owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medicaid provider agreement. Failure of the provider to comply with the terms of the conditional agreement will result in termination of the provisional Medicaid provider agreement without appeal.

2.3 Medicaid Nursing Facility Bed Certification Process

Current providers who wish to change their Medicaid-certified beds, and providers who wish to enter the Medicaid program, may do so by following the process outlined below. A written request to change Medicaid-certified beds must contain the following information:

- Number and location of facility beds
- Current certification designation of all facility beds by unit or wing
- Requested number and proposed location of new Medicaid beds. (It may be helpful to attach a layout of your facility to show the current and proposed distribution of beds.)

A provider may request a change in Medicaid bed certification 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 effective with the beginning of the next quarter after approval is granted.

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 within 45 days.

2.3.A Bed Certification Process for Medicaid Enrolled Providers

Nursing facilities that are currently enrolled with Medicaid and that want to change the number of Medicaid-certified beds must file a written request with their SSA licensing officer and with the SMA, MDCH LTC Services. 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 required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests and Dual Certification sections of this bulletin.

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.

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

The following applies to providers operating existing facilities that have not participated in the Medicaid program before, or providers seeking to re-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, MDCH LTC Services. 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 required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the LTC Rate Setting section 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 as a Medicaid provider as outlined in the Medicaid Provider Enrollment section of this bulletin.

2.3.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 sending a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA licensing officer, the LTC Services section and the LTC Rate Setting section.

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 section. 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 section of this bulletin. In addition, dual certification requirements apply as outlined in the Dual Certification section of this bulletin.

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, MDCH LTC Services. 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 required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the LTC Rate Setting section 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.

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

2.3.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 a written request with the SSA licensing officer and file a request with the SMA, MDCH LTC Services. 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 the LTC Rate Setting section will be notified in writing. 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.

If not already enrolled, the provider must enroll in Medicaid as outlined in the Medicaid Provider Enrollment section of this bulletin.

Section 3: Medicaid Provider Enrollment

To enroll with Medicaid, a nursing facility provider must:

- Receive written notice from the SMA indicating approval for Medicaid bed certifications.
- Receive an LC-180 from the SSA indicating authorization for 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 LTC Rate Setting section. (Requests for a New Provider Information Packet may be made to the LTC Rate Setting section 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 Provider Enrollment Agreement. (Requests for a provider enrollment application may be made to MDCH Provider Enrollment at 517-335-5492.)

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

- A copy of the letter from MDCH authorizing the CON (for new providers and CHOW).
- Written notice from the SMA, MDCH LTC Services 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 LTC Rate Setting section that the provider has the required data on file.
- A completed Provider Enrollment Agreement.
- A copy of the nursing facility license.

Nursing facility providers are required to enroll with the State of Michigan Vendor and Contractor Payment System in the event that Medicaid must issue payment outside of the claims processing system (i.e., an emergency payment voucher). Providers can enroll on-line at www.cpexpress.state.mi.us or call the Payee Registration Helpline at (517) 373-4111 (Lansing area) or (888) 734-9749. **NOTE:** In order for the SMA to issue an emergency payment voucher, the Federal Employer ID number registered with the Vendor and Contractor Payment System must agree with the Federal Employer ID on file with the LTC Rate Setting section and the nursing facility enrollment file with MDCH Provider Enrollment.

Section 4: Loss or Reduction of Medicaid Certification

4.1 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, 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 noted below to protect the best interests of residents faced with transfer.

4.2 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, a 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.

4.3 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 re-location of all residents.

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

- The timeline for voluntary closure or withdrawal from the program
- The process for relocation

- The LTC options available to residents, including community-based care
- Contact information for assistance, such as 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 Unit, LTC Rate Setting section, the SSA licensing officer, the SMA, MDCH LTC Services, and the local FIA office.

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 participation but remains open as a 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 of state plan services as long as Medicaid residents remain in the facility.

The interagency agreement referenced in the Nursing Facility Closure Protocol section of this bulletin 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 section of this bulletin would apply.

Section 5: Re-Entry after De-certification

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

- Submission of a request for re-admission to the SSA, 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 the other enrollment criteria outlined in this policy.

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

The process for re-entering the Medicaid program includes:

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 Medicaid for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Certification Requests apply as outlined in this policy.

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. • **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 ten working days to determine the significance of any findings and the resultant action plan. The results of 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, then Medicaid enrollment will be approved. If the SSA determines that the conditions for re-entry have not been met, then 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 the following: • 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. • 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. 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.

Section 6: Unavailable 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 voluntarily using the State's unavailable bed policy.

Medicaid allows nursing facilities to designate beds as unavailable, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Nursing Facility reimbursement chapter (LTC Medicaid Provider Manual, Chapter VII).

Contact Information

LTC Services
Medical Services Administration
Michigan Department of Community Health
PO Box 30479
Lansing, MI 48909-7979

LTC Rate Setting Section
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.

MDCH Provider Enrollment
517-335-5492

Manual Maintenance

Retain this bulletin for future reference.

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