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JANUARY 23, 2007

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CONSUMER TASK FORCE

UPDATE OF PROJECTS

JANUARY 2007

Self- Determination in Long Term Care Project
January 2007

Burnham Brook in Battle Creek enrolled the first participant in Self Determination. They will enroll two more this month. UPCAP is close behind with two enrollments planned in January. Tri-county Office on Aging has also identified potential participants and will be contracting with a fiscal intermediary this month.

Two fiscal intermediaries have had readiness reviews conducted.

The participant education pieces have been finalized and I can send them to anyone on the task force who is interested. Thanks again for your input.

We are working out the “kinks” in the process as we make these initial enrollments, such as looking at the language in the agreements and the time it is taking to enroll. We are striving to make this as easy as possible for all concerned.

Policy and practice guidelines for Person Centered Planning are almost ready for review.

The quality measurement process and the phase in plan for the rest of the state are the priorities being addressed at this time.

We are finalizing some policy guidelines and parameters for goods and services and savings that may occur for self-determination participants.

Next steps include finishing an operations manual, getting feedback on the participant education materials from the national program office, drafting the training curriculum for the rest of the waiver sites and finishing the quality measuring tools.

Michigan's LTC Connections
December Activities

Information and Assistance (I & A) service is being delivered in all four regions. Because the partnerships already provided some level of I & A, existing programs were able to transfer clients and new LTCC staff was able to assist hundreds of persons during the first 3 months.

PA 634

HB 5389 was passed and signed by the Governor. It supports key principles related to independence of the staff, and provides additional requirements related to evaluation and data collection.

Evaluation

An Evaluation Steering Committee was formed. They held their first meeting December 20th. The group will consolidate the goals, prioritize the objectives and identify measures and sources of measurement. The group includes a Quality Assurance staff person from each site. The QA staff will meet to incorporate evaluation activities into the quality assurance program.

Training

Staff from all four sites met for 1 ½ days training. The topics covered include: conducting level of care determination, persons centered planning processes, role of the options counselor, and assisting persons who wish to transition out of a nursing facility.

Board and Consumer Advisory

Each LTCC site has identified members; the UP board met in December, the other sites have meetings scheduled through out January. Among the first activities of the new boards will be to approve incorporation activities, select an executive director, provide feedback on standards, and provide guidance on evaluation priorities.

LTC Commission
January 07

There was no December Commission meeting.

Independence Plus and Money Follows the Person Grants

January, 2007

MIChoice version of the PCP in LTC Policy and Practice Guideline

Thanks to those of you who were involved with the PCP Action League for your valuable input on the draft PCP in LTC document. This document will be revised and sent out to a broader set of readers for additional review within the next monthly cycle of the Consumer Task Force. The scope of the document is for PCP in MIChoice Self-Determination Programs at this time.

Self-Determination Training, Documents and Conference Planning

- It is time to begin planning the 2007 June Self-Determination Conference. If you have an interest in helping to plan this event, please contact Rob Curtner at 517 335-8710 to be included in the planning meetings.
- Additional training for Working with Fiscal Intermediaries, Consumers as Employers, and other topics is being planned at this time.
- A revision of the many of the documents describing the legal, programmatic and consumer support features for Self-Determined arrangements has been completed. Thanks to Ellen Sugrue Hyman for her efforts to accomplish these revisions. These documents have been submitted to the DCH Mental Health Administration for review.
- The next Self-Determination Leadership Implementation Seminar will be in March.

1915bc Waiver Development

- An internal draft of a concept paper describing the scope, purpose and methods for a cost neutral Medicaid benefit in one or two counties in support of community living options for elders and persons with disabilities is being developed.
- We are studying the experience of the Wisconsin Family Care Program to learn how they have successfully supported community living by providing supports and health care as an elective alternative to nursing home care.
- On December 12, Mike Head presented a brief overview of this project and answered questions to the House Appropriations DCH sub-committee.

(Rob was on vacation from Jan. 1-12)

Medicaid Infrastructure Grant (MIG) Update:
January 2007

There are presently 898 Freedom to Work (FTW) participants. This is up from 866 last month.

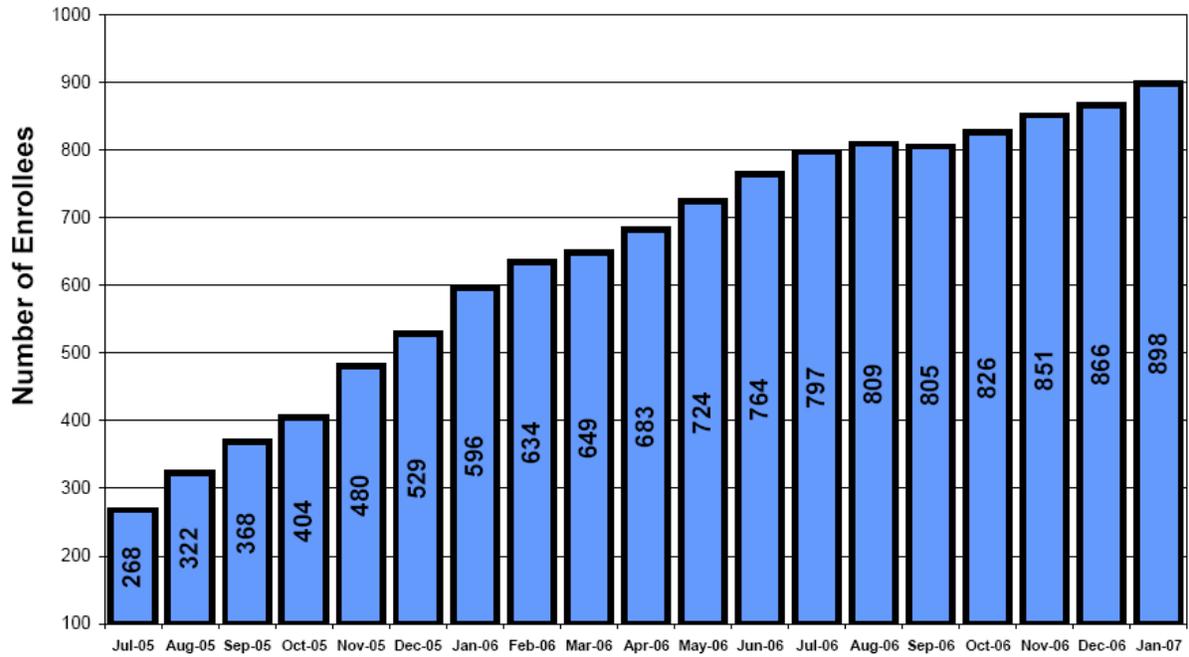
The MIG continues to work with Medical Services Administration (MSA) to resolve FTW issues as well as other concerns.

- Teresa provided MSA with three (3) disregards to be considered for people already enrolled in FTW. These disregards included COLA, increased SSDI checks due to greater earnings, and workers compensation. Presently it's possible that if a person needed to take time off or was laid off involuntarily they might not be eligible if their unearned income had increased above 100% of the Federal Poverty Level.
- Theresa and Jackie have written suggested policy, procedure, and forms for MSA to implement to address Freedom Accounts as outlined in the Freedom to Work State Plan Amendment which allows individuals enrolled in FTW to have higher earnings and resources.
- We are also working with MSA to potentially transition current AD Care Medicaid eligible individuals to FTW so they may have greater earnings. Joe, Jackie, and Theresa have drafted an informational letter for MSA to mail to eligible working AD Care participants. Joe is working with the MIG's technical assistance contractor to determine how to best seek a larger Comprehensive MIG for 2008 if enough current AD Care participants are transitioned to FTW by mid-year.

Marty will be jointly presenting with Social Security Administration (SSA) at Goodwill in Grand Rapids in mid-February. He also has presentations being scheduled at local SSA offices. In addition, Marty is leading a small committee looking into what a "clearinghouse" would look like to accent other work incentives outreach across Michigan. Marty has received feedback from six (6) individuals about the user friendliness of Work World software that "projects" the impact of work for an individual.

Joe attended the MRS/MCB Partnership Forum committee meeting on January 11, 2007. This forum's focus is to "reduce impediments toward increased employment for persons with disabilities." The three committees meeting from this group are Communication and Information Sharing, Soft Skills, and Focused Marketing. Joe sees the work of these committees as foundational to the MIGs continuing efforts to partner with organizations and impact systemic change. Each of these committees also has a recurring theme to work with employers. Joe is working to facilitate collaboration with the work of the Michigan Business Leadership Network.

Michigan FTW Enrollees January 2007



**MONTHLY FREEDOM TO WORK ENROLLMENT
BY COUNTY**

County Code	County Name	Beneficiary ID				
1	Alcona	2		52	Marquette	8
2	Alger	1		53	Mason	4
3	Allegan	10		54	Mecosta	5
4	Alpena	1		55	Menominee	5
5	Antrim	6		56	Midland	6
6	Arenac	4		57	Missaukee	1
7	Baraga	1		58	Monroe	13
8	Barry	1		60	Montmorency	3
9	Bay	35		61	Muskegon	33
10	Benzie	3		62	Newaygo	10
11	Berrien	28		63	Oakland	72
12	Branch	5		65	Ogemaw	1
13	Calhoun	18		67	Osceola	4
14	Cass	3		68	Oscoda	1
15	Charlevoix	6		69	Otsego	7
16	Cheboygan	1		70	Ottawa	17
17	Chippewa	8		71	Presque Isle	1
19	Clinton	7		72	Roscommon	4
21	Delta	7		73	Saginaw	4
22	Dickinson	5		74	St. Clair	12
23	Eaton	11		75	St. Joseph	12
24	Emmet	6		76	Sanilac	6
25	Genesee	27		78	Shiawassee	6
26	Gladwin	3		79	Tuscola	2
27	Gogebic	5		80	VanBuren	5
28	Grand Traverse	20		81	Washtenaw	40
29	Gratiot	3		82	Wayne	78
30	Hillsdale	5		83	Wexford	2
31	Houghton	5				898
32	Huron	6				
33	Ingham	41				
34	Ionia	3				
35	Iosco	1				
36	Iron	3				
37	Isabella	4				
38	Jackson	12				
39	Kalamazoo	56				
40	Kalkaska	2				
41	Kent	88				
43	Lake	1				
44	Lapeer	8				
46	Lenawee	11				
47	Livingston	6				
49	Mackinac	2				
50	Macomb	51				
51	Manistee	4				

<i>Issue</i>	<i>Explanation</i>	<i>Potential Solution</i>	<i>Action/Timeframe</i>
<p>PAS/PCS Issue</p> <p>As of today Persons needing PAS/PCS to manage personal needs while at work cannot accomplish this.</p>	<p>Persons needing PAS/PCS to accomplish personal needs are limited at how long during the day they can be away from home. <u>Because they cannot take care of personal needs at work, they end up working less or choosing not to work at all.</u> The FTW law itself prohibits the use of PAS/PCS in the work place, ie “FTW 106a (3) - ...and does not include personal assistance services in the workplace.”</p>	<p>-Work with MSA to draft language to amend the State Plan. This will be part of our Medicaid State Plan. -The State Plan Language will override the FTW Language. -Mike, Joe and Theresa will work with MSA -If no word on SPA by Friday, June 16, Ed Kemp will initiate contact with CMS to ensure the SPA process is moving.</p>	<p>-Submission expected by early April -<u>May 11</u> Rough draft submitted to CMS on per Ed + Logan -<u>May 23</u> Rough draft sent to Adrienne, MIG Grant Officer, for consideration -<u>May23</u> Mike Head encouraged further MSA action -<u>June 13</u> Ed Kemp has not heard back from CMS on the cursory review of the SPA. After the whole submission process is complete, which is expected early this fall, the Effective Date for the PAS piece is projected to be July 1, 2006. -<u>June 23</u> Received email from Nancy Bishop that they have heard from CMS and the PCS State Plan Language is a go ahead with a few clarifications on areas not having to do with the workplace or the community. -<u>July 11</u> Per Ed Kemp-MSA, an attestation letter stating that a state plan amendment allowing personal care services to be used at work will be submitted in July 2006, has been written. Sue Moran will sign and forward to the MIG for the 2007 Grant submission. -<u>Aug 15</u> SP Amendment package is expected sent to CMS by the end of August. Notification will be sent to Joe when this occurs. Ed Kemp outlined next steps. 1) There will need to be a bulletin written for distribution. 2) Two issues still need to be resolved: a) # of evaluations necessary, and b) how the Mental Health side might utilize this availability of PAS. -<u>Sep 12</u> An amendment to increase the</p>

			<p>reimbursement rate levels for personal caregivers is being submitted to CMS. The amendment concerning PAS/PCS will have to wait till after a meeting with Mike Head, Paul Reinhardt, Pat Barrie, Irene Kazmerski, and others meet to discuss and resolve the mental health side of the issue.</p> <p><u>-OCT 10-</u> The PAS amendment was sent to CMS on September 28th. A draft bulletin for this policy has been created. Joe will send it to Ed Kemp with copies to Susan Yontz and Mike Head. CMS has 90 days to respond. MSA does not anticipate any additional issues. In the meantime we will continue the bulletin and policy process.</p> <p><u>-Nov 14</u> We now have a SPA No. 06-16. CMS has sent back questions regarding the Home Help program itself not necessarily involving the PCA/PSA. A response will need to be prepared. Input will go through Mike Head to Ed Kemp. A meeting is planned to be scheduled to work on the response immediately after the Thanksgiving Holiday.</p> <p>-JAN 10 Asked about how the State was doing on responding to CMS inquiries regarding PAS. Ed Kemp was not present at the meeting to give update and no one else had an update. Joe will follow up.</p>
<p>Case Review/Earnings Level Issue</p> <p>Presently, after 12 months a person earning over SGA – upon their yearly DHS</p>	<p>DHS defers to PEM 260 for directive as to yearly review and PAM 815 as to guidance on the process of review. <u>DHS Diary Date set for automatic annual review of a person with a disability set at one year. The review looks at earnings, then disability.</u> The current FTW law supports this. The FTW law states eligibility standards in 106a (2) specifically “(a).... or would be found</p>	<p>-Working with MSA, and DHS – MRT Division.</p> <p>-Short term solution “interim update” to DHS proposed.</p> <p>-Long-term procedure being determined.</p> <p>- Need to review cases w/out considering disability.</p> <p>-Need to change procedure manual</p>	<p>-MSA, DDS/MRT, SSA, & consultants from WI teleconferenced on Feb 9 to determine process</p> <p><u>-Feb/Mar</u> Mi Job Concerns increased</p> <p><u>-Mar/Apr</u> advised MSA of MI JOBS concerns</p> <p><u>- April</u> MSA met with MI Jobs late in April</p> <p><u>-May 16</u> Jackie & Theresa provide re-worked forms & created cover letter to MSA</p> <p>-MSA begins 10 day concurrence process and</p>

<p>case review, the person is seen as “not” disabled, and kicked out of FTW because of earnings level.</p>	<p>to be disabled except for earnings in excess of the SGA level as established by the U.S. SSA”</p>	<p>(PEM) manual to disregard earnings consideration in the case of FTW participants - Jackie & Theresa assigned to work with MSA & complement process -Theresa will assure that Linda does receive copies of the documents she needs (PEM 260 & 174).</p>	<p>seeks DHS endorsement - Anticipate a July 1st implementation - <u>June 13</u> Linda stated that she needed the revised version of PEM 260 sent to her, and also PEM 174. Discussion as to process of creating a new form occurred. An ALJ letter was initiated to alert them of this issue so that they could kick it back to MSA and avoid unnecessary hearings. - <u>July 11</u> MSA will provide Jackie with changes from DSS. They will also provide MIG with the status of the policy and a timeline for implementation. MSA is going to look into pursuing a possible “interim waiver” of disability determination for freedom to work participants impacted by this problem. MSA will obtain a list of possible FTW individuals up for annual review and consider how this may be used to advise local offices so individuals do not receive notices about being ineligible. -<u>Jul 19</u> MSA, represented by Logan Dreasky, and Linda Kusnier attended MI Job Coalition Meeting to go over the strategy that will be employed to effectively keep adverse actions from occurring in the case of persons whose DHS Medicaid case is up for annual review. At this time Logan explained that a query will be developed to identify the cases for review and a list would be compiled. As a pre-emptive strategy, once the cases are identified, the local office will be informed and the case will have the review date extended by 12 months. This will allow MSA enough time to come up with the appropriate policy to deal with the issue. -<u>Jul 26</u> MIG Received email from MSA, who</p>
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			<p>stated that with the assistance of DHS, they have developed the query to identify cases with current or upcoming review dates. The plan is to begin reviewing the cases at DCH beginning the week of August 7, 06. Any action extending the review dates will be completed by DCH.</p> <p><u>-Aug 15</u> No list yet, but should be complete soon. Staff from MSA will manually make the changes to review dates through December. The policy should be done by then. The new instruction to MRT will say to disregard income when making the medical review.</p> <p><u>Sept 12</u> Joe stated frustration with lack of movement on this issue and underscored MIJobs coalition concerns. Logan and Ed suggested inviting Sue Moran and Steve Fitton to next MI JOBS meeting.</p> <p><u>Sept 13</u> Logan made a decision to have Linda Kusnier start reviews of all current FTW enrollees on 9/25. This will be completed by 9/29. She will review each enrollee, select those with Oct, Nov, Dec, Jan, Feb & Mar. review dates and move the review date forward 1 year. Linda will log this data and advise DHS so they are aware of the changes. This way it can be handled within MSA. Logan would have her start this next week, but she's out of the office on vacation.</p> <p><u>-Oct 10</u> Linda received the printout for the AD-CARE consumers. The criterion for the printout was more extensive than just those on FTW who needed a review so the list was approximately 800 names. Only 4 individuals needed to have their review dates advanced ahead. About 80% of this list is coded as AD-CARE, and it appears on the surface, that</p>
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			<p>there may have been miscoding errors. Some of these consumers had earned income above the AD-CARE level and likely should be in FTW.</p> <p>-Nov 14 Linda reviewed cases in September and the forwarded the re-determination dates as appropriate. There is a new Joint Manual Process that is slowing the process of getting the necessary new policy in place. Therefore, MSA will continue to work with DHS to extend review dates as necessary. In January 2007, the topic will be brought up again to see where things are at that point.</p>
<p>Unearned Income Issue</p> <p>Current FTW individuals receive or achieve unexpected unearned income, placing them in a status with unearned income above FPL.</p>	<p><u>Some unearned income results as a direct benefit from working</u>, such as: unemployment, workers compensation, and working at higher earnings, thereby increasing the amount of SSDI check received in the case of temporary layoffs or medical leave. <u>Other factors that could cause an unexpected rise in unearned income include the death of a parent, receipt of child support, or receipt of spousal support.</u> FTW Law 106a (2) (c) states, "The individual has unearned income level of not more than 100% of the current federal poverty guidelines." Yet this seems to contradict with 106a (4) (c) which speaks to "temporary breaks in employment that do not exceed 24 months if temporary breaks are the result of an involuntary layoff or are determined to be medically necessary." <u>Because of a person's past work record, the amount of unearned income collected during these temporary breaks from employment may actually bring a person above the FPL threshold and make them ineligible to participate in FTW.</u></p>	<p>-The benefits derived from working are received as unearned income, ie unemployment, comp pay, disability leave, etc.</p> <p>-The intent is not to be penalizing people who work</p> <p>- Theresa assisted by Joe, will develop list of items to be included in future inclusive FTW disregard for submission to Logan by June 30.</p>	<p>-<u>Early March</u>... Advised Logan & Linda with outline of several different ways that unearned income may impact people, especially during period of non-employment. Joe and Theresa</p> <p>-<u>Mid March</u>... Unemployment is being submitted as a disregard amendment to the Administrative Rules as State Plan supplement per Logan with CMS</p> <p>-<u>Early May</u> Logan noted that other factors impacting unearned income may be considered with a "broad" %'general disregard for current FTW participants</p> <p>-Anticipate discussing during June Ed/Logan mtg.</p> <p>-<u>June 13</u> Good news, the unemployment issue is now a part of the policy in print as of Program Policy Bulletin #2006-010, p6 of 11. Discussed the development of an inclusive disregard that would have items of unearned income that is received either directly or indirectly related to being a benefit of working.</p> <p>-<u>June 30</u> The list of unearned items with some policy language was developed by Theresa and then forwarded to Logan at MSA</p>

			<p><u>-July 11</u> Members will review the suggested disregards and consider others. Ed Kemp of MSA suggested that we needed to get Mike Head to assist in seeking new administrative policy on disregards. Joe will follow up with Mike if the list is conclusive at the August meeting.</p> <p><u>-Aug 15</u> Some discussion occurred. A recommendation was made by Tony to add VA and SSDI death benefits to the second list. Theresa will modify list and send it back to Logan. Also she will look more into the possibility of using a disregard by a percentage amount. Logan informed us that these disregards would be for someone entering as well as already in the FTW eligibility category, because we cannot treat people differently.</p> <p><u>-Sept 12</u> Nothing has moved on this. Nothing we can do at this time. Need Plan of Action (PLN) on this. Per Ed Kemp there needs to be a meeting with Mike and others on this. Ed will put this on his Friday agenda with Steve Fitton.</p> <p><u>-OCT 10</u> The issue was discussed with Steve Fitton. Logan will provide Steve with rationale for each type of disregard before Steve will approve. Theresa provided Logan with some of the rationale that she had and has agreed to assist if needed.</p> <p><u>-JAN 10</u> Theresa provided Logan Dreasky with the top three disregards that would be most helpful to people with disabilities that are working and wish to remain eligible for FTW Medicaid. Logan Dreasky will move the list forward to Ed Kemp and Steve Fitton. A question rose about disregarding</p>
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			<p>COLAs. Disregarding COLAs automatically seems to occur as a matter of policy within the department. Verification of this fact is necessary.</p>
<p>Aging Out Issue</p> <p>FTW participants approaching age 65+ accumulating resources, savings, retirement, etc. must now dissolve these resources in order to retain Medicaid eligibility.</p>	<p>FTW Law specifically states in 106a (2)(b) <u>“To be eligible, “the individual is at least 16 years of age and younger than 65 years of age.”</u> Michigan’s Medicaid Buy-In Law is authorized under the TWIIA, which has an age limit for participation of 16-65.</p>	<p>-One course of action could be to try to pass a Medicaid Buy-In under the Balanced Budget Act as other states are attempting to do. The Balanced Budget Act allows for all ages to participate but has other restrictions as to income earned and savings.</p> <p>-Theresa will discuss with NCHSD and look into which states either have done this or are about to accomplish the passing of both.</p> <p>-Theresa will follow up with NCHSD and/or Connecticut on this topic.</p>	<p>-NCHSD informed us that Connecticut is attempting to pass a BBA as of this year to address the “aging out” issue. Anticipate results from CT by early July.</p> <p><u>-July 11</u> Neither Theresa nor Joe has heard anything back from Connecticut on their progress. Theresa will make contact with Connecticut and other sources to look into this issue and possible resolutions.</p> <p><u>-July 13</u> Theresa received notification that Connecticut efforts to pass a MBI under the BBA have been successful. More details to follow.</p> <p><u>-July 17</u> CT did pass legislation allowing the state to cover persons who are 65 and older using the Balanced Budget Act. According to their policy analyst, Larry Carlson, their proposed State Plan Amendment will add a Balanced Budget Act group to their Medicaid Buy-In. The BBA has no restriction of participation according to age. CT can now cover these individuals provided they meet the other provisions (disability, employment, and financial of their buy-in eligibility criteria.) CT. will be using 1902(r)(2) in order to extend the TWWIIA income and asset limits to the BBA Group.</p> <p><u>-Sept 12</u> Theresa is working on a concept paper for this issue. Ed Kemp said he would like a copy of it sent to him and Logan for discussion purposes next time. He also said that we would need to draft Bulletin language for this issue. Theresa said she would add</p>

			that to the concept paper, and solicit Jackie's help with Bulletin language. - <u>OCT 10</u> Theresa presented work plan on this issue, and is presently drafting concept paper outlining options to resolving this issue. Once a decision is made on a course of action, Theresa will draft the accompanying bulletin.
<p>Premium Issue</p> <p>The current FTW premiums fees are seen as "cliffs." The variance in premium amount leaves big differences from one level to the next, which can be triggered by a simple .50 cents increase in pay.</p>	<p>The FTW Law allows for Medicaid Buy-In premiums to be on a sliding scale. Specifically the FTW Law states in 106a "(5) (c) "the Premium sliding fee scale shall have no more than 5 tiers." <u>An unintended consequence of setting the fee scale as MI did (using an SSI methodology for counting income) resulted in individuals having to earn around \$4,000 a month before paying the first level of premium, which was set at \$50.00.</u></p>	<ul style="list-style-type: none"> - Consider a MSA Administrative Policy Change in the existing current premium fee scale. -One Suggestion includes changing to a % scale for individual income level; or go from 100% FPL To 250% of FPL to begin paying premium. - Another possibility would be to switch to a sliding scale based on percentage of countable income. -Some states have premiums that start at the point of any earnings and/or may include unearned income 	<p>-<u>Aug 15</u> It was suggested that we consider using % for eligibility into the program. And it should also be noted that % was suggested here as a way to make premiums smoother from one level to the next. -<u>Sept 12.</u> It was suggested by Tony that we might want to look at and compile suggestions using different premium scales or methodology for premiums. Theresa will assist by providing an analysis from NCHSD on what other states have for their premium systems.</p>
<p>Marriage Penalty Issue</p> <p>The FTW participant's earnings are "deemed" to the spouse and the spouse becomes ineligible for Medicaid and other supports.</p>	<p>The issue of deeming is a problem for FTW participants who have a spouse receiving supportive benefits, such as SSI, due to a disabling condition. A part of the working spouses' income is deemed to the other spouse. This results in the other spouses' benefits possibly being reduced or eliminated.</p>	<ul style="list-style-type: none"> -This is a federal challenge within SSA -The WIAG group meets in Chicago and this is a topic they are considering. Tony Wong, Karen Larsen, & June Morse participate. 	<p>-<u>Aug 15</u> A question was raised, why we couldn't use the provisions in 1902 to specify this group individually, and make a State administrative rule that would eliminate the problem of deeming between spouses. Logan referred us to a piece of guidance issued from CMS that may be of help. More research to be done in this area. Sept 12 Tony is going to write up a possible state solution to this Federal problem using the 1902 (r)(2) provisions. He would like some feedback on a document he is preparing for the WIAG committee.</p>
<p>Part B Premiums Issue</p>	<p>The state DHS policy FTW, PEM 174, clearly states,"a person eligible for medical assistance under FTW is not eligible for</p>	<p>-Theresa will further research potential implications of this factor within the FTW program</p>	<p>-<u>June13</u> MSP premiums were discussed briefly as the issue also involves concurrently eligible for ADCARE. Linda concurred with</p>

<p>Some FTW persons become responsible to pay the Medicare premium for Part B without being advised of this impact.</p>	<p>ALMB.” FTW participants may be required to pay Part B costs when they achieve certain earnings levels. Currently Individuals are not made aware of this before switching to FTW.</p>	<p>-Consider whether a change in Administrative policy is needed -Need to develop method to inform participants that they may be required to pay their Medicare Part B premiums as they begin working.</p>	<p>Theresa’s findings that people did not have to pay Medicare Part B premiums because of switching to FTW, but because of a rise in their income as a result of working. -JAN 10 We acquired information at this meeting that there is a new sliding scale to part B premiums with costs starting at \$93.60 plus \$12.50 and with a scale going up from there. At this time there doesn’t seem like there would be an impact for our current FTW participants, but that may change if and when we have participants in the higher income brackets.</p>
<p>Waiver Issue</p> <p>People are asking about being in FTW while using waivers.</p>	<p>People want to be able to remain within a waiver, work, and participate in FTW, but they have been told they can’t. People prefer waivers because of the PSA/PCA services. Waivers have a higher income limit to be economically eligible than other Medicaid programs. FTW is an eligibility category and by using the “Freedom Accounts” a person should remain or be eligible for the MI Choice Waiver.</p>	<p>-Discussed with Pam McNabb & Jackie Tichnell. Eligibility would depend on slots and earnings? - Mike Head noted that FTW was an eligibility Category, whereas the MI Choice waiver is a Program Category. -May 18...Jackie forwarded an overview of why we believe FTW should be able to work in conjunction with this waiver</p>	<p>-Anticipate discussion of this topic during June Ed/Logan meeting. <u>-June 13</u> Logan and Linda acknowledged receipt of the overview memo from Jackie suggesting that a person may utilize both MI Choice Waiver and FTW eligibility at the same time. MSA will further review the memo, meet with Bob Orme, waiver policy analyst and make a suggestion to Ed on how to proceed. <u>-July 13</u> Both FTW and MI Choice are a Medicaid Eligibility. The issue appears to be in the interpretation of policies. MSA will discuss with both DHS and waiver agents. <u>-Aug 15</u> regarding a discussion on the term “Nursing Home Level of Care” and how this plays into people on the My Choice waiver using FTW. Some discussion needs to occur on the interpretation of long term care terminology and the interaction between the MICHoice Waiver and FTW. Ed will meet with Bob Orhm and others. <u>Sept 12</u> Per Ed Kemp , once meetings begin on SPEs needs to be set up with Bob Ohrm and Ed Kemp said that the topic of “Nursing</p>

			<p>Home Level of Care” NHLC could be one of the first issues to be discussed and resolved. We want the waiver agents to understand that NHLC can be delivered in the community. Remember Olmstead. And that in some cases people with that level of health needs still live active lives including working.</p> <p><u>-OCT10</u> Ed was not in attendance. Joe will check with him individually to see where things are on this issue.</p> <p><u>-Nov 14</u> Ed said Jim Schwartz will discuss and advise Waiver Agents that a person can be on both a MI CHOICE Waiver and FTW at the December Waiver general meeting.</p> <p><u>-Jan 10</u>-Mike Head met with Ed in December to address this. Logan did not know if this had formally been addressed. Joe will check with Ed.</p>
<p>Economic Earnings Issue</p> <p>SSDI recipients that are FTW enrollees remain discouraged from earning over SGA until a person can minimally replace their SSDI check. Ties into the Federal SSA action on SGA. People are unlikely to work in order to have less \$ in their pockets.</p>	<p>People with disabilities work to make money just like anyone else. Individuals are commonly unwilling to accept work that won't minimally replace their check. <u>It costs PWD money \$ to work, in some cases people with disabilities incur large expenses in order to work.</u> In addition, individuals remain concerned of the future need of medical coverage. Some progress has been made in this area through the TWIIA and reinstatement of benefits provision within.</p>	<p>-Need to do research on what it would take to eliminate SGA and allow persons to wean off benefits slowly.</p> <p>-Work with the MI JOB Coalition and others working towards a solution to the issue of SGA</p> <p>- PWDS need to gain skills to qualify for a higher paying job, so they can earn enough to take the leap of faith off the system.</p>	<p>-Feb & April “Think Work” summits suggest growing effort by Mi Jobs Coalition to seek demonstration/pilot grant from SSA to disregard SGA as a standard for persons with SSDI.</p>
<p>Deductible Issue</p>	<p>As of January 2004 through August 01 2005 (Prior to the institutionalization of the LAO2</p>		<p>- July 13 Concern was expressed as to what if anything can be done to capture persons who</p>

<p>As of January 2004, PWD may have been put into Spend-Down eligibility category (now referred to as the Deductible Program) instead of being referred to the FTW eligibility category.</p>	<p>prompt), PWD may have inadvertently been put into spend-down (now referred to as the Deductible Program) when applying for Medicaid benefits because of having earned income combined with unearned income that placed total earnings over the FPL. Some of these individuals should have been FTW participants.</p>		<p>were missed. -Aug 15 Additional discussion occurred. No action -OCT 10 There was some discussion as to what/who this population is. Linda Kusnier is working on the December 2003 persons that were spend down prior to January 2004 and would have been FTW persons except for the implementation date. Tony was thinking this was the same group of persons. Logan will pursue with Linda</p>
<p>AD Care Issue</p> <p>PWDs that come in to apply for Medicaid and are working below 100% FPL are automatically referred to AD Care.</p>	<p>It is the policy of DHS to place eligible individuals into the most beneficial MA category for the person. Yet, <u>some individuals with disabilities who have jobs and are actively working are placed into ADCARE rather than FTW.</u> These individuals have a combined income below FPL. The benefit of placing working PWDs to FTW would increase the program enrollment numbers and bring more federal grant dollars to the state ultimately providing greater opportunities to individuals with disabilities.</p>	<p>-Take a look at DHS policy and procedures and determine if changes are needed. If so, make recommendations to MSA. Theresa and Jackie -Study the challenges of transferring working persons with disabilities from ADCARE to FTW to be sure that no harm would occur (recall that some would then need to pay the Part B premium of \$88.50/mo.)</p> <p>*People will only have to pay their Part B premium as their income rises above the poverty level. At that point they would no longer be eligible for ACARE or the Medicare subsidy because they would be over income.</p>	<p>-June 13 Discussed briefly about the possibility of simply moving all eligible ADCARE people onto FTW to allow these individuals to take full advantage of the FTW program. Ed Kemp did not feel that anything would prohibit this from being done. Estimated time to completion, approximately two months per Ed Kemp -June 13 additional note Per Logan...when creating the hierarchy of Eligibility for the new bridges system FTW was placed above ADCARE. Additionally the new bridges system will allow targeted letters to be mailed to certain Medicaid eligible persons -July 11 MSA indicated that the actuarial division is concerned about moving AD CARE individuals to FTW. Joe will ask Mike to pursue this with Ed Kemp. Ed is going to talk with the actuarial department as well. There was discussion about the issue of choice for persons "moving" from AD Care to FTW. Additionally it was also noted that consumers do need to be made aware that they have FTW, and what advantages for self sufficiency that offers to them. Possible methods of informing consumers once they are</p>

			<p>transferred to FTW were discussed.</p> <p><u>-Aug 15</u> Ed will get this topic on the agenda for his next meeting with Mike as the LTC department head, along with others. There are an estimated 74,000 ADCARE participants.</p> <p><u>-Sept 12</u> Estimate number of ADCARE beneficiaries with income from earnings is 6161. Ed Kemp will get this topic on the Friday agenda with Steve Fitton.</p> <p><u>-OCT 10</u> Julie is to provide associated dollars with this group. MSA administration does support the concept of moving these 1consumers to FTW. Mike Head concerned about the timing. It is necessary to do this soon so that we can use this for future Medicaid funding.. Logan will develop a plan to get this process done. The importance of educating consumers to make an informed choice was one again stressed.</p> <p><u>-Nov 14</u> Joe shared a draft memo to advise AD CARE participants. Joe will edit again and share it at the December meeting.</p> <p>-JAN 10 Joe submitted a letter collaboratively written with assistance of Jackie and reviewed by Theresa to go out to the 6000 + people that are being considered for transition from ADCARE to FTW. The letter explains what FTW is and how it can benefit the individual. Most importantly, it will tell them where to get more information. Jackie suggested that it would be helpful if the letters sent out included the WIPA brochure. Discussion of transferring people over to FTW from ADCARE went on. There was lengthy discussion regarding the issue of married AD</p>
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			<p>Care consumers. What is the impact on each of the partners? Currently, the FPL used for AD Care would be as a family of two (a higher level than family of one). The FTW person would need to have unearned income below 100% of FPL. Per Logan Dreasky, it was determined that this would not immediately impact the AD Care spouse who would continue to be considered in a family of two under AD Care. There would be no initial impact, until there were more earnings in the AD Care group. If both people had unearned income below FPL and earnings (even very small earnings) then they'd both be FTW eligible and remain Medicaid eligible as long as they individually met FTW criteria. And it was also suggested to included with the letter</p> <p>an option of choice by saying "if you do not wish to participate in freedom to work Medicaid call (case worker or MSA?) The only challenge to this language is that written this way the letter requires an affirmative rather than a passive response from individuals if they do not wish to participate in FTW. Next step Joe will work with Tony re: use of WIPA brochure/contact info, letter will be rewritten with the recent input and forwarded to Logan for his review.. When approved, MSA will handle the mailing out of the letters.</p>
<p>Freedom Accounts Issue</p> <p>FTW enrollees are not aware of Freedom</p>	<p>The advantage to Freedom Accounts is that <u>PWDs can set aside income to save for things they need, and still qualify for Medicaid benefits and medical coverage under the MA program.</u></p>	<p>-Determine how to build awareness among FTW enrollees to promote increased earnings & savings while retaining needed benefits.</p>	<p>- July 11 Logan Shared that MSA is working with DHS on the Bridges project and that the Bridges System has a "placeholder" to trigger the system designers to allow for Freedom Accounts in the new system. This would tell</p>

<p>Accounts and commonly don't know the benefits of utilizing these accounts to build savings or increase earnings.</p>			<p>the system to automatically put savings into Freedom Accounts during the budget creation process by DHS workers. MIG needs to work with MSA on developing a process to handle this issue with DHS. Jackie, Theresa & Joe will meet on 7/20/06.</p> <p>-7/20/06 Jackie, Theresa and Joe met and developed a plan to address this issue through creating a form and making changes to the PEMs.</p> <p>-Aug 15 Theresa reported that she has located within the PEMs a DHS Form that will serve the purpose of designating freedom accounts by consumers of DHS services. She also has drafted new PEM language and directions for the use of this form. Theresa is in the process of going through the PEMS to see where modifications need to occur to affected PEMs, and is drafting a memo on this to be submitted with the suggested changes.</p> <p><u>-OCT 10</u> Theresa shared a draft Bulletin announcing this policy. She provided Logan with a copy. MSA will review and provide the office with comments. Tony suggested adding a section on consumer responsibilities and consequences to the bulletin and the brochure he is working on. Theresa suggested modifying DHS Form 503 Asset Verification Form to include designation for Freedom Accounts, creating a new DHS Form for FTW. A suggestion occurred to modify the FTW DHS Form since Freedom Accounts can also include money from income. Make it a similar but New Form with its own Form Number.</p>
<p>SSA 1619 transition to FTW</p>	<p>Persons presently in 1619 status may earn or save their way onto FTW, but <u>are fearful to take that leap because they are unsure that</u></p>	<p>-Research possible ways to address MA policy to allow this transition to be seamless.</p>	<p>-TBD</p>

<p>Presently smooth transition to FTW is not assured.</p>	<p><u>transition</u> into FTW Medicaid <u>will be a seamless process.</u></p>		
<p>Working from Home and HUD Housing</p>	<p><u>Persons living in HUD housing are told that they cannot engage in business activities out of their home.</u> This severely limits some employment opportunities for PWDs.</p>	<p>-Theresa will check HUD policy and also with a few contacts she has within the advocacy field that often helps PWDs with housing issues regarding subsidized housing.</p>	<p>-June 16 Ref Jackie Blankenship (MSHDA) thru Sue Eby (MDCH) thru Glen Ashley (MDDC-MDCH)</p> <p>HUD Regulations: 24 CFR 982.551 Obligations of Participant states (h) Use and occupancy of unit - (1) The family must use the assisted unit for residence by the family. The unit must be the family's only residence. (5) Members of the household may engage in legal profit making activities in the unit, but only if such activities are incidental to primary use of the unit for residence by members of the family.</p> <p>24 CFR 982.516 discusses family income and composition; and 24 CFR Part 5.609 discusses family income; 24 CFR Part 5.611 discusses adjusted income</p> <p>HUD's Housing Choice Voucher Program Guidebook says this about income inclusions – "The net income from operation of a business or profession. Expenditures for business expansion or amortization of capital indebtedness shall not be used as deductions in determining net income. An allowance for depreciation of assets used in a business or profession may be deducted, based on straight line depreciation, as provided in Internal Revenue Service regulations. Any withdrawal of cash or assets from the operation of a business or profession will be included in income, except to the extent the withdrawal is reimbursement of cash or assets invested in the operation by the family."</p>
<p>Michigan First - Health Care Program</p>	<p>Does this new waiver have any impact on the Freedom to Work Program?</p>		<p>-July 13 Jackie Tichnell contacted Susan Yontz. What we know so far is that it is an 1115 waiver, there is no draft available to share, and there is no template. Susan will let people know that we are interested in learning more information and she will get back to us.</p> <p>-August 8 Theresa has done some research into this and drafted a memo giving the</p>

			message that from all materials so far there appears to be no adverse effects to FTW participants. This new MI health program may in fact offer health care to people with disabilities who wouldn't otherwise have access to health care.
FTW training in DHS offices (and elsewhere) to NOT include References to not being on a Spend Down/ Deductible.	The current training module used by DHS makes reference to FTW not being for people on the deductible Medicaid program.	The fact of people being on a deductible being the reason for exclusion from FTW is really not true. The qualifying eligibility criteria used for FTW is the same as for ADCARE eligibility, using an SSI category income breakdown.	

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1 ALCONA	CJ	05/12/06	09/19/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0		
2 ALGER	Brandy	08/15/06	08/15/06	1			1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	Provider wishes to work in Marquette ONLY
3 ALLEGAN	Brandy	07/21/06	08/02/06	13	02/28/07		2	6	4	0	1	0	0	1	4	2	1	0	0	0	0	New provider responses - never done HH before
4 ALPENA	CJ	05/12/06	07/11/06	5			1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	The Provider that attended was from Montmorency County.
5 ANTRIM	CJ	05/12/06	04/20/06	2			2	2	2	0	0	0	0	1	1	1	0	0	0	0	0	
6 ARENAC	Sarah	02/06/06	03/06/06	24			1	7	5	0	0	0	0	1	3	1	1	0	1	1	1	
7 BARAGA	Brandy	06/28/06	07/13/06	3			1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Provider didn't show
8 BARRY	CJ	02/13/06	01/26/06	9			1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
9 BAY	Sarah	02/06/06	03/06/06	97	02/06/07	8	4	25	17	0	0	1	3	28	219	49	3	1	0	1	1	
10 BENZIE	CJ	05/12/06	04/05/06	4			1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
11 BERRIEN	Brandy	06/28/06	07/18/06	45			2	7	4	0	0	1	0	0	0	0	0	0	0	2	0	
12 BRANCH	Brandy	08/25/06	09/14/06	9			1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
13 CALHOUN	Brandy	06/28/06	06/08/06	24			1	3	2	0	1	0	0	0	0	0	0	0	0	0	0	
14 CASS	Brandy	06/28/06	07/27/06	7			1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1 Provider has not phone no. - inactive
15 CHARLEVOIX	CJ	05/12/06	04/25/06	1			1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	
16 CHEBOYGAN	CJ	06/28/06	05/02/06	2			1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
17 CHIPPEWA	Brandy	06/28/06	07/11/06	4			1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	
18 CLARE	CJ	03/06/06	04/06/06	13			1	3	6	0	0	0	0	2	10	2	0	0	0	0	0	
19 CLINTON	CJ	07/01/05	09/20/05	12	01/16/07	0	2	6	1	0	1	0	0	1	5	1	0	2	0	1	1	
20 CRAWFORD	CJ	05/09/06	04/26/06	6			1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
21 DELTA	Brandy	06/28/06	07/12/06	9			1	4	1	0	1	0	0	0	0	0	1	0	0	0	0	
22 DICKINSON	Brandy	06/28/06	07/13/06	7			1	3	2	0	0	0	0	0	0	0	0	0	1	0	0	

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23	EATON	CJ	07/01/05	02/15/06	13	01/16/07	0	4	2	3	0	0	0	0	4	15	4	1	1	0	0
24	EMMET	CJ	06/28/06	04/25/06	5			1	2	2	1	0	0	0	0	0	0	0	0	0	0
25	GENESEE	Sarah	07/01/05	11/29/05	259	2/2, 2/12, 2/19		7	45	33	0	0	1	0	39	314	61	1	0	7	10
26	GLADWIN	CJ	03/06/06	04/06/06	13			1	6	5	0	0	0	0	1	5	2	0	0	0	1
27	GOGEBIC	Brandy	07/21/06	08/16/06	4			1	3	1	0	0	0	0	0	0	0	1	0	1	0
28	GRAND TRAVERSE	CJ	05/12/06	05/25/06	11			1	6	5	1	0	2	0	0	0	0	0	0	0	0
29	GRATIOT	CJ	02/13/06	09/20/06	4			1	1	0	0	0	0	0	0	0	0	0	0	0	0
30	HILLSDALE	Tanya	05/12/06	06/27/06	7		4	2	2	0	0	1	0	0	0	0	0	0	0	0	0
31	HOUGHTON	Brandy	06/28/06	07/13/06	6			1	0	0	0	0	0	0	0	0	0	0	0	0	0
32	HURON	Sarah	03/06/06	05/30/06	6			1	1	0	0	0	1	0	1	1	1	0	0	0	0
33	INGHAM	CJ	07/01/05	08/01/05	99	01/16/07	9	14	48	31	0	2	2	1	72	545	132	4	1	1	3
34	IONIA	CJ	02/13/06	02/07/06	22	01/17/07	3	1	3	3	0	0	0	0	4	12	4	0	0	0	1
35	IOSCO	CJ	05/12/06	09/12/06	3			1	2	2	0	0	0	0	0	0	0	0	0	0	0
36	IRON	Brandy	07/21/06	07/13/06	6			1	1	1	0	0	0	0	0	0	0	0	0	0	0
37	ISABELLA	Sarah	04/06/06	05/08/06	9			1	1	2	0	0	0	0	1	7	2	0	0	0	1
38	JACKSON	Leesa	04/14/06	04/19/06	24			3	10	3	0	0	7	0	1	3	1	0	0	0	0
39	KALAMAZOO	Brandy	05/12/06	05/16/06	65	03/29/07		2	24	10	0	3	3	5	1	5	1	0	0	5	0
40	KALKASKA	CJ	05/12/06	04/20/06	2			1	1	0	0	0	0	1	0	0	0	0	0	0	0
41	KENT	Ian	06/28/06	06/14/06	158			4	42	36	5	5	1	2	15	106	24	1	0	1	0
42	KEWEENAW	Brandy	06/28/06	07/13/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0
43	LAKE	CJ	04/03/06	07/27/06	2			1	2	1	0	0	1	0	1	4	2	0	0	0	0
44	LAPEER	Sarah	06/28/06	07/27/06	16			1	7	5	0	0	0	0	1	5	1	0	0	0	0

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45 LEELANAU	CJ	05/12/06	05/25/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	
46 LENAWEE	Leesa	05/12/06	06/13/06	13			1	2	1	0	0	0	1	0	0	0	0	0	0	0	
47 LIVINGSTON	CJ	07/01/05	01/30/06	5	01/16/07	0	1	1	1	0	0	0	0	2	10	3	0	0	0	0	<i>with Ingham</i>
48 LUCE	Brandy	06/28/06	07/12/06	1			1	1	1	0	0	0	0	0	0	0	0	0	0	0	
49 MACKINAC	Brandy	05/12/06	05/02/06	2			1	0	0	0	0	0	0	1	0	0	0	0	0	0	<i>Provider didn't show</i>
50 MACOMB	Sarah	7/1/05 & 3/06/06	09/20/05	111	02/27/07		5	43	15	1	0	0	6	43	386	83	2	1	4	4	
51 MANISTEE	CJ	05/04/06	04/05/06	7			1	1	0	0	0	0	1	0	0	0	0	0	0	0	<i>Provider never returned application</i>
52 MARQUETTE	Brandy	07/21/06	08/15/06	13			1	3	4	0	0	0	0	0	0	0	0	0	0	0	
53 MASON	Brandy	07/21/06	08/02/06	3			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
54 MECOSTA	Brandy	05/12/06	04/18/06	11			1	5	2	0	0	1	0	0	0	0	0	0	2	0	
55 MENOMINEE	Brandy	06/28/06	07/12/06	11			1	8	5	0	0	0	0	1	2	1	0	0	3	0	
56 MIDLAND	Sarah	02/06/06	03/08/06	13			1	5	1	0	0	0	0	1	5	2	0	0	0	0	
57 MISSAUKEE	CJ	05/12/06	04/05/06	7			1	4	6	0	0	0	0	1	5	2	0	0	0	0	
58 MONROE	Leesa	05/12/06	06/22/06	8			1	2	1	0	0	1	0	0	0	0	0	0	0	0	
59 MONTCALM	Brandy	05/12/06	02/07/06	27			1	12	7	0	0	0	0	3	12	3	1	0	2	0	
60 MONTMORENCY	CJ	06/28/06	08/24/06	3			1	1	1	0	0	0	0	0	0	0	0	0	0	0	<i>Provider didn't show</i>
61 MUSKEGON	Brandy	05/12/06	05/04/06	50			2	13	8	0	0	2	0	0	0	0	0	0	2	0	<i>one provider from Ottawa</i>
62 NEWAYGO	Brandy	08/15/06	07/27/06	8	02/20/07		1	1	1	0	0	0	0	1	3	1	0	0	0	0	
63 OAKLAND	CJ	07/01/05	11/15/05 & 1/5/06	214	01/31/07	11	12	65	38	1	0	5	5	69	432	113	2	1	2	11	
64 OCEANA	Brandy	07/21/06	08/02/06	11			1	5	4	0	0	0	0	0	0	0	1	0	0	0	
65 OGEMAW	CJ	05/12/06	05/10/06	9			1	4	3	0	0	0	0	0	0	0	0	0	0	0	

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66	ONTONAGON	Brandy	07/21/06	08/16/06	7		1	5	3	0	0	1	1	1	2	1	0	0	0	0	
67	OSCEOLA	CJ	03/06/06	04/18/06	10		1	3	2	0	0	0	0	0	0	0	0	0	1	0	
68	OSCODA	CJ	06/28/06	08/24/06	3		1	1	1	0	0	0	0	1	1	1	0	0	0	0	
69	OTSEGO	CJ	05/29/06	09/19/06	12		1	10	7	1	0	0	0	5	21	5	0	0	1	0	
70	OTTAWA	Brandy	05/12/06	05/24/06	12		1	6	4	0	0	1	1	0	0	0	1	0	0	0	
71	PRESQUE ISLE	CJ	06/28/06	07/11/06	2		1	1	0	0	0	0	0	0	0	0	0	0	1	0	
72	ROSCOMMON	CJ	05/12/06	05/23/06	8		1	3	1	0	0	0	0	0	0	0	0	0	0	0	
73	SAGINAW	Sarah	02/06/06	01/19/06 & 1/5/06	198	01/25 + 02/09	39	2	28	23	0	0	2	0	30	226	42	0	0	2	7
74	ST. CLAIR	Sarah	06/28/06	07/27/06	42		2	11	9	1	0	0	0	4	34	7	0	0	1	0	
75	ST. JOSEPH	Brandy	06/28/06	06/20/06	4		1	3	1	0	0	0	2	0	0	0	0	0	0	0	
76	SANILAC	Sarah	03/06/06	06/07/06	10		2	4	3	0	0	0	0	0	0	0	0	0	0	1	
77	SCHOOLCRAFT	Brandy	08/15/06	08/15/06	3		1	1	0	0	0	0	0	1	0	0	0	0	0	0	<i>Provider decided the registry wasn't for him</i>
78	SHIAWASSEE	CJ	01/30/06	01/30/06	24	01/16/07	0	4	20	6	0	0	1	0	0	0	1	0	0	1	<i>with Ingham.</i>
79	TUSCOLA	Sarah	03/06/06	06/07/06	10		1	9	3	0	0	0	0	1	6	2	0	0	0	0	
80	VAN BUREN	Brandy	06/28/06	06/20/06	22	01/30/07	1	1	4	1	0	1	2	4	16	6	0	0	0	0	<i>Left message 11/29 to schedule I.S.</i>
81	WASHTENAW	Leesa	07/01/05	09/21/06	66	01/18/07	6	3	15	12	0	1	0	9	42	10	0	0	1	0	
82	WAYNE	Leesa	11/12/06	09/12/06	1454	01/24/2007 (2 sessions)		9	157	107	38	7	7	4	8	54	11	0	1	2	0
83	WEXFORD	CJ	05/12/06	04/05/06	17		1	7	5	0	0	0	0	2	7	2	1	0	0	0	
TOTALS			83	83	3462	21	81	148	757	489	49	22	42	36	363	2528	586	23	8	43	43
Remaining			0	0																	
Change from 12/20/06 report					+271	+17	+35	+3	+29	+80	+7	+9	+1	+4	+55	+408	+91	+5	0	+8	-42

COUNTY	Registry Management Associate	Date of Brochure Mailing	Date of DHS Meeting	# Responding to Brochure	Date of Upcoming Orientations	# of RSVPs for Upcoming Orientation	# of Orientations Held	Total # of Providers at Orientation	# of Approved Providers	# of Providers Approval Pending	# Pending for referrals more than 2 mths	# of Providers Denied	# of Orientation Walk outs	# of Consumers	# of Referrals made	# of referral letters sent or calls made	# Inactive due to enough work	# Inactive does not wish to be on registry	# Inactive other	Removed from registry
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67 Counties have approved providers

17 Counties without approved providers.

9 counties where we have tried but been unsuccessful in getting providers who could be approved to Intro Sessions (can't find a time, didn't show, showed but were ineligible or decided they weren't interested, showed but were actually from another County): Alger, Baraga, Gratiot, Hillsdale, Huron, Kalkaska, Mackinac, Montmorency, Schoolcraft

3 have Providers Pending Approval: Iosco, Manistee, Otsego

3 have had no response to the brochure mailing: Alcona, Keewenaw, Leelanau

1 Had a provider but the provider took another job and became inactive: Presque Isle

Michigan Department
of Community Health



Jennifer M. Granholm, Governor
Janet Olszewski, Director

YOU ARE INVITED TO ATTEND
THE
MICHIGAN'S
LONG-TERM CARE CONNECTION
(“SINGLE POINT OF ENTRY”)
INFORMATIONAL FORUM

January 22, 2007

Capital View Building

Conference Rooms A, B, C

210 Townsend Street, Lansing, Michigan
(Driving directions on back)

10:00 am – Noon

An informational session for stakeholders and persons interested in learning about the newly forming Michigan Long-Term Care Connection (Single Point of Entry) for long-term care services in Michigan. Presentations will be followed by a question and answer period.

Sponsored by the Office of Long-Term Care Supports & Services
Michigan Department of Community Health

For More Information: 517.373.3860 or thelen@michigan.gov **RSVP not required.**

The Michigan Long-Term Care Connection (Single Point of Entry) will be a highly-visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services & supports, in accordance with their preferences.

DRIVING DIRECTIONS

January 22, 2007 Capital View Building, Conf Rooms A, B, C

210 Townsend Street, Lansing, Michigan

The Capitol View Building is located on the southeast corner of West Allegan Street and Townsend Street. Parking is available, for a fee, in two city-run parking ramps. One ramp is located on Townsend Street, adjacent to the Capitol View Building. The other ramp is at the corner of West Allegan Street and South Capitol Avenue. Parking is also available at meters throughout the downtown area.

From Grand Rapids: Take I-96E to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to West Main Street and continue down West Main Street. Turn left on to Walnut Street (see map below).

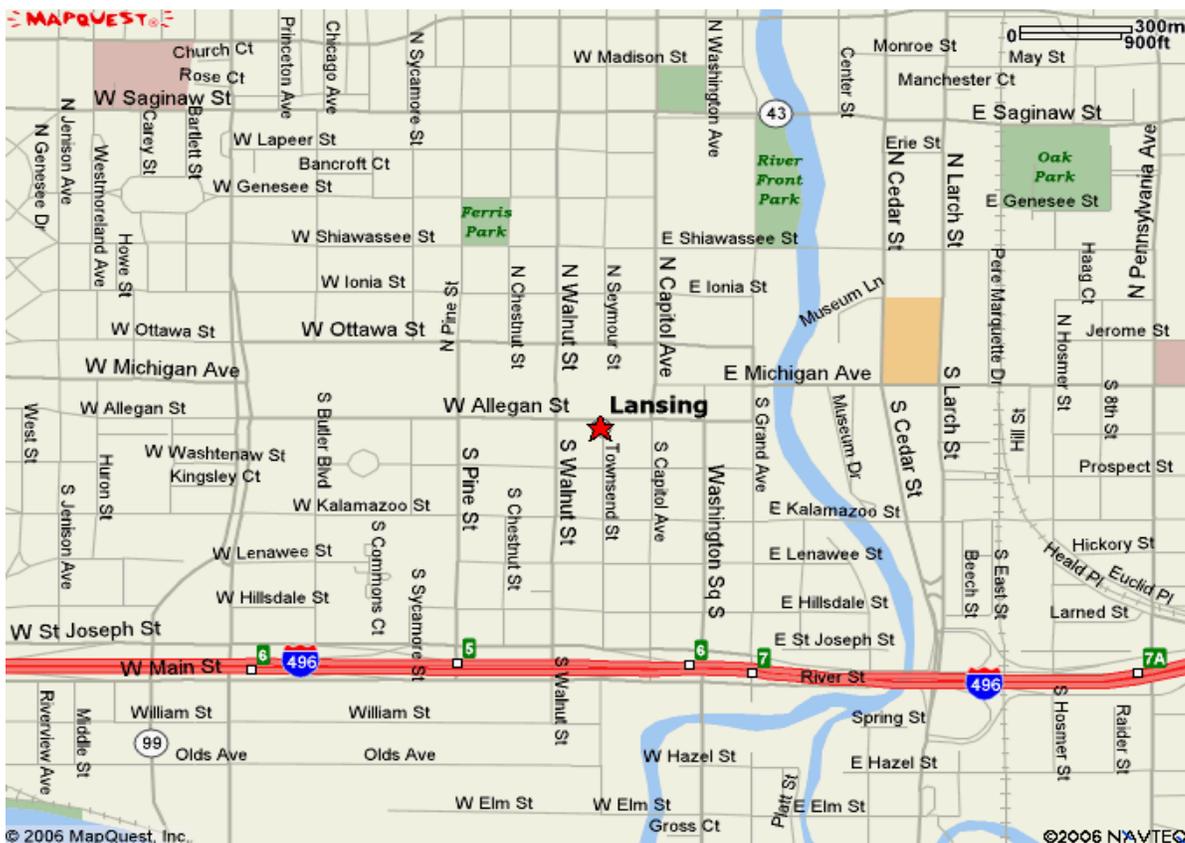
From Clare and Points North: Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to West St. Joseph Street and continue on St. Joseph Street for one block. Turn right on to Walnut Street (see map below)

From Flint: Take I-69W to US-127S. Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Detroit: Take I-96W to Lansing which runs right into I-496W. Get on I-496W and continue to Exit 6 which is Walnut Street. Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Jackson and Points South: Take US-127N from Jackson to Lansing. At I-96, I-496 will join US-127N. Follow I-496W to the Walnut Street Exit (Exit 5). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

From Southwest Michigan (Kalamazoo-Benton Harbor-St. Joseph Area): Travel North on I-69 to Lansing. Follow I-69 to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to W. Main Street and continue down W. Main Street. Turn left on to Walnut Street (see map below)



Act No. 634
Public Acts of 2006
Approved by the Governor
December 30, 2006
Filed with the Secretary of State
January 4, 2007
EFFECTIVE DATE: January 4, 2007

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Shaffer, Amos, Vander Veen, Caul, Proos, LaJoy, Marleau, Nitz, Pearce, Zelenko, Byrnes, Alma Smith, Farrah, Pastor, Casperson, Kahn, Kooiman, Palsrok, Newell, Ball, Green, Stahl, Robertson, Wojno, Gillard, Clack, Bennett, Mortimer, Hansen, Sheen, Farhat, Sak, Emmons, Vagnozzi, Donigan, Hune, Garfield, Polidori, Spade, Byrum, Gosselin, Gleason, Waters, McConico, Anderson, Stewart, Kolb, Lipsey, Meyer, Hummel, Williams, Adamini, Brown, Virgil Smith, Hopgood, Kathleen Law, Bieda, Meisner, Acciavatti, Condino, Stakoe, Caswell, Nofs, Wenke, Ward, Steil, Huizenga, Moolenaar, Angerer, Baxter, Booher, Cheeks, Clemente, Espinoza, Gonzales, Hildenbrand, Rick Jones, Leland, Lemmons, III, Lemmons, Jr., McDowell, Miller, Moore, Rocca, Hood and Murphy

ENROLLED HOUSE BILL No. 5389

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," (MCL 400.1 to 400.119b) by adding sections 109i and 109j.

The People of the State of Michigan enact:

Sec. 109i. (1) The director of the department of community health shall designate and maintain locally or regionally based single point of entry agencies for long-term care that shall serve as visible and effective access points for individuals seeking long-term care and that shall promote consumer choice and quality in long-term care options.

(2) The department of community health shall monitor single point of entry agencies for long-term care to assure, at a minimum, all of the following:

(a) That bias in functional and financial eligibility determination or assistance and the promotion of specific services to the detriment of consumer choice and control does not occur.

(b) That consumer assessments and support plans are completed in a timely, consistent, and quality manner through a person-centered planning process and adhere to other criteria established by this section and the department of community health.

- (c) The provision of quality assistance and supports.
 - (d) That quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.
 - (e) Consumer access to an independent consumer advocate.
 - (f) That data and outcome measures are being collected and reported as required under this act and by contract.
 - (g) That consumers are able to choose their supports coordinator.
- (3) The department of community health shall establish and publicize a toll-free telephone number for areas of the state in which a single point of entry agency is operational as a means of access.
- (4) The department of community health shall require that single point of entry agencies for long-term care perform the following duties and responsibilities:
- (a) Provide consumers and any others with unbiased information promoting consumer choice for all long-term care options, services, and supports.
 - (b) Facilitate movement between supports, services, and settings in a timely manner that assures consumers' informed choice, health, and welfare.
 - (c) Assess consumers' eligibility for all medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.
 - (d) Assist consumers in obtaining a financial determination of eligibility for publicly funded long-term care programs.
 - (e) Assist consumers in developing their long-term care support plans through a person-centered planning process.
 - (f) Authorize access to medicaid programs for which the consumer is eligible and that are identified in the consumer's long-term care supports plan. The single point of entry agency for long-term care shall not refuse to authorize access to medicaid programs for which the consumer is eligible.
 - (g) Upon request of a consumer, his or her guardian, or his or her authorized representative, facilitate needed transition services for consumers living in long-term care settings if those consumers are eligible for those services according to a policy bulletin approved by the department of community health.
 - (h) Work with designated representatives of acute and primary care settings, facility settings, and community settings to assure that consumers in those settings are presented with information regarding the full array of long-term care options.
 - (i) Reevaluate the consumer's eligibility and need for long-term care services upon request of the consumer, his or her guardian, or his or her authorized representative or according to the consumer's long-term care support plan.
 - (j) Except as otherwise provided in subdivisions (k) and (l), provide the following services within the prescribed time frames:
 - (i) Perform an initial evaluation for long-term care within 2 business days after contact by the consumer, his or her guardian, or his or her authorized representative.
 - (ii) Develop a preliminary long-term care support plan in partnership with the consumer and, if applicable, his or her guardian or authorized representative within 2 business days after the consumer is found to be eligible for services.
 - (iii) Complete a final evaluation and assessment within 10 business days from initial contact with the consumer, his or her guardian, or his or her authorized representative.
 - (k) For a consumer who is in an urgent or emergent situation, within 24 hours after contact is made by the consumer, his or her guardian, or his or her authorized representative, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative.
 - (l) Except as provided in subsection (20), for a consumer who receives notice that within 72 hours he or she will be discharged from a hospital, within 24 hours after contact is made by the consumer, his or her guardian, his or her authorized representative, or the hospital discharge planner, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian, his or her authorized representative, or the hospital discharge planner.
 - (m) Initiate contact with and be a resource to hospitals within the area serviced by the single point of entry agencies for long-term care.
 - (n) Provide consumers with information on how to contact an independent consumer advocate and a description of the advocate's mission. This information shall be provided in a publication prepared by the department of community health in consultation with these entities. This information shall also be posted in the office of a single point of entry agency.
 - (o) Collect and report data and outcome measures as required by the department of community health, including, but not limited to, the following data:
 - (i) The number of referrals by level of care setting.

- (ii) The number of cases in which the care setting chosen by the consumer resulted in costs exceeding the costs that would have been incurred had the consumer chosen to receive care in a nursing home.
 - (iii) The number of cases in which admission to a long-term care facility was denied and the reasons for denial.
 - (iv) The number of cases in which a memorandum of understanding was required.
 - (v) The rates and causes of hospitalization.
 - (vi) The rates of nursing home admissions.
 - (vii) The number of consumers transitioned out of nursing homes.
 - (viii) The average time frame for case management review.
 - (ix) The total number of contacts and consumers served.
 - (x) The data necessary for the completion of the cost-benefit analysis required under subsection (11).
 - (xi) The number and types of referrals made.
 - (xii) The number and types of referrals that were not able to be made and the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.
- (p) Maintain consumer contact information and long-term care support plans in a confidential and secure manner.
- (q) Provide consumers with a copy of their preliminary and final long-term care support plans and any updates to the long-term care plans.
- (5) The department of community health, in consultation with the office of long-term care supports and services, the Michigan long-term care supports and services advisory commission, the department, and the office of services to the aging, shall promulgate rules to establish criteria for designating local or regional single point of entry agencies for long-term care that meet all of the following criteria:
- (a) The designated single point of entry agency for long-term care does not provide direct or contracted medicaid services. For the purposes of this section, the services required to be provided under subsection (4) are not considered medicaid services.
 - (b) The designated single point of entry agency for long-term care is free from all legal and financial conflicts of interest with providers of medicaid services.
 - (c) The designated single point of entry agency for long-term care is capable of serving as the focal point for all individuals, regardless of age, seeking information about long-term care in their region, including individuals who will pay privately for services.
 - (d) The designated single point of entry agency for long-term care is capable of performing required consumer data collection, management, and reporting.
 - (e) The designated single point of entry agency for long-term care has quality standards, improvement methods, and procedures in place that measure consumer satisfaction and monitor consumer outcomes.
 - (f) The designated single point of entry agency for long-term care has knowledge of the federal and state statutes and regulations governing long-term care settings.
 - (g) The designated single point of entry agency for long-term care maintains an internal and external appeal process that provides for a review of individual decisions.
 - (h) The designated single point of entry agency for long-term care is capable of delivering single point of entry services in a timely manner according to standards established by the department of community health and as prescribed in subsection (4).
- (6) A single point of entry agency for long-term care that fails to meet the criteria described in this section or other fiscal and performance standards prescribed by contract and subsection (7) or that intentionally and knowingly presents biased information that is intended to steer consumer choice to particular long-term care supports and services is subject to disciplinary action by the department of community health. Disciplinary action may include, but is not limited to, increased monitoring by the department of community health, additional reporting, termination as a designated single point of entry agency by the department of community health, or any other action as provided in the contract for a single point of entry agency.
- (7) Fiscal and performance standards for a single point of entry agency include, but are not limited to, all of the following:
- (a) Maintaining administrative costs that are reasonable, as determined by the department of community health, in relation to spending per client.
 - (b) Identifying savings in the annual state medicaid budget or limits in the rate of growth of the annual state medicaid budget attributable to providing services under subsection (4) to consumers in need of long-term care services and supports, taking into consideration medicaid caseload and appropriations.

- (c) Consumer satisfaction with services provided under subsection (4).
- (d) Timeliness of delivery of services provided under subsection (4).
- (e) Quality, accessibility, and availability of services provided under subsection (4).
- (f) Completing and submitting required reporting and paperwork.
- (g) Number of consumers served.
- (h) Number and type of long-term care services and supports referrals made.

(i) Number and type of long-term care services and supports referrals not completed, taking into consideration the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(8) The department of community health shall develop standard cost reporting methods as a basis for conducting cost analyses and comparisons across all publicly funded long-term care systems and shall require single point of entry agencies to utilize these and other compatible data collection and reporting mechanisms.

(9) The department of community health shall solicit proposals from entities seeking designation as a single point of entry agency and, except as provided in subsection (16) and section 109j, shall initially designate not more than 4 agencies to serve as a single point of entry agency in at least 4 separate areas of the state. There shall not be more than 1 single point of entry agency in each designated area. An agency designated by the department of community health under this subsection shall serve as a single point of entry agency for an initial period of up to 3 years, subject to the provisions of subsection (6). In accordance with subsection (17), the department shall require that a consumer residing in an area served by a single point of entry agency designated under this subsection utilize that agency if the consumer is seeking eligibility for medicaid long-term care programs.

(10) The department of community health shall evaluate the performance of single point of entry agencies under this section on an annual basis.

(11) The department of community health shall engage a qualified objective independent agency to conduct a cost-benefit analysis of single point of entry, including, but not limited to, the impact on medicaid long-term care costs. The cost-benefit analysis required in this subsection shall include an analysis of the cost to hospitals when there is a delay in a patient's discharge from a hospital due to the hospital's compliance with the provisions of this section.

(12) The department of community health shall make a summary of the annual evaluation, any report or recommendation for improvement regarding the single point of entry, and the cost-benefit analysis available to the legislature and the public.

(13) Not earlier than 12 months after but not later than 24 months after the implementation of the single point of entry agency designated under subsection (9), the department of community health shall submit a written report to the senate and house of representatives standing committees dealing with long-term care issues, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on community health, and the senate and house fiscal agencies regarding the array of services provided by the designated single point of entry agencies and the cost, efficiencies, and effectiveness of single point of entry. In the report required under this subsection, the department of community health shall provide recommendations regarding the continuation, changes, or cancellation of single point of entry agencies based on data provided under subsections (4) and (10) to (12).

(14) Beginning in the year the report is submitted and annually after that, the department of community health shall make a presentation on the status of single point of entry and on the summary information and recommendations required under subsection (12) to the senate and house of representatives appropriations subcommittees on community health to ensure that legislative review of single point of entry shall be part of the annual state budget development process.

(15) The department of community health shall promulgate rules to implement this section not later than 270 days after submitting the report required in subsection (13).

(16) The department of community health shall not designate more than the initial 4 agencies designated under subsection (9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless all of the following occur:

- (a) The written report is submitted as provided under subsection (13).
- (b) Twelve months have passed since the submission of the written report required under subsection (13).
- (c) The legislature appropriates funds to support the designation of additional single point of entry agencies.

(17) A single point of entry agency for long-term care shall serve as the sole agency within the designated single point of entry area to assess a consumer's eligibility for medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(18) Although a community mental health services program may serve as a single point of entry agency to provide services to individuals with mental illness or developmental disability, community mental health services programs are not subject to the provisions of this act.

(19) Medicaid reimbursement for health facilities or agencies shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(20) The provisions of this section and section 109j do not apply after December 31, 2011.

(21) Funding for the MI Choice Waiver program shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(22) A single point of entry agency for long-term care may establish a memorandum of understanding with any hospital within its designated area that allows the single point of entry agency for long-term care to recognize and utilize an initial evaluation and preliminary long-term care support plan developed by the hospital discharge planner if those plans were developed with the consumer, his or her guardian, or his or her authorized representative.

(23) For the purposes of this section:

(a) "Administrative costs" means the costs that are used to pay for employee salaries not directly related to care planning and supports coordination and administrative expenses necessary to operate each single point of entry agency.

(b) "Administrative expenses" means the costs associated with the following general administrative functions:

(i) Financial management, including, but not limited to, accounting, budgeting, and audit preparation and response.

(ii) Personnel management and payroll administration.

(iii) Purchase of goods and services required for administrative activities of the single point of entry agency, including, but not limited to, the following goods and services:

(A) Utilities.

(B) Office supplies and equipment.

(C) Information technology.

(D) Data reporting systems.

(E) Postage.

(F) Mortgage, rent, lease, and maintenance of building and office space.

(G) Travel costs not directly related to consumer services.

(H) Routine legal costs related to the operation of the single point of entry agency.

(c) "Authorized representative" means a person empowered by the consumer by written authorization to act on the consumer's behalf to work with the single point of entry, in accordance with this act.

(d) "Guardian" means an individual who is appointed under section 5306 of the estates and protected individuals code, 1998 PA 386, MCL 700.5306. Guardian includes an individual who is appointed as the guardian of a minor under section 5202 or 5204 of the estates and protected individuals code, 1998 PA 386, MCL 700.5202 and 700.5204, or who is appointed as a guardian under the mental health code, 1974 PA 258, MCL 300.1001 to 300.2106.

(e) "Informed choice" means that the consumer is presented with complete and unbiased information on his or her long-term care options, including, but not limited to, the benefits, shortcomings, and potential consequences of those options, upon which he or she can base his or her decision.

(f) "Person-centered planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the consumer desires or requires.

(g) "Single point of entry" means a program from which a current or potential long-term care consumer can obtain long-term care information, screening, assessment of need, care planning, supports coordination, and referral to appropriate long-term care supports and services.

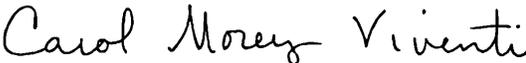
(h) "Single point of entry agency" means the organization designated by the department of community health to provide case management functions for consumers in need of long-term care services within a designated single point of entry area.

Sec. 109j. The department of community health shall not designate more than the initial 4 agencies designated under section 109i(9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless the conditions of section 109i(16) are met and the legislature repeals this section.

This act is ordered to take immediate effect.



Clerk of the House of Representatives



Secretary of the Senate

Approved

Governor

Act No. 674
Public Acts of 2006
Approved by the Governor
January 8, 2007
Filed with the Secretary of State
January 10, 2007
EFFECTIVE DATE: January 10, 2007

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Vander Veen, Zelenko, Newell, Marleau, Brandenburg, Gaffney, Hummel, Caswell, Stahl, Amos, Green, Hansen, Booher, Sheen, Kahn and Huizenga

ENROLLED HOUSE BILL No. 6478

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending sections 112b, 112c, and 112e (MCL 400.112b, 400.112c, and 400.112e), as added by 1995 PA 85; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

Sec. 112b. As used in this section and sections 112c to 112e:

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

(b) "Long-term care insurance policy" means a policy described in chapter 39 of the insurance code of 1956, 1956 PA 218, MCL 500.3901 to 500.3955.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in section 1917(b) of the social security act, 42 USC 1396p.

(d) “Long-term care partnership program policy” means a qualified long-term care insurance policy that the commissioner of the office of financial and insurance services certifies as meeting the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(e) “Medicaid” means the program of medical assistance established by the department of community health under section 105.

Sec. 112c. (1) Subject to subsection (5), the department of community health in conjunction with the office of financial and insurance services and the department of human services shall establish a long-term care partnership program in Michigan to provide for the financing of long-term care through a combination of private insurance and medicaid. It is the intent of the long-term care partnership program to do all of the following:

(a) Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

(b) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under medicaid without first being required to substantially exhaust their resources.

(c) Alleviate the financial burden on the state’s medical assistance program by encouraging the pursuit of private initiatives.

(2) An individual who is a beneficiary of a Michigan long-term care partnership program policy is eligible for assistance under the state’s medical assistance program using the asset disregard as provided under subsection (5).

(3) The department of community health shall pursue reciprocal agreements with other states to extend the asset disregard to Michigan residents who purchased long-term care partnership policies in other states that are compliant with title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(4) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (5), shall not be considered when determining any of the following:

(a) Medicaid eligibility.

(b) The amount of any medicaid payment.

(c) Any subsequent recovery by the state of a payment for medical services or long-term care services.

(5) Not later than 270 days after the effective date of the amendatory act that added this subsection, the department of community health shall apply to the United States department of health and human services for an amendment to the state’s medicaid state plan to establish that the assets an individual owns and may retain under medicaid and still qualify for benefits under medicaid at the time the individual applies for benefits is increased dollar-for-dollar for each dollar paid out under the individual’s long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

(6) If the long-term care partnership program is discontinued, an individual who purchased a Michigan long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

(7) The department of community health shall contract with the Michigan medicare medicaid assistance program or department of community health designated single point of entry agencies, or both, to provide counseling services under the Michigan long-term care partnership program.

(8) The department of community health, in consultation with the department of human services and the office of financial and insurance services, shall develop a notice to consumers detailing in plain language the pertinent provisions of qualified state long-term care insurance partnership policies as they relate to medicaid eligibility and shall determine the appropriate distribution of the notice. The notice shall be available in a printable form on the office of financial and insurance services’s website.

(9) The department, the department of community health, and the office of financial and insurance services shall post, on their respective websites, information on how to access the national clearinghouse established under the federal deficit reduction act of 2005, Public Law 109-171, when the national clearinghouse becomes available to consumers.

Sec. 112e. The department of community health, in consultation with the department of human services and the office of financial services, may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, as necessary to implement the partnership program in accordance with the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and applicable federal regulations or guidelines.

Enacting section 1. Section 112d of the social welfare act, 1939 PA 280, MCL 400.112d, is repealed.

This act is ordered to take immediate effect.



Clerk of the House of Representatives



Secretary of the Senate

Approved

Governor

U.S. Department of Health and Human Services | Administration on Aging

Own Your Future

Long-Term Care Awareness Campaign



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The Own Your Future Campaign is sponsored by 3 agencies within the U.S. Department of Health and Human Services: the Centers for Medicare and Medicaid (CMS), the Office of the Assistant Secretary of Planning and Evaluation (ASPE) and the Administration on Aging (AoA). The National Governors Association (GSA) has been a key partner in promoting the Campaign with the nation's Governors and state governments.

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The 2007 New Freedom Initiative Conference

Access to Community Living: Promoting Independence and Choice

March 5-7, 2007

Marriott Waterfront Hotel
Baltimore, Maryland

The Centers for Medicare & Medicaid Services (CMS) announces its 7th New Freedom Initiative Conference, "Access to Community Living: Promoting Independence and Choice."

"Choice and Independence" is a key pillar of CMS' vision for a person-centered long term services and supports system for the future. The 2007 conference will focus on the policies, programs and tools, including opportunities authorized by the Deficit reduction Act of 2007, available to shape and carry out the vision.

The agenda will include presentations on CMS's Roadmap for Reform and perspectives from consumers and advocates. Concurrent sessions will address components of programs that promote independence and choice. Participants will have opportunities to meet with CMS officials to discuss the roadmap, the options available and give their recommendations for reform.

Registration Application

Participants must apply to register for the conference. CMS will approve up to ten registrants from each state. Additional applicants may be approved once all states have had a chance to register. We encourage participation by Medicaid directors and staff, grantee project directors and staff who work on your grants or who are working on programs that promote home and community based services, consumers and other stakeholders.

To begin your application process, please go to www.nashp.org/cmsconference2007 and select "Register on line" at the bottom of the page, or contact Jackie Tichnell at 517-335-7803.

Please do not make airline or hotel reservations until your application has been approved by CMS. You will receive an email confirmation once it has been approved.

There is no registration fee for this conference. Funds for the travel and hotel costs may be available from the grants awarded to your state. A limited number of scholarships will be available to cover the travel costs for consumers. (See registration application).

Poster session

We welcome proposals for the poster session which will be part of the conference reception on Monday evening from 5:30 - 7:00 pm. The general poster session request form is attached.

For More Information: Contact Jen Tabor at the National Academy for State Health Policy (jtabor@nashp.org or 207-874-6524) if you have questions. More information about the conference will be posted to the conference web site as it becomes available at - www.nashp.org/cmsconference2007 .