



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

# Modernizing Continuum of Care (MCC) November 14, 2017 Skilled Nursing Facility (SNF) & Hospice

**“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”**

**-Provider Relations**

# Agenda

- Modernizing Continuum of Care (MCC)
  - Policy Information
  - Admission & Enrollment Forms
  - Discharge & Disenrollment
  - Claim
- Program Enrollment Type (PET)
- CHAMPS Changes
  - Display
  - Entering a Nursing Facility admission and discharge
  - Entering a Hospice enrollment and disenrollment
- Visual Aid
- Upcoming Training Dates
- Provider Resources

# Modernizing Continuum of Care (MCC)

---

# Policy Information

- MSA 1717, MSA 1718 and MSA 1719
- Modernizing Continuum of Care (MCC) project is designed to alleviate paper processes and manual intervention when adding admissions and enrollments for beneficiaries.
- Changes for all providers:
  - Level of Care (LOC) codes will be replaced with Program Enrollment Type (PET) codes which will identify a beneficiary's type of admission or Managed Care enrollment along with their living arrangements.
  - Patient Pay Amounts (PPA) will be displayed separately in a new 'Patient Pay' section at the bottom of the CHAMPS eligibility response page.
  - Medicaid Health Plan Providers will need to enroll in CHAMPS ([MSA 17-04](#)).
  - Managed care entities will move from multiple CHAMPS provider identification numbers (CHAMPS provider IDs) to a single provider ID per contract.

# Admission & Enrollment Forms

- Specific providers will directly enter admission/discharge or enrollment/disenrollment information in CHAMPS.
- All paper MSA 2565-C forms must be submitted to MDHHS by **December 15, 2017**.
  - This will allow adequate time for the paper form to be processed by the caseworker prior to MCC implementation.
- If after the implementation of MCC there is no admission or enrollment on file, a new admission or enrollment will need to be completed in CHAMPS.

# Discharge & Disenrollment

- Discharges & Disenrollment's will also be completed within CHAMPS.
- When an admission record at a second facility is created, the previous facilities admission record will be auto end-dated one day prior to the new admission record.
- Dependent on the program type, the admission record may or may not be auto end-dated.
  - e.g., Nursing Facility to Hospice, Hospice to Nursing Facility
    - Hospice to Hospice is exempt from this auto end-date process

# Claim

- The Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) for a beneficiary not having a PET on file will remain the same CARC and RARC for no LOC on file.
  - CARC: 251, 22, 96, 26, B7
  - RARC: N146, N598, N216
- If you are reviewing eligibility within CHAMPS for dates of service prior to MCC implementation the LOC record has been converted to a PET.

# Program Enrollment Type (PET) Codes

---



# PET Codes

- Crosswalk list of LOC to new PET MSA 1717
- PET codes will be a seven character code:
  - First three characters indicate program type
  - The last four characters indicate the living arrangement
- LOC codes 07 and 11 now crosswalk to multiple PET codes:
  - MHP-COMM for beneficiaries residing in the community
  - MHP-NFAC for beneficiaries in nursing facilities
  - MHP-HOSH for beneficiaries receiving hospice at home
  - MHP-HOSR for beneficiaries receiving hospice in one of the state's 16 licensed hospice residential facilities
  - MHP-HOSN for beneficiaries receiving hospice in a nursing facility

# PET Codes (cont.)

- Previously LOC 02:
  - LTC-NFAC Nursing Facility
  - LTC-CMCF Nursing Facility county medical care facility
- Previously LOC 16:
  - HOS-COMM Hospice at Community
  - HOS-NFAC Hospice as Nursing Facility
  - HOS-RESID Hospice at Residence Facility
  - MIC-HOSH Hospice at Community, along with MI Choice

# PET Codes (cont.)


- Previously LOC 55 and LOC 56
  - EXM-PASR Long Term Care Exempt PASR
  - EXM-MPRR Long Term Care Exempt MPRO
  - EXM-ALJD Long Term Care Exempt ALJD
  - EXM-DIVM Long Term Care Exempt for Divestment

# CHAMPS Changes\*

---

Screen changes within CHAMPS

  \*

- Select Profile
- CHAMPS Full Access
- CHAMPS Limited Access
- Claims Access
- Domain Administrator
- Eligibility Inquiry
- NF Admission 
- Prior Authorization Access
- Provider Enrollment Access
- View Provider Enrollment

- In order to enter or view admission information select the appropriate profile  
Available profiles: Hospital Admission, Hospice Admission, NF Admission, SPF Admin, PACE Enrollment and MI Choice Enrollment

Member ID: \_\_\_\_\_ Name: \_\_\_\_\_

Close

Fee for Service Dental Coverage (Note: Refer to Medicaid Provider Manual/MDHHS website for details on covered services including PA, copay and other requirements. Some services may not be covered if age 21 and older.)

INQUIRY DATE RANGE: 12/15/2016 - 12/15/2016  
 GENDER: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 CASE NUMBER: \_\_\_\_\_  
 CASE PHONE: EXT: \_\_\_\_\_  
 CASE EMAIL: \_\_\_\_\_  
 COUNTY OF RESIDENCE: \_\_\_\_\_  
 MAGI CATEGORY: \_\_\_\_\_  
 MA PROGRAM CODE: \_\_\_\_\_  
 CITIZENSHIP: \_\_\_\_\_  
 REDETERMINATION DATE: 01/31/2012

COMMERCIAL / OTHER: N  
 CSHCS RESTRICTIONS: N  
 MHP PCP: Y  
 BMP PROVIDER RESTRICTION: N  
 INDICATORS: N  
 COST SHARE MET: Y  
 CAP AMOUNT REMAINING(\$): 0.00  
 WORKER LOAD NUMBER: \_\_\_\_\_  
 MDHHS PHONE: \_\_\_\_\_  
 MDHHS COUNTY: \_\_\_\_\_

[Print Member Summary](#)  
[Non Covered Service Types](#)

**BENEFIT PLANS**

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
MA-MC	MHP-COMM	MANAGED CARE	4318627	<a href="#">Click To View Service Types</a>	01/06/2011	01/06/2011	10/01/2004	12/31/2999
CSHCS-MC	MHP-COMM	MANAGED CARE	2304993	<a href="#">Click To View Service Types</a>	09/18/2011	09/18/2011	09/09/2011	12/31/2999
MME-MC	MHP-COMM	MANAGED CARE	2304999	<a href="#">Click To View Service Types</a>	01/06/2011	01/06/2011	09/01/2009	12/31/2999
ICO-MC	ICO-COMM	MANAGED CARE	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999
NH	LTC-NFAC	FEE FOR SERVICE	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999
MC-EXM	EXM-CCI	NO BENEFITS	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999

View Page: 1 Page Count SaveToXLS Viewing Page: 1

**PATIENT PAY**

Services Applicable	Patient Pay Amount	PPA Start Date	PPA End Date
LTC/In-Patient	120.00	01/01/2014	12/31/2999

View Page: 1 Page Count SaveToXLS Viewing Page: 1

- Within the benefit plan section of the CHAMPS eligibility screen the PET will now be displayed to indicate the beneficiary enrollment type
  - All prior LOC records will be converted to PET's prior to implementation

Member ID: \_\_\_\_\_ Name: \_\_\_\_\_

Close

Fee for Service Dental Coverage (Note: Refer to Medicaid Provider Manual/MDHHS website for details on covered services including PA, copay and other requirements. Some services may not be covered if age 21 and older.)

INQUIRY DATE RANGE: 12/15/2016 - 12/15/2016	COMMERCIAL / OTHER: N
GENDER:	CSHCS RESTRICTIONS: N
DATE OF BIRTH:	MHP PCP: Y
CASE NUMBER:	BMP PROVIDER RESTRICTION: N
CASE PHONE: EXT:	INDICATORS: N
CASE EMAIL:	COST SHARE MET: Y
COUNTY OF RESIDENCE:	CAP AMOUNT REMAINING(\$): 0.00
MAGI CATEGORY:	WORKER LOAD NUMBER: .
MA PROGRAM CODE:	MDHHS PHONE: .
CITIZENSHIP:	MDHHS COUNTY: .
REDETERMINATION DATE: 01/31/2012	

[Print Member Summary](#)  
[Non Covered Service Types](#)

**BENEFIT PLANS**

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
MA-MC	MHP-COMM	MANAGED CARE	4318627	<a href="#">Click To View Service Types</a>	01/06/2011	01/06/2011	10/01/2004	12/31/2999
CSHCS-MC	MHP-COMM	MANAGED CARE	2304993	<a href="#">Click To View Service Types</a>	09/18/2011	09/18/2011	09/09/2011	12/31/2999
MME-MC	MHP-COMM	MANAGED CARE	2304999	<a href="#">Click To View Service Types</a>	01/06/2011	01/06/2011	09/01/2009	12/31/2999
ICO-MC	ICO-COMM	MANAGED CARE	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999
NH	LTC-NFAC	FEE FOR SERVICE	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999
MC-EXM	EXM-CCI	NO BENEFITS	2813568	<a href="#">Click To View Service Types</a>	12/24/2013	12/24/2013	01/01/2014	12/31/2999

View Page: 1 Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

**PATIENT PAY**

Services Applicable	Patient Pay Amount	PPA Start Date	PPA End Date
LTC/In-Patient	120.00	01/01/2014	12/31/2999

View Page: 1 Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

- The Patient Pay amount (PPA) is displayed within it's own section at the bottom of the member eligibility screen within CHAMPS
  - The PPA amount will be returned in the same loop/segment within the 271 response

Close Add Enrollment/Admission

### Member Enrollment/Admission List

Filter By [dropdown] [input] Filter By [dropdown] [input] Filter By [dropdown] [input]  
All [dropdown] Go Save Filters My Filters ▾

Action	Transaction ID	Member ID	First Name	Last Name	Start Date	End Date	Status	Created By	Created Date
Select ▾					03/08/2014	12/31/2999	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					05/22/2014	05/25/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					02/20/2014	02/21/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					02/06/2014	02/09/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					01/29/2014	03/03/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					04/02/2014	08/30/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					07/05/2014	07/18/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					03/16/2014	03/17/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					06/12/2014	06/14/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					11/30/2013	02/15/2014	COMPLETED	Process, Data Conversion	08/13/2017

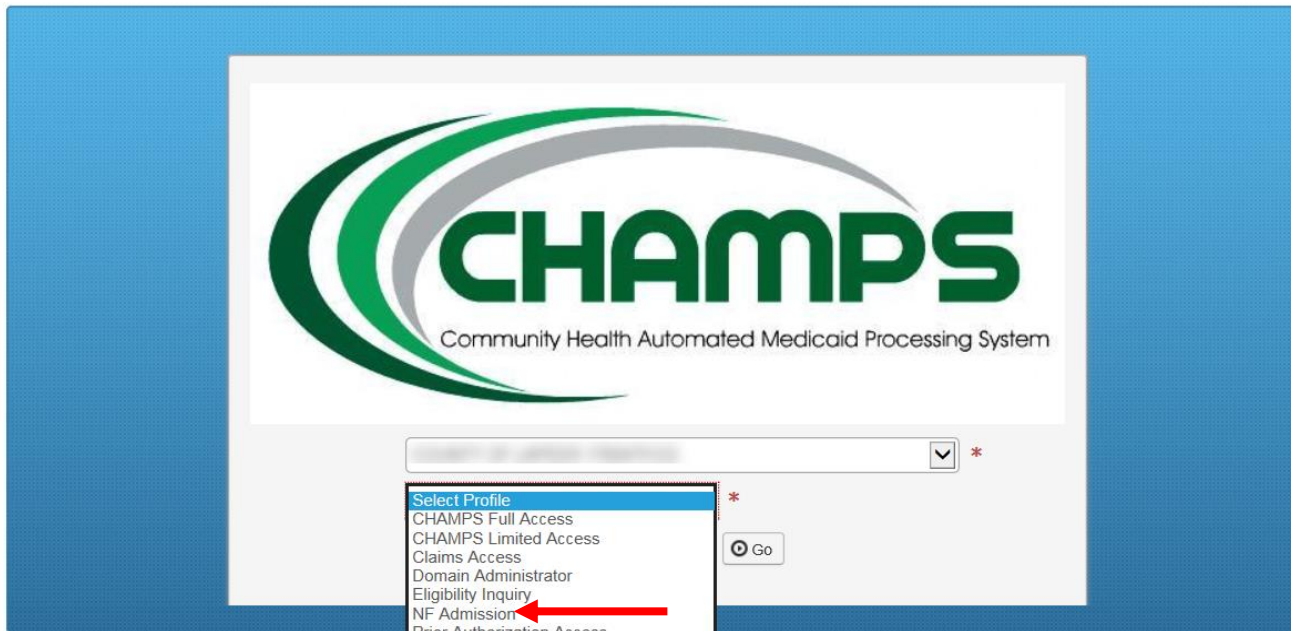
- This is the roster page which will list all admissions submitted under the NPI that is logged into CHAMPS



# Entering a Nursing Facility admission

---

Steps on how to enter a Nursing Facility admission within CHAMPS



- In order to enter or view admission information select the appropriate profile  
Available profiles: Hospital Admission, Hospice Admission, NF Admission, SPF Admin, PACE Enrollment and MI Choice Enrollment

CHAMPS

My Inbox ▾ Provider ▾ Member ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal

NPI: [REDACTED] Name: [REDACTED]

Latest update

**System Notification**

Due to R9-6.5 Release, the CHAMPS system will be down between 7:00 PM Friday, December 15th through 8:00 AM Saturday, December 17th, 2016. This outage will affect the CHAMPS system access for all functionality.

**My Reminders**

Filter By [ ] [ ] [Go] Save Filters My Filters ▾

Alert Type	Alert Message	Alert Date	Due Date	Read
No Records Found !				

**Calendar**

13:01 8 September 2017 Friday

2017 September

Mo	Tu	We	Th	Fr	Sa	Su
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	
←		Today		→		

- After logging into CHAMPS
- Click Member tab
- Select Program Enrollment/Admission

Close Add Enrollment/Admission ←

Action	Transaction ID	Member ID	First Name	Last Name	Start Date	End Date	Status	Created By	Created Date
Select ▾					03/08/2014	12/31/2999	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					05/22/2014	05/25/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					02/20/2014	02/21/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					02/06/2014	02/09/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					01/29/2014	03/03/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					04/02/2014	08/30/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					07/05/2014	07/18/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					03/16/2014	03/17/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					06/12/2014	06/14/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select ▾					11/30/2013	02/15/2014	COMPLETED	Process, Data Conversion	08/13/2017

View Page: 2 Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- Within the roster page click Add Enrolment/Admission
- Throughout the entire admission/enrollment process all fields marked with a red asterisk are required

CHAMPS

My Inbox Provider Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name:

### Member Information

<b>*Program Type</b>	<b>*NPI/Provider ID:</b>	<b>Provider Name:</b>
NURSING FACILITY		
<b>Medicaid ID</b>	<b>SSN</b>	<b>*Date of Birth</b>
Medicaid ID	XXX-XX-XXXX	MM/DD/YYYY
<b>*First Name</b>	<b>Middle Name</b>	<b>*Last Name</b>
<b>*Gender</b>	<b>Marital Status</b>	
---SELECT---	---SELECT---	

Next

- New CHAMPS admission and enrollment screen
- Enter the Medicaid ID
- If no Medicaid ID enter all required information
- Click Next

CHAMPS < My Inbox > Provider > Member >

Provider Portal > Member Enrollment Admission List

NPI: [Redacted] Provider Name: [Redacted] [Close]

Member Information [x] Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification

### Admission/Enrollment Information

**\*Date of Admission/Enrollment**

**\*Is this stay custodial or rehabilitative ?**  
 Custodial  Rehabilitative

**\*Type of Facility**

**\*Facility Contact Person**

**\*Is the Individual Expected to Move to Community?**  
 No  Yes

**\*Is this Admission Likely to be 30 days or Longer?**  
 No  Yes

**Primary Diagnosis Code**

**\*Is this stay for Hospice Services?**  
 No  Yes

**Comments**

**\*Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?**  
 No  Yes

**\*Facility Phone Number**

**\*Is the Individual Expected to Return Home within 12 months of Facility Admission Date?**  
 No  Yes

**Estimated Length of Stay (in Months)**

**Secondary Diagnosis Code**

**\*Has this patient already been discharged from this facility?**  
 No  Yes

**Next**

- The Admission/Enrollment Information screen will need all information related to the admission
- Click Next

The screenshot displays the CHAMPS web application interface. The top navigation bar includes the CHAMPS logo, a user profile icon, and menu items: My Inbox, Provider, and Member. A secondary navigation bar contains utility icons: Quick Find, Note Pad, External Links, My Favorites, Print, and Help. The breadcrumb trail reads: Provider Portal > Member Enrollment Admission List > LOCD List > Member Enrollment Admission List. The main header shows the NPI and Provider Name fields, with a Close button on the right. A left sidebar lists various information categories: Member Information, Admission Information (highlighted), Discharge Information, Responsible Party Info, Address Information, Previous Facility Info, Insurance Information, Upload Documents, and Certification. The main content area is titled "Admission/Enrollment Information" and contains several form fields and questions, including: Date of Admission/Enrollment (04/01/2016), Is this stay custodial or rehabilitative? (Custodial selected), Type of Facility (dropdown), Is the Individual Anticipated to have Out-of-Pocket Medical Expenses? (No selected), Facility Contact Person, Facility Phone Number, Is the Individual Expected to Move to Community? (No selected), Is this Admission Likely to be 30 days or Longer? (No selected), Primary Diagnosis Code, Secondary Diagnosis Code, Is this stay for Hospice Services? (No selected), and Has this patient already been discharged from this facility? (No selected). A "Comments" text area is also present. A modal dialog box titled "Message from webpage" is overlaid on the form, containing a question mark icon and the text: "An ongoing active NF Admission record is already present in CHAMPS for the same member with [redacted]. Do you still want to continue?". The dialog has "OK" and "Cancel" buttons.

- If there's an existing admission/enrollment you will receive this soft error.
- Click Ok to continue or cancel

The screenshot displays the CHAMPS Member Enrollment Admission List interface. The top navigation bar includes 'My Inbox', 'Provider', and 'Member' tabs. The main content area is titled 'Responsible Party Information' and contains the following form fields:

- First Name:** Input field with placeholder text 'First Name'.
- Middle Name:** Input field with placeholder text 'Middle initial'.
- Last Name:** Input field with placeholder text 'Last Name'.
- Relationship to Patient:** Dropdown menu with 'Select' as the current selection.
- Phone number:** Input field.

A 'Next' button is located at the bottom right of the form area, highlighted with a red box.

- Enter Responsible Party Information if different than the beneficiary/patient.
- Click Next



CHAMPS My Inbox Provider Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information ✓

Admission Information ✓

Discharge Information

Responsible Party Info ✓

Address Information →

Previous Facility Info

Insurance Information

Upload Documents

Certification

### Address Information

Address Type	Address	Actions
		<input type="button" value="Add"/>

- If Address Information pre-populates click Next
- Click Add to enter address information
  - *Note: Home address information must be entered for submitting an admission for a patient who has no Medicaid ID number.*

The screenshot displays the CHAMPS Member Enrollment Admission List interface. The top navigation bar includes the CHAMPS logo, navigation tabs for 'My Inbox', 'Provider', and 'Member', and utility icons for 'Quick Find', 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The breadcrumb trail shows 'Provider Portal > Member Enrollment Admission List'. The main content area is titled 'Address Information' and features a table with columns for 'Address Type', 'Address', and 'Actions'. An 'Add' button is located below the table. The form below the table contains several fields: a dropdown for 'Address Type', text boxes for 'Address Line 1', 'Address Line 2', and 'Address Line 3', dropdowns for 'State/Province' (set to 'OTHER'), 'City/Town' (set to 'OTHER'), and 'Country' (set to 'UNITED STATES'), and a 'Zip Code' field. A 'Validate Address' button is positioned below the 'Zip Code' field. At the bottom of the form, there are 'Save' and 'Cancel' buttons. A 'Next' button is located at the bottom right of the page.

- Select the address type and enter the required asterisked information
- Click Validate Address
- Click Save
- Click Next

- Member Information ✓
- Admission Information ✓
- Discharge Information
- Responsible Party Info ✓
- Address Information ✓
- Previous Facility Info
- Insurance Information
- Upload Documents
- Certification

### Previous Provider/Facility Information

**Previous Service Location**

**Previous Provider/Facility Admission/Enrollment Date**

**Previous Provider/Facility Discharge/Disenrollment Date**

**Previous Provider/Facility NPI/Provider ID**

**Previous Provider/Facility Name**

**Previous Provider/Facility Contact Person**

**Previous Provider/Facility Contact Phone Number**

Next

- Enter the prior facility information if applicable
- Click Next

CHAMPS

My Inbox ▾ Provider ▾ Member ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] Close

Member Information ✓

Admission Information ✓

Discharge Information

Responsible Party Info ✓

Address Information ✓

Previous Facility Info ✓

Insurance Information →

Upload Documents

Certification

### Other Insurance Information

Other Insurance Available: [View TPL](#)

Type of Insurance	Insurance Company	Policy Number	Group Number	Beneficiary Identifier	Policy Holder Employer Name	Policy Holder Name
<input type="button" value="Add"/>						

Next

- Click View TPL if hyperlink to review the other insurance information on file for the beneficiary
- Click Next

The screenshot displays the CHAMPS Member Enrollment Admission List interface. The top navigation bar includes the CHAMPS logo, navigation tabs for 'My Inbox', 'Provider', and 'Member', and utility icons for 'Quick Find', 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The breadcrumb trail shows 'Provider Portal > Member Enrollment Admission List'. The main content area is titled 'Other Insurance Information' and includes a table with columns for insurance details. An 'Add' button is highlighted with a red box.

Type of Insurance	Insurance Company	Policy Number	Group Number	Beneficiary Identifier	Policy Holder Employer Name	Policy Holder Name
<input type="button" value="Add"/>						

- If the beneficiary has other insurance not listed on their TPL information screen click Add to enter the insurance information

- Member Information ✓
- Admission Information ✓
- Discharge Information
- Responsible Party Info ✓
- Address Information ✓
- Previous Facility Info ✓
- Insurance Information
- Upload Documents
- Certification

## Other Insurance Information

Other Insurance Available: [View TPL](#)

Type of Insurance	Insurance Company	Policy Number	Group Number	Beneficiary Identifier	Policy Holder Employer Name	Policy Holder Name
<input type="button" value="Add"/>						

**\*Type of Insurance:**

**Policy Holder First Name:**

**Policy Holder Last Name:**

**Policy Holder SSN:**

**Policy Holder Date of Birth:**

- Select the type of insurance
- Enter policy holder information
- Click Save
- Click Next

CHAMPS

My Inbox Provider Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name:

Close

Member Information ✓

Admission Information ✓

Discharge Information

Responsible Party Info ✓

Address Information ✓

Previous Facility Info ✓

Insurance Information ✓

Upload Documents →

Certification

## Upload Documents

Type of Document	ID	Description
------------------	----	-------------

Add

Next

- At this time the Upload Documents page is not being used
- Click Next

CHAMPS

My Inbox ▾ Provider ▾ Member ▾

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] XClose

Member Information ✓  
 Admission Information ✓  
 Discharge Information  
 Responsible Party Info ✓  
 Address Information ✓  
 Previous Facility Info ✓  
 Insurance Information ✓  
 Upload Documents ✓  
**Certification**

### Certification

**Member Certification**

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in the Admission Information Section above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

**Signature of Member/Authorized Representative** **Date**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Member/Authorized Representative First Name** **\*Member/Authorized Representative Last Name**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

**Provider Certification**

In accordance with the Michigan Medicaid Provider Manual, Eligibility Chapter, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.

**Provider Signature** **Date**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Provider First Name** **\*Provider Last Name**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Submit

- Place a check next to both the member and provider certification boxes
  - Note :The fields for signature and date cannot be modified as these fields need to be completed once the admission notice is printed.
- Type the provider representative completing the admission
- Click Submit



# Member Certification Message

- I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in the Admission Information Section above, the name(s) and address(es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

# Provider Certification (cont.)

- NF Provider:

In accordance with the Michigan Medicaid Provider Manual, Eligibility Chapter, Section 12.1, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.

The screenshot shows the CHAMPS Member Enrollment Admission List page. A confirmation dialog box titled "Summary" is displayed in the center. The dialog contains the following information:

- Program Type:** Nursing Facility
- Medicaid ID:** [Redacted]
- Member Name:** [Redacted]
- Date Of Admission/Enrollment:** 01/01/2017
- Date Of Discharge/Disenrollment:** [Redacted]

Below the summary information, it states: "If the Summary information is accurate, click OK to Submit, else click Cancel to return to the form to make corrections." The "OK" button is highlighted with a red box. The background shows the "Certification" section of the form, including fields for Member/Authorized Representative First Name and Last Name, and the Provider Certification section with a signature and date field.

- After clicking submit you will receive a confirmation summary page
- Click Ok
  - *Note: Click Cancel if any of the information displayed is incorrect in order to update the information prior to submitting the admission*

CHAMPS < My Inbox > Provider > Member >

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] Close

**Certification**

**Member Certification**

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in the Admission Information Section above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

**Signature of Member/Authorized Representative**      **Date**

Signature: [REDACTED]      Date: [REDACTED]

**\*Member/Authorized Representative First Name**      **\*Member/Authorized Representative Last Name**

Donald      Duck

**Provider Certification**

In accordance with the Michigan Medicaid Provider Manual, Eligibility Chapter, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.

**Provider Signature**      **Date**

Signature: [REDACTED]      Date: [REDACTED]

**\*Provider First Name**      **\*Provider Last Name**

Amanda      MDHHS

Print

- Print the admission so the beneficiary or authorized representative and provider representative can sign the admission notice
- It is the providers responsibility to retain the admission notice in the beneficiaries record



**\*\*Sample admission notice\*\***

**MICHIGAN MEDICAID MEMBER ENROLLMENT ADMISSION FORM**

**Applicant Information**

NPI: 1234567890  
PROVIDER NAME: Nursing Facility

**Member Information**

Program Type: NURSING FACILITY  
SSN (Last 4 Digits): 0000  
First Name: SAMPLE  
Middle Name:  
Marital Status:  
Medicaid ID: 00000XXXXX  
Date Of Birth: 01/01/1950  
Last Name: SAMPLE  
Gender: Female

**Admission/Enrollment Information**

Date of Admission/Enrollment: 01/01/2017  
Type of Facility: County Medical Care Facility  
Facility Contact Person: Mrs Jones  
Primary Diagnosis Code:  
Estimated Length of Stay (in Months):  
Facility Contact Phone Number: (517) 555-1212  
Secondary Diagnosis Code:

Is the Individual Expected to Move to Community ? : NO  
Is the Individual Anticipated to have Out-of-Pocket Medical Expenses? : NO  
Type of Stay custodial or rehabilitative : Rehabilitative  
Is this Admission likely to be 30 days or longer? : NO  
Is this stay for Hospice Services : NO  
Is the Individual Expected to Return Home within 12 months of Facility Admission Date ? : NO  
Has this patient already been discharged from this facility ? : NO

**Discharge/Disenrollment Information**

Type of Discharge/Disenrollment:  
Reason:  
Remarks:  
Discharge to:  
Address Line1:  
Address Line3:  
State/Province:  
Zip Code:  
Date of Discharge/Disenrollment:  
Name of facility (If Applicable):  
Address Line2:  
City/Town:  
County:  
Country:

**Responsible Party Information**

First Name: Mr.  
Last Name: Jones  
Phone Number: (517) 555-1212  
Middle Name:  
Relationship to Patient: Husband

**Address Information**

ADDRESS TYPE :Home  
ADDRESS :320 S Walnut St, 48933

Beneficiary First Name  
SAMPLE

Medicaid ID  
00000XXXXX

- After clicking print the admission notice will pop-up as a PDF
- Click print from the PDF version to complete



CHAMPS

My Inbox ▾ Provider ▾ Member ▾

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

**Member Information**

- Member Information
- Admission Information
- Discharge Information
- Responsible Party Info
- Address Information
- Previous Facility Info
- Insurance Information
- Upload Documents
- Certification**

### Certification

**Member Certification**

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in the Admission Information Section above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

**Signature of Member/Authorized Representative** **Date**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Member/Authorized Representative First Name** **\*Member/Authorized Representative Last Name**

Donald \_\_\_\_\_ Duck \_\_\_\_\_

**Provider Certification**

In accordance with the Michigan Medicaid Provider Manual, Eligibility Chapter, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.

**Provider Signature** **Date**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Provider First Name** **\*Provider Last Name**

Amanda \_\_\_\_\_ MDHHS \_\_\_\_\_

Print

- Click Member Enrollment Admission List hyperlink or Close to return to the roster list page

# Entering a Discharge

---

Steps for completing a Nursing Facility discharge within CHAMPS

Close Add Enrollment/Admission

### Member Enrollment/Admission List

Filter By [ ] [ ] Filter By [ ] [ ] Filter By [ ] [ ]  
All [ ] Go Save Filters My Filters

Action	Transaction ID	Member ID	First Name	Last Name	Start Date	End Date	Status	Created By	Created Date
Select Delete Discharge/Disenroll Edit Details Review View Details View Eligibility					03/08/2014	12/31/2999	COMPLETED	Process, Data Conversion	08/13/2017
Select					05/22/2014	05/25/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					02/20/2014	02/21/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					02/06/2014	02/09/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					01/29/2014	03/03/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					04/02/2014	08/30/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					07/05/2014	07/18/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					03/16/2014	03/17/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					06/12/2014	06/14/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					11/30/2013	02/15/2014	COMPLETED	Process, Data Conversion	08/13/2017

- Roster page:
- Next to the Member ID needing to be discharged, from the action column select Discharge/Dis-enroll



CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information  
Admission Information  
**Discharge Information**  
Responsible Party Info  
Address Information  
Previous Facility Info  
Insurance Information  
Upload Documents  
Certification  
Review

### Discharge/Disenrollment Information

**\*Type of Discharge/Disenrollment**

---SELECT---  
VLN-Voluntary  
DTH-Death  
IVLN-Involuntary  
--SELECT--

**\*Date of Discharge/Disenrollment**

MM/DD/YYYY

**Remarks**

**Discharge to**

Select

**Name of facility (If Applicable)**

The Address Information is conditionally required. Please complete if known.

**Address Line 1:** \* (Enter Street Address or PO Box Only)

**Address Line 2:**

**Address Line 3:**

**City/Town:** \* OTHER

**State/Province:** \* OTHER

**County:** OTHER

**Country:** \* UNITED STATES

**Zip Code:**

Validate Address

**Submit**

- Select the type of discharge from the dropdown
- Enter the required asterisked information
- Click Submit when complete

CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information **Discharge Information** Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: DTH-Death

\*Reason: Death

\*Date of Death: MM/DD/YYYY

Remarks:

Discharge to: Select

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: \* (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province: \* OTHER

City/Town: \* OTHER

County: OTHER

Country: \* UNITED STATES

Zip Code: -

Validate Address

Submit

- When type of discharge DTH-Death is selected the reason pre-populates as death.
- Enter the date of death
- Click Submit

CHAMPS < My Inbox ▾ Provider ▾ Claims ▾ Reference ▾ Member ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Member Enrollment Admission List

NPI: Provider Name Close

Member Information  
Admission Information  
**Discharge Information**  
Responsible Party Info  
Address Information  
Previous Facility Info  
Insurance Information  
Upload Documents  
Certification  
Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: VLN-Voluntary ▾

\*Date of Discharge/Disenrollment: MM/DD/YYYY

\*Reason: --SELECT--  
Home  
Community  
Facility  
Hospital  
State Psych  
Jail

Remarks:

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: \* (Enter Street Address or PO Box Only)  
Address Line 2: \*  
Address Line 3: \*  
State/Province: \* OTHER ▾  
Country: \* UNITED STATES ▾

City/Town: \* OTHER ▾  
County: OTHER ▾  
Zip Code: -

Validate Address

Submit

- Type of discharge VLN-Voluntary is selected you have 5 reasons available to select:
  - Home
  - Community
  - Facility
  - Hospital State Psych
  - Jail

CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

MyInbox Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: IVLN-Involuntary

\*Date of Discharge/Disenrollment: MM/DD/YYYY

\*Reason: --SELECT--  
 Non-Payment  
 Welfare of Resident/Needs cannot be met  
 Safety of Other Residents  
 Facility Closure  
 Emergency - Flood, Fire etc.  
 Not eligible for LTC

Remarks:

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: (Enter Street Address or PO Box Only)  
 Address Line 2:  
 Address Line 3:  
 City/Town: OTHER  
 State/Province: OTHER  
 County: OTHER  
 Country: UNITED STATES  
 Zip Code: Validate Address

Submit

- Type of discharge IVLN-Involuntary is selected you have 6 reasons available to select:
  - Non-Payment
  - Welfare of Resident/Needs cannot be met
  - Safety of Other Residents
  - Facility Closure
  - Emergency-Flood, Fire etc.
  - Not eligible for LTC

The screenshot shows the CHAMPS Member Enrollment Admission List interface. A summary dialog box is displayed, containing the following information:

- Program Type:** Nursing Facility
- Medicaid ID:** [REDACTED]
- Medicaid Name:** [REDACTED]
- Date Of Admission/Enrollment:** 04/01/2016
- Date Of Discharge/disenrollment:** 01/01/2017

Below the summary information, a message states: "If the Summary information is accurate, click OK to Submit, else click Cancel to return to the form to make corrections." Two buttons are visible: "Cancel" and "Ok". The "Ok" button is highlighted with a red box.

The background interface includes a navigation menu on the left with options like "Member Info", "Admission Info", "Discharge Info", "Responsible Party", "Address Info", "Previous Facilities", "Insurance Information", "Upload Documents", "Certification", and "Review". The main form area contains fields for "Discharge to" (a dropdown menu), "Name of facility (If Applicable)", "Address Line 1", "Address Line 2", "Address Line 3", "State/Province", "City/Town", "County", "Country", and "Zip Code". A "Validate Address" button is located below the zip code field. A "Submit" button is visible at the bottom right of the form.

- After clicking submit you will receive the confirmation summary page
- Click Ok
  - Note: Click Cancel if any of the information displayed is incorrect in order to update the information prior to submitting the discharge

CHAMPS < My Inbox > Provider > Member >

Provider Portal > Member Enrollment Admission List

NPI: [Redacted] Provider Name: [Redacted] Close

Member Information [x] Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification

### Admission/Enrollment Information

\*Date of Admission/Enrollment  
MM/DD/YYYY

\*Is this stay custodial or rehabilitative?  
 Custodial  Rehabilitative

\*Type of Facility  
Select

\*Facility Contact Person

\*Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?  
 No  Yes

\*Facility Phone Number

\*Is the Individual Expected to Move to Community?  
 No  Yes

\*Is the Individual Expected to Return Home within 12 months of Facility Admission Date?  
 No  Yes

\*Is this Admission Likely to be 30 days or Longer?  
 No  Yes

Estimated Length of Stay (in Months)  
Select

Primary Diagnosis Code

Secondary Diagnosis Code

\*Is this stay for Hospice Services?  
 No  Yes

\*Has this patient already been discharged from this facility?  
 No  Yes

Comments

Next

- Discharging the Resident while entering the admission
  - *Has the patient already been discharged from this facility*
- Click Next.

# Example Nursing Facility Admissions

- The following slides display some example error messages that will pop-up when entering an admission for a beneficiary who is currently enrolled in one of the following programs:
  - PACE
  - ICO
  - Medicaid Health Plans
  - Hospice
- For the following program types the admission will end date the enrollment if the beneficiary is admitted to a SNF:
  - MICHoice and HCBS
- Per current MSA policy admissions must have an active LOCD tool that covers the date of the admission

The screenshot shows the CHAMPS Member Enrollment Admission List form. The form is titled "Admission/Enrollment Information" and contains several sections with input fields and radio buttons. A modal dialog box titled "Message from webpage" is overlaid on the form, displaying a question: "The member is currently in the PACE program. Do you still want to continue?". The dialog box has "OK" and "Cancel" buttons. The form includes fields for "Date of Admission/Enrollment" (11/01/2016), "Type of Facility" (County Medical Care Facility), "Facility Contact Person" (Lynn), and "Primary Diagnosis Code" (LOADING...). There are also several questions with radio buttons, such as "Is this stay custodial or rehabilitative?", "Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?", "Is the Individual Expected to Move to Community?", "Is this Admission Likely to be 30 days or Longer?", "Is this stay for Hospice Services?", and "Has this patient already been discharged from this facility?". A "Next" button is visible in the bottom right corner of the form.

- Entering a Nursing Facility Admission for a beneficiary who is enrolled in PACE on the date of admission.
- Click Ok to continue the admission
  - *Note: The PACE enrollment will remain active and the PET will end date one day prior to the SNF admission.*



CHAMPS < My Inbox > Provider > Claims > Reference > Member >

MyInbox > Member Eligibility Inquiry > Member Benefit Level

Member ID: [REDACTED] Name: [REDACTED]

Close

INQUIRY DATE RANGE: [REDACTED] COMMERCIAL / OTHER: Y  
 GENDER: [REDACTED] CSHCS RESTRICTIONS: N  
 DATE OF BIRTH: [REDACTED] MHP PCP: N  
 CASE NUMBER: [REDACTED] BMP PROVIDER RESTRICTION: N  
 CASE PHONE: [REDACTED] EXT: [REDACTED] INDICATORS: N  
 CASE EMAIL: [REDACTED]  
 COUNTY OF RESIDENCE: [REDACTED]  
 MAGI CATEGORY: [REDACTED] WORKER LOAD NUMBER: [REDACTED]  
 MA PROGRAM CODE: [REDACTED] MDHHS PHONE: [REDACTED]  
 CITIZENSHIP: [REDACTED] MDHHS COUNTY: [REDACTED]  
 REDETERMINATION DATE: [REDACTED]

[Print Member Summary](#)  
[Non Covered Service Types](#)

**BENEFIT PLANS**

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
<a href="#">PACE</a>	PCE-CMCF	MANAGED CARE	[REDACTED]	<a href="#">Click To View Service Types</a>	11/13/2017	11/13/2017	10/01/2017	11/13/2017
<a href="#">PACE</a>	PCE-COMM	MANAGED CARE	[REDACTED]	<a href="#">Click To View Service Types</a>	11/13/2017	11/13/2017	09/01/2017	09/30/2017

View Page: 1 | Go | Page Count | SaveToXLS | Viewing Page: 1 | First | Prev | Next | Last

- Entering a Nursing Facility Admission during a PACE open enrollment period.
- The existing PET or BP will become inactive and the new PCE-CMCF will become active effective the admission date
  - Note the PACE BP will remain to indicate that PACE is the overseeing program.

The screenshot shows the CHAMPS web application interface. The main content area is titled "Admission/Enrollment Information". A modal dialog box titled "Message from webpage" is centered on the screen, containing the following text: "The member is currently in the MIChoice program. Do you still want to continue?". Below the text are "OK" and "Cancel" buttons. The background form includes the following fields and options:

- Date of Admission/Enrollment:** 06/29/2016
- Is this stay custodial or rehabilitative?:**  Custodial  Rehabilitative
- Type of Facility:** County Medical Care Facility
- Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?:**  No  Yes
- Facility Contact Person:** Lynn
- Is the Individual Expected to Move to Community?:**  No  Yes
- Is this Admission Likely to be 30 days or Longer?:**  No  Yes
- Primary Diagnosis Code:** LOADING...
- Secondary Diagnosis Code:** LOADING...
- Is this stay for Hospice Services?:**  No  Yes
- Has this patient already been discharged from this facility?:**  No  Yes
- Comments:** (Empty text area)

- Entering a Nursing Facility Admission for a beneficiary who is enrolled in MIChoice or HCBS on the date of admission.
- Click Ok to continue the admission
  - *Note: After clicking Ok the enrollment and PET on file will end date one day prior to the SNF admission.*

The screenshot shows the CHAMPS web application interface. The top navigation bar includes 'My Inbox', 'Provider', and 'Member' tabs. The main content area is titled 'Admission/Enrollment Information'. A modal dialog box is open, displaying a question: 'The member is currently in the Hospice program. Do you still want to continue?' with 'OK' and 'Cancel' buttons. The form fields visible include:

- Date of Admission/Enrollment:** 10/01/2017
- Is this stay custodial or rehabilitative?:**  Custodial  Rehabilitative
- Type of Facility:** County Medical Care Facility
- Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?:**  No  Yes
- Facility Contact Person:** Lynn
- Is the Individual Expected to Move to Community?:**  No  Yes
- Is this Admission Likely to be 30 days or Longer?:**  No  Yes
- Primary Diagnosis Code:** (Loading indicator)
- Secondary Diagnosis Code:** (Loading indicator)
- Is this stay for Hospice Services?:**  No  Yes
- Has this patient already been discharged from this facility?:**  No  Yes
- Comments:** (Empty text box)

- Entering a Nursing Facility Admission for a beneficiary who is enrolled in Hospice on the date of admission.
- Click Ok to continue the admission

The screenshot shows the CHAMPS Member Enrollment Admission List interface. A modal window is open, displaying an error message in red text: "VM\_BVM.402712:An NF Admission record with [redacted] is already present in CHAMPS from 06/01/2017. Please enter Discharge Details for the NF Admission record you are trying to enter." The modal has a "Close" button in the top left and "Details" and "Copy To Clipboard" buttons in the top right. The background interface includes a navigation menu on the left with options like "Member Information", "Admission Information", "Discharge Information", "Responsible Party Info", "Address Information", "Previous Facility Info", "Insurance Information", "Upload Documents", and "Certification". The top navigation bar shows "My Inbox", "Provider", and "Member" tabs, along with utility icons for "Quick Find", "Note Pad", "External Links", "My Favorites", "Print", and "Help".

- When entering a Nursing Facility admission it's important the admissions are completed in order.
- Providers will receive this error message if the admissions are completed out of order.

The screenshot shows the CHAMPS web application interface. The top navigation bar includes 'My Inbox', 'Provider', and 'Member' tabs. The main content area is titled 'Admission/Enrollment Information' and contains several form fields and questions:

- Date of Admission/Enrollment:** 10/01/2017
- Is this stay custodial or rehabilitative?**  Custodial  Rehabilitative
- Type of Facility:** County Medical Care Facility
- Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?**  No  Yes
- Facility Contact Person:** Lynn
- Is the Individual Expected to Move to Community?**  No  Yes
- Is this Admission Likely to be 30 days or Longer?**  No  Yes
- Primary Diagnosis Code:** (Field with 'LOADING...' indicator below it)
- Secondary Diagnosis Code:** (Empty field)
- Is this stay for Hospice Services?**  No  Yes
- Has this patient already been discharged from this facility?**  No  Yes
- Comments:** (Empty text area)

A modal dialog box titled 'Message from webpage' is overlaid on the form, containing the text: 'The member is currently in the Hospice program. Do you still want to continue?' with 'OK' and 'Cancel' buttons. A 'Next' button is visible in the bottom right corner of the form area.

- Completing a Nursing Facility admission after a beneficiary revokes their Hospice benefits.
  - *The Hospice provider must disenroll the beneficiary to end date NFAC-HOS PET.*

CHAMPS

My inbox ▾ Provider ▾ Member ▾

claim,su ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Member Enrollment > Admission List

Close

**VM\_BVM.402765:A Hospice Provider must enter a Hospice Admission Record for Hospice services rendered in the Nursing Facility.**

Details Copy To Clipboard

Member Information

Admission Information

Discharge Information

Responsible Party Info

Address Information

Previous Facility Info

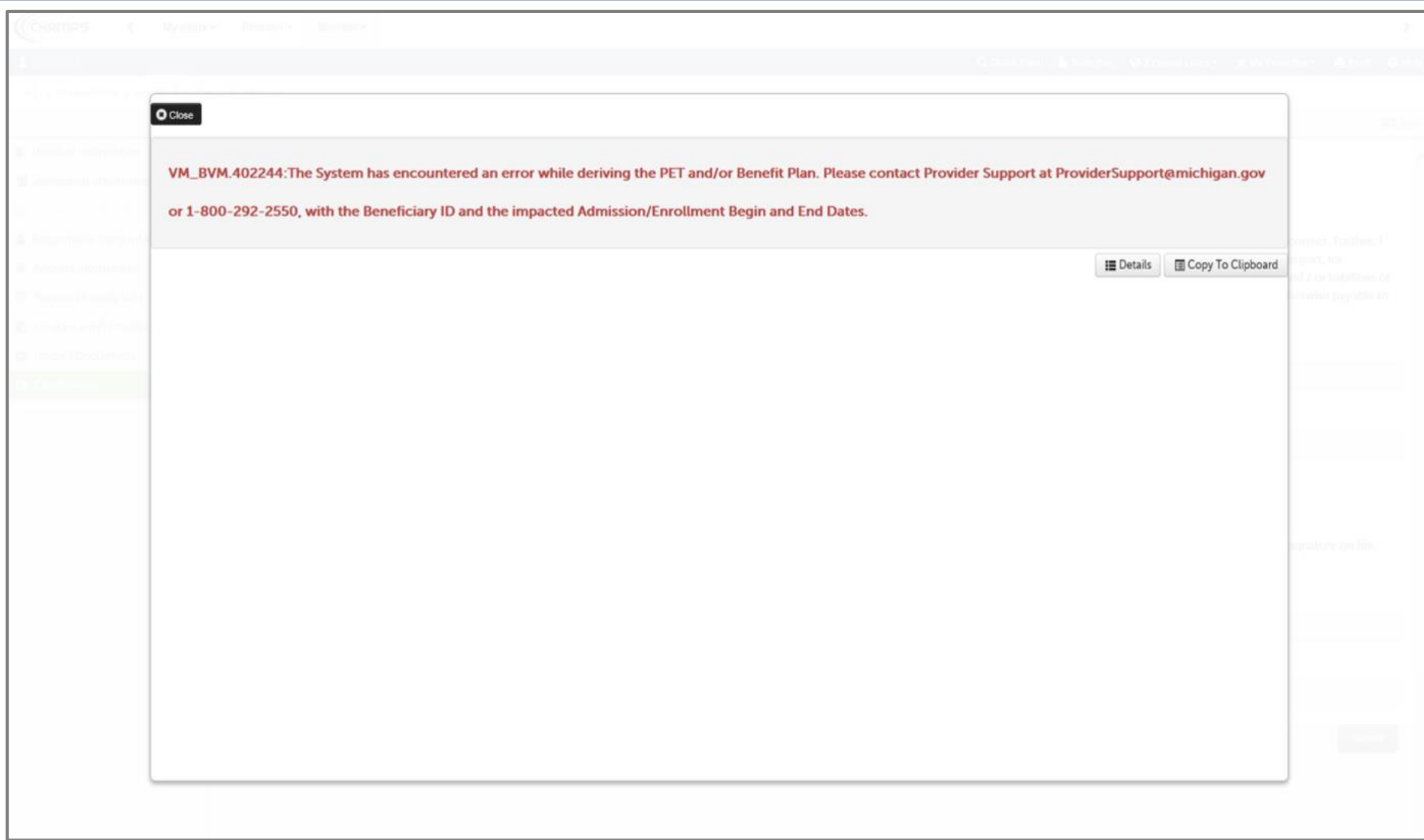
Insurance Information

Upload Documents

Certification

Next

- When entering the Nursing Facility Admission the question asked “Is this stay for Hospice”? If the SNF select yes, you will receive this error.
- The hospice provider must submit the enrollment for Hospice services being performed in a SNF.



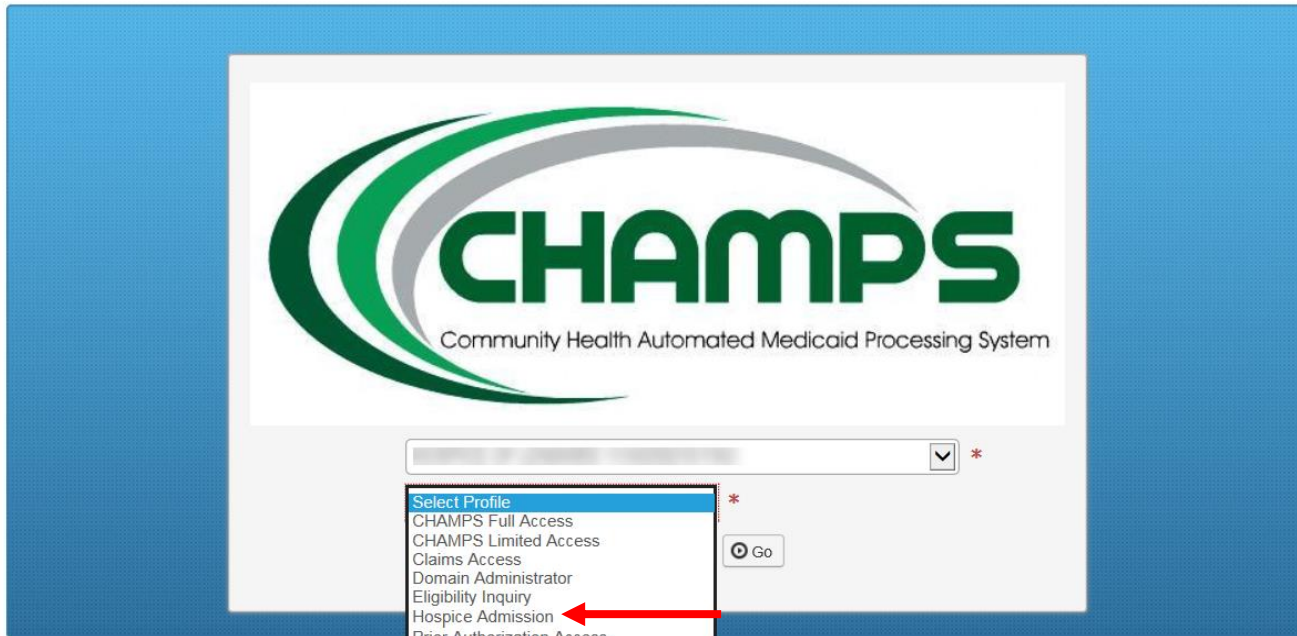
- There may be instances when there is an issue with the beneficiary ID attempting to be enrolled, in those instances providers will receive this error message.
- Contact Provider Support be sure to include the beneficiary number, dates of enrollment and NPI

# Entering a Hospice Enrollment

---

Steps for completing a Hospice enrollment within  
CHAMPS





- Select the Billing NPI from the domain dropdown
- Select the Hospice admission profile
- Click Go

The screenshot shows the CHAMPS Member portal. The top navigation bar includes 'My Inbox', 'Provider', and 'Member' tabs. A dropdown menu is open under 'Member', listing 'ELIGIBILITY INQUIRY' and 'PROGRAM ENROLLMENT/ADMISSION'. A red arrow points to 'PROGRAM ENROLLMENT/ADMISSION'. Below the menu is a 'System Notification' banner with a blue background and white text: 'Due to R9-6.5 Release, the CHAMPS system will be down between 7:00 PM Friday, December 16th through 8:00 AM Saturday, December 17th, 2016. This outage will affect the CHAMPS system access for all functionality.' At the bottom, the 'My Reminders' section has a filter bar and a table with columns: Alert Type, Alert Message, Alert Date, Due Date, and Read. The table is empty, with the text 'No Records Found!' displayed in red.

- After logging into CHAMPS
- Click Member tab
- Select Program Enrollment/Admission

CHAMPS < My Inbox > Provider > Member >

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] Close

### Member Information

<b>*Program Type</b> HOSPICE	<b>*NPI/Provider ID:</b> [REDACTED]	<b>Provider Name:</b> [REDACTED]
<b>*Medicaid ID</b> Medicaid ID	<b>SSN</b> XXX-XX-XXXX	<b>Date of Birth</b> MM/DD/YYYY
<b>First Name</b> [REDACTED]	<b>Middle Name</b> [REDACTED]	<b>Last Name</b> [REDACTED]
<b>*Gender</b> ---SELECT---	<b>Marital Status</b> ---SELECT---	

Next

- New CHAMPS enrollment screen
- Enter the Medicaid ID
- Click Next

CHAMPS < My Inbox > Provider > Member >

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal > Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification

### Admission/Enrollment Information

**\*Date of Admission/Enrollment**

**\*Type of Facility**  
  
 Community  
 Nursing Facility  
 Residence

**\*Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?**  
 No  Yes

**\*Facility Phone Number**

**\*Is the Individual Expected to Move to Community?**  
 No  Yes

**\*Is the Individual Expected to Return Home within 12 months of Facility Admission Date?**  
 No  Yes

**\*Is this Admission Likely to be 30 days or Longer?**  
 No  Yes

**Estimated Length of Stay (in Months)**

**Primary Diagnosis Code**

**Secondary Diagnosis Code**

**Attending Physician NPI**

**Attending Physician Name**

**\*Has this patient already been discharged from this facility?**  
 No  Yes

**Comments**

- Select the type of facility in which hospice services will be provided.
- Enter all other required information, as indicated with a red asterisk.

CHAMPS < My Inbox ▾ Provider ▾ Member ▾

Provider Portal > Member Enrollment Admission List

NPI: [redacted] Provider Name: [redacted] Close

Member Information ✓

Admission Information

Discharge Information

Responsible Party Info

Address Information

Previous Facility Info

Insurance Information

Upload Documents

Certification

### Admission/Enrollment Information

\*Date of Admission/Enrollment  
01/01/2017

\*Type of Facility  
Nursing Facility

\*Nursing Facility NPI:  
[text input]

\*Nursing Facility Date of Admission:  
MM/DD/YYYY

\*Facility Contact Person  
[text input]

\*Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?  
 No  Yes

\*Nursing Facility Name:  
[text input]

\*Facility Phone Number  
[text input]

\*Is the Individual Expected to Move to Community?  
 No  Yes

\*Is this Admission Likely to be 30 days or Longer?  
 No  Yes

Primary Diagnosis Code  
[text input]

Attending Physician NPI  
[text input]

\*Has this patient already been discharged from this facility?  
 No  Yes

\*Is the Individual Expected to Return Home within 12 months of Facility Admission Date?  
 No  Yes

Estimated Length of Stay (in Months)  
Select

Secondary Diagnosis Code  
[text input]

Attending Physician Name  
[text input]

Comments  
[text area]

Next

- If type of facility selected is Nursing Facility the following additional fields are required:
  - Nursing Facility NPI
  - Nursing Facility date of admission
  - Contact Person and phone number

The screenshot displays the CHAMPS Member Enrollment Admission List interface. The top navigation bar includes the CHAMPS logo, a back arrow, and tabs for "My Inbox", "Provider", and "Member". A utility bar contains "Quick Find", "Note Pad", "External Links", "My Favorites", "Print", and "Help". The breadcrumb trail shows "Provider Portal" > "Member Enrollment Admission List". A header bar displays "NPI:" and "Provider Name:" with a "Close" button. A left sidebar lists menu items: "Member Information", "Admission Information", "Discharge Information", "Responsible Party Info" (highlighted), "Address Information", "Previous Facility Info", "Insurance Information", "Upload Documents", and "Certification". The main content area is titled "Responsible Party Information" and contains the following fields:

- First Name:** Input field with placeholder "First Name".
- Middle Name:** Input field with placeholder "Middle initial".
- Last Name:** Input field with placeholder "Last Name".
- Relationship to Patient:** Dropdown menu with "Select" and a downward arrow.
- Phone number:** Input field.

A "Next" button is located in the bottom right corner of the form area, highlighted with a red box.

- Enter Responsible Party Information if different than the beneficiary/patient.
- Click Next

CHAMPS

My Inbox ▾ Provider ▾ Member ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] Close

Member Information ✓

Admission Information ✓

Discharge Information

Responsible Party Info ✓

**Address Information →**

Previous Facility Info

Insurance Information

Upload Documents

Certification

### Address Information

Address Type	Address	Actions
<input type="button" value="Add"/>		

Next

- If Address Information pre-populates click Next
- Click Add to enter address information

CHAMPS My Inbox Provider Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification

### Address Information

Address Type	Address	Actions
<input type="button" value="Add"/>		

**\*Address Type:**  
Select Address Type

Address Line 1: \*   
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: \* OTHER

State/Province: \* OTHER

County: OTHER

Country: \* UNITED STATES

Zip Code:  -

Next

- Select the address type and enter the required asterisked information
- Click Validate Address
- Click Save
- Click Next



The screenshot shows the CHAMPS web application interface. At the top, there is a navigation bar with the CHAMPS logo, a breadcrumb trail (My Inbox > Provider > Member), and utility links (Quick Find, Note Pad, External Links, My Favorites, Print, Help). Below the navigation bar, the page title is 'Provider Portal > Member Enrollment Admission List'. The main content area is titled 'Previous Provider/Facility Information' and contains several form fields:

- Previous Service Location:** A dropdown menu labeled 'Select Facility'.
- Previous Provider/Facility Admission/Enrollment Date:** A date input field with a calendar icon, placeholder 'MM/DD/YYYY'.
- Previous Provider/Facility Discharge/Disenrollment Date:** A date input field with a calendar icon, placeholder 'MM/DD/YYYY'.
- Previous Provider/Facility NPI/Provider ID:** A text input field.
- Previous Provider/Facility Name:** A text input field.
- Previous Provider/Facility Contact Person:** A text input field.
- Previous Provider/Facility Contact Phone Number:** A text input field.

A 'Next' button is located in the bottom right corner of the form area, highlighted with a red box.

- Enter the prior facility information if applicable
- Click Next

The screenshot displays the CHAMPS Member Enrollment Admission List interface. The top navigation bar includes the CHAMPS logo and tabs for 'My Inbox', 'Provider', and 'Member'. The main content area is titled 'Other Insurance Information' and features a table with the following columns: Type of Insurance, Insurance Company, Policy Number, Group Number, Beneficiary Identifier, Policy Holder Employer Name, and Policy Holder Name. A red arrow points to the 'View TPL' link under 'Other Insurance Available:'. A red box highlights the 'Next' button in the bottom right corner.

- Click View TPL if hyperlinked to review the other insurance information on file for the beneficiary
- Click Next

- Member Information ✓
- Admission Information ✓
- Discharge Information
- Responsible Party Info ✓
- Address Information ✓
- Previous Facility Info ✓
- Insurance Information
- Upload Documents
- Certification

## Other Insurance Information

Other Insurance Available: [View TPL](#)

Type of Insurance	Insurance Company	Policy Number	Group Number	Beneficiary Identifier	Policy Holder Employer Name	Policy Holder Name
<input type="button" value="Add"/>						

**\*Type of Insurance:**

**Policy Holder First Name:**

**Policy Holder Last Name:**

**Policy Holder SSN:**

**Policy Holder Date of Birth:**

- Select the type of insurance
- Enter policy holder information
- Click Save
- Click Next

CHAMPS My Inbox Provider Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information ✓

Admission Information ✓

Discharge Information

Responsible Party Info ✓

Address Information ✓

Previous Facility Info ✓

Insurance Information ✓

Upload Documents →

Certification

## Upload Documents

Type of Document	ID	Description
------------------	----	-------------

Add

Next

- At this time the Upload Documents page is not being used
- Click Next

CHAMPS < My Inbox > Provider > Member >

Provider Portal > Member Enrollment Admission List

NPI: [redacted] Provider Name: [redacted] XClose

- Member Information
- Admission Information
- Discharge Information
- Responsible Party Info
- Address Information
- Previous Facility Info
- Insurance Information
- Upload Documents
- Certification**

### Certification

**Member Certification**

I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in the Member Information section above. The enrollment is effective the date entered in the Admission Information section above, and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program. If eligibility verification indicates a patient-pay amount, I understand that I must pay that amount, each month, to the hospice for my care. Any applicable patient-pay amount, Insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Health and Human Services.

**Signature of Member/Authorized Representative**  **Date**

**\*Member/Authorized Representative First Name**  **\*Member/Authorized Representative Last Name**

**Witness Signature**  **Witness Attestation Date**

**\*Witness First Name**  **\*Witness Last Name**

**Provider Certification**

In accordance with the Michigan Medicaid Provider Manual, Hospice Chapter, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.

**Provider Signature**  **Date**

**\*Provider First Name**  **\*Provider Last Name**

**Submit**

- Print the admission so the beneficiary or authorized representative, the provider representative and witness can sign the admission notice.
- It is the providers responsibility to retain the admission notice in the beneficiaries record.



\*\*Sample admission notice\*\*

MICHIGAN MEDICAID MEMBER ENROLLMENT ADMISSION FORM

Applicant Information

NPI: 1234567890
PROVIDER NAME: HOSPICE FACILITY

Member Information

Program Type: HOSPICE Medicaid ID: 0000000XXX
SSN (Last 4 Digits): 0000 Date Of Birth: 01/01/1950
First Name: SAMPLE Last Name: SAMPLE
Middle Name: Gender: Male
Marital Status: Married

Admission/Enrollment Information

Date of Admission/Enrollment: 09/01/2017
Type of Facility: Community Estimated Length of Stay (in Months):
Facility Contact Person: Amanda Facility Contact Phone Number: (517) 555-1212
Primary Diagnosis Code: Secondary Diagnosis Code:
Attending Physician NPI: Attending Physician Name:

Is the Individual Expected to Move to Community? : NO
Is the Individual Anticipated to have Out-of-Pocket Medical Expenses? : NO
Is this Admission likely to be 30 days or longer? : NO
Is the Individual Expected to Return Home within 12 months of Facility Admission Date? : NO
Has this patient already been discharged from this facility? : NO

Discharge/Disenrollment Information

Type of Discharge/Disenrollment: Date of Discharge/Disenrollment:
Reason:
Remarks:
Discharge to: Name of facility (If Applicable):
Address Line1: Address Line2:
Address Line3: City/Town:
State/Province: County:
Zip Code: Country:

Responsible Party Information

First Name: Middle Name:
Last Name: Relationship to Patient:
Phone Number:

Address Information

ADDRESS TYPE :Home
ADDRESS :320 S Walnut St, 48933

Beneficiary First Name
SAMPLE

Medicaid ID
0000000XXX

- After clicking print the admission notice will pop-up as a PDF
Click print from the PDF version to complete



# Member Certification Message

- I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in the Admission Information Section above, the name(s) and address(es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

# Provider Certification

- Hospice Provider:

In accordance with the Michigan Medicaid Provider Manual, Hospice Chapter, Section 3.2, I completed the information on this form and will maintain the beneficiary's, or his or her authorized representative's, signature on file. The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed.



# Entering a Hospice Disenrollment

---

Steps for completing a Hospice disenrollment within  
CHAMPS

Close Add Enrollment/Admission

Member Enrollment/Admission List

Filter By [dropdown] [input] Filter By [dropdown] [input] Filter By [dropdown] [input]  
 All [dropdown] Go Save Filters My Filters [dropdown]

Action	Transaction ID	Member ID	First Name	Last Name	Start Date	End Date	Status	Created By	Created Date
Select Delete Discharge/Disenroll Edit Details Review View Details View Eligibility					03/08/2014	12/31/2999	COMPLETED	Process, Data Conversion	08/13/2017
Select					05/22/2014	05/25/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					02/20/2014	02/21/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					02/06/2014	02/09/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					01/29/2014	03/03/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					04/02/2014	08/30/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					07/05/2014	07/18/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					03/16/2014	03/17/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					06/12/2014	06/14/2014	COMPLETED	Process, Data Conversion	08/13/2017
Select					11/30/2013	02/15/2014	COMPLETED	Process, Data Conversion	08/13/2017

- Roster page:
- Next to the Member ID needing to be disenrolled, from the action column select Discharge/Disenroll

CHAMPS < My Inbox ▾ Provider ▾ Claims ▾ Reference ▾ Member ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Member Enrollment Admission List

NPI: Provider Name: Close

Member Information  
Admission Information  
**Discharge Information**  
Responsible Party Info  
Address Information  
Previous Facility Info  
Insurance Information  
Upload Documents  
Certification  
Review

### Discharge/Disenrollment Information

**\*Type of Discharge/Disenrollment**

---SELECT---  
VLN-Voluntary  
DTH-Death  
IVLN-Involuntary  
--SELECT--

**\*Date of Discharge/Disenrollment**

MM/DD/YYYY

**Remarks**

**Discharge to**

Select

**Name of facility (If Applicable)**

The Address Information is conditionally required. Please complete if known.

**Address Line 1:** \* (Enter Street Address or PO Box Only)

**Address Line 2:**

**Address Line 3:**

**City/Town:** \* OTHER

**State/Province:** \* OTHER

**County:** OTHER

**Country:** \* UNITED STATES

**Zip Code:**

Validate Address

**Submit**

- Select the type of disenrollment from the dropdown
- Enter the required asterisked information
- Click Submit

CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

Provider Portal Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information **Discharge Information** Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: DTH-Death

\*Reason: Death

\*Date of Death: MM/DD/YYYY

Remarks:

Discharge to: Select

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: \* (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province: \* OTHER

City/Town: \* OTHER

County: OTHER

Country: \* UNITED STATES

Zip Code: -

Validate Address

Submit

- When type of disenrollment DTH-Death is selected the reason pre-populates as death.
- Enter the date of death
- Click Submit

CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

MyInbox Member Enrollment Admission List

NPI: Provider Name: Close

Member Information  
Admission Information  
**Discharge Information**  
Responsible Party Info  
Address Information  
Previous Facility Info  
Insurance Information  
Upload Documents  
Certification  
Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: VLN-Voluntary

\*Date of Discharge/Disenrollment: MM/DD/YYYY

\*Reason: --SELECT--  
Voluntary Disenrollment  
Other

Remarks:

Discharge to: Select

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: \* (Enter Street Address or PO Box Only)  
Address Line 2:  
Address Line 3:  
City/Town: \* OTHER  
State/Province: \* OTHER  
County: OTHER  
Country: \* UNITED STATES  
Zip Code: -  
Validate Address

Submit

- Type of disenrollment VLN-Voluntary is selected you have 2 reasons available to select:
  - Voluntary Disenrollment
  - Other

CHAMPS My Inbox Provider Claims Reference Member

Quick Find Note Pad External Links My Favorites Print Help

MyInbox Member Enrollment Admission List

NPI: Provider Name: Close

Member Information Admission Information Discharge Information Responsible Party Info Address Information Previous Facility Info Insurance Information Upload Documents Certification Review

### Discharge/Disenrollment Information

\*Type of Discharge/Disenrollment: IVLN-Involuntary

\*Date of Discharge/Disenrollment: MM/DD/YYYY

\*Reason:
 

- SELECT--
- Loss of Medicaid Coverage
- Change in condition and no longer qualifies for Hospice services
- Beneficiary moves out of Hospice Service area
- Hospice elects to terminate beneficiary's enrollment
- Other

Remarks:

Name of facility (If Applicable):

The Address Information is conditionally required. Please complete if known.

Address Line 1: \* (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: \* OTHER

State/Province: \* OTHER

County: OTHER

Country: \* UNITED STATES

Zip Code: -

Validate Address

Submit

- Type of disenrollment IVLN-Involuntary is selected you have 5 reasons available to select:
  - Loss of Medicaid Coverage
  - Change in condition and no longer qualifies for Hospice Services
  - Beneficiary moves out of Hospice Service area
  - Hospice elects to terminate beneficiary's enrolment
  - Other

The screenshot shows the CHAMPS Member Enrollment Admission List form. The form is titled "Discharge/Disenrollment Information" and includes fields for "Type of Discharge/Disenrollment" (set to VLN-Voluntary) and "Date of Discharge/Disenrollment" (set to 10/01/2017). A summary dialog box is displayed in the center, containing the following information:

- Program Type:** Hospice
- Medicaid ID:** [Redacted]
- Medicaid Name:** [Redacted]
- Date Of Admission/Enrollment:** 09/01/2017
- Date Of Discharge/disenrollment:** 10/01/2017

The dialog box also includes a message: "If the Summary information is accurate, click OK to Submit, else click Cancel to return to the form to make corrections." and two buttons: "Cancel" and "OK". The "OK" button is highlighted with a red box.

The form also includes fields for "Address Line 1", "Address Line 2", "Address Line 3", "State/Province", "Country", "City/Town", "County", and "Zip Code". A "Validate Address" button is located next to the "Zip Code" field. A "Submit" button is located at the bottom right of the form.

- After clicking submit you will receive the confirmation summary page
- Click Ok
  - *Note: Click Cancel if any of the discharge information displayed is incorrect in order to update the information prior to submitting the discharge*

# Examples Hospice Enrollments

- The following slides show example messages that will be displayed when entering an enrollment for a beneficiary who is currently enrolled in one of the following programs:
  - ICO
  - PACE
  - Medicaid Health Plans
  - Nursing Facility
- For the following program types the admission will end date the enrollment if the beneficiary is enrolled into Hospice:
  - MICHoice and HCBS



The screenshot shows the CHAMPS Member Enrollment Admission List form. The form is titled "Admission/Enrollment Information" and includes fields for "Date of Admission/Enrollment" (11/05/2016), "Type of Facility" (Residence), "Facility Contact Person", "Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?" (No), "Is the Individual Expected to Move to Community?" (No), "Is this Admission Likely to be 30 days or Longer?" (No), "Primary Diagnosis Code", "Secondary Diagnosis Code", "Attending Physician NPI", "Attending Physician Name", and "Has this patient already been discharged from this facility?" (No). A "LOADING..." indicator is visible in the center of the form. A dialog box titled "Message from webpage" is overlaid on the form, asking "The member is currently in the PACE program. Do you still wish to continue?" with "OK" and "Cancel" buttons. A "Next" button is visible in the bottom right corner of the form.

- Entering a new Hospice enrollment for a beneficiary who is enrolled in PACE
- Click Ok to continue the enrollment
  - *Note: PACE, ICO, MHP admissions will remain active, Benefit Plans will end one day prior to new admission*

CHAMPS < My Inbox > Provider > Claims > Reference > Member >

MyInbox > Member Eligibility Inquiry > Member Benefit Level

Member ID: [REDACTED] Name: [REDACTED]

Close

INQUIRY DATE RANGE: 09/01/2017 - 11/13/2017

GENDER: [REDACTED] COMMERCIAL / OTHER: Y

DATE OF BIRTH: [REDACTED] CSHCS RESTRICTIONS: N

CASE NUMBER: [REDACTED] MHP PCP: N

CASE PHONE: [REDACTED] EXT: [REDACTED] BMP PROVIDER RESTRICTION: N

CASE EMAIL: [REDACTED] INDICATORS: N

COUNTY OF RESIDENCE: [REDACTED]

MAGI CATEGORY: [REDACTED] WORKER LOAD NUMBER: [REDACTED]

MA PROGRAM CODE: [REDACTED] MDHHS PHONE: [REDACTED]

CITIZENSHIP: [REDACTED] MDHHS COUNTY: [REDACTED]

REDETERMINATION DATE: [REDACTED]

[Print Member Summary](#)  
[Non Covered Service Types](#)

**BENEFIT PLANS**

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
<a href="#">PACE</a>	PCE-HOSH	MANAGED CARE	[REDACTED]	<a href="#">Click To View Service Types</a>	11/08/2017	11/08/2017	10/01/2017	11/13/2017
<a href="#">PACE</a>	PCE-COMM	MANAGED CARE	[REDACTED]	<a href="#">Click To View Service Types</a>	11/08/2017	11/08/2017	09/01/2017	09/30/2017

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

- Entering a Hospice services in the community enrollment during a PACE open enrollment period.
- The existing PET or BP will become inactive and the new PCE-HOSH will become active effective the admission date
  - Note the PACE BP will remain to indicate that PACE is the overseeing program.

CHAMPS < My Inbox > Provider > Claims > Member >

Quick Find Note Pad External Links My Favorites Print Hel

> MyInbox > Member Eligibility Inquiry > Member Enrollment Admission List > Member Eligibility Inquiry > Member Benefit Level

Member ID: [REDACTED] Name: [REDACTED]

Close

INQUIRY DATE RANGE: 10/01/2017 - 11/08/2017

GENDER: [REDACTED] COMMERCIAL / OTHER: Y

DATE OF BIRTH: [REDACTED] CSHCS RESTRICTIONS: N

CASE NUMBER: [REDACTED] MHP PCP: N

CASE PHONE: [REDACTED] EXT: [REDACTED] BMP PROVIDER RESTRICTION: N

CASE EMAIL: [REDACTED] INDICATORS: N

COUNTY OF RESIDENCE: [REDACTED] WORKER LOAD NUMBER: [REDACTED]

MAGI CATEGORY: [REDACTED] MDHHS PHONE: [REDACTED]

MA PROGRAM CODE: [REDACTED] MDHHS COUNTY: [REDACTED]

CITIZENSHIP: [REDACTED]

REDETERMINATION DATE: [REDACTED]

[Print Member Summary](#)  
[Non Covered Service Types](#)

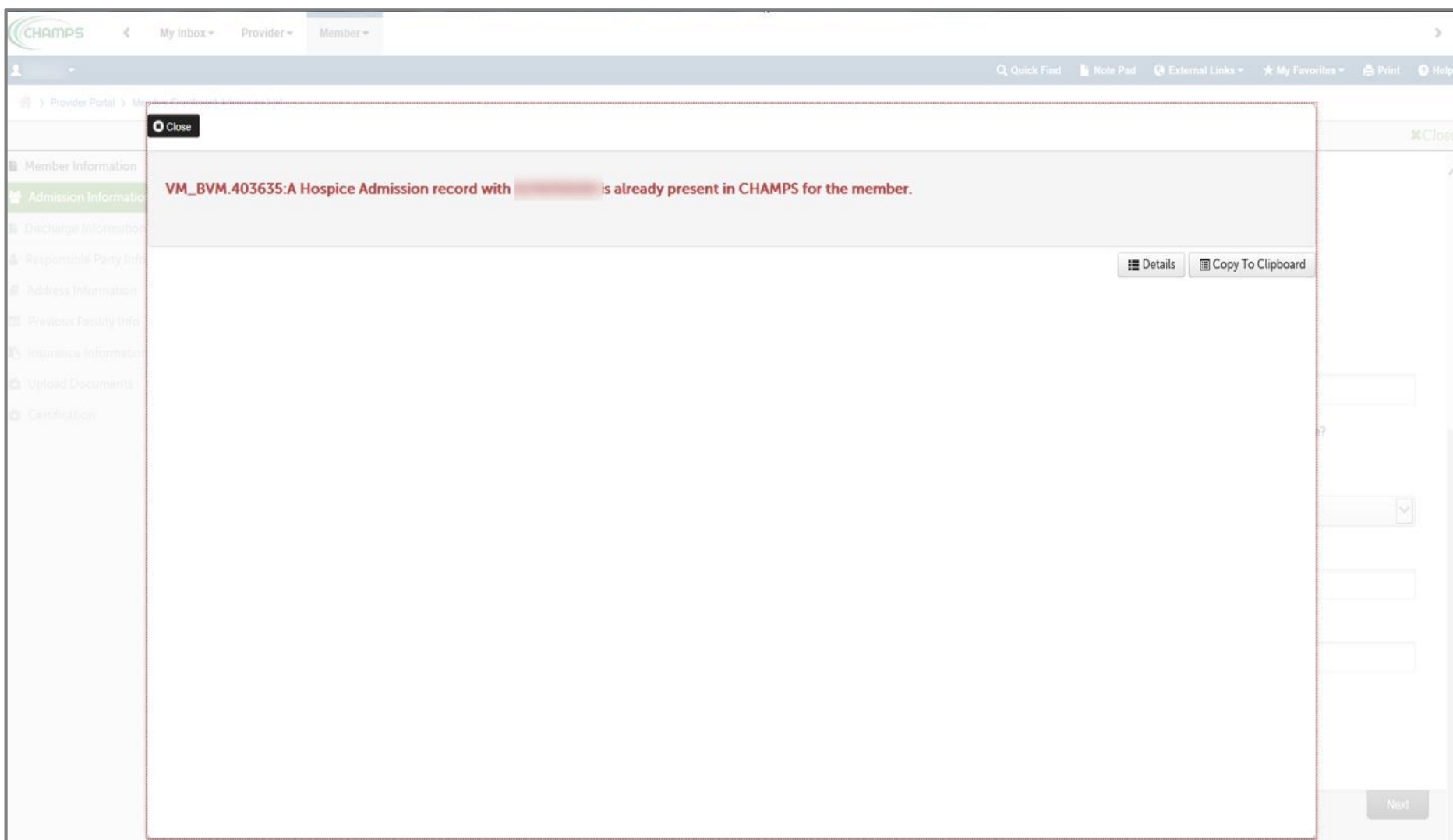
BENEFIT PLANS

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
<a href="#">PACE</a>	<a href="#">PCE-HOSH</a>	MANAGED CARE	[REDACTED]	<a href="#">Click To View Service Types</a>	11/08/2017	11/08/2017	10/01/2017	11/08/2017

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- Entering a Hospice services in the community enrollment during a PACE open enrollment period.
- The existing PET or BP will become inactive and the new PCE-HOSH will become active effective the admission date
  - Note the PACE BP will remain to indicate that PACE is the overseeing program.





- Entering a Hospice enrollment for a beneficiary who is enrolled in Hospice on the same date.
- Click Close
- The first Hospice must disenroll the beneficiary prior to the second Hospice completing their enrollment.

The screenshot shows the CHAMPS web application interface. The main content area is titled "Admission/Enrollment Information". A modal dialog box is open in the center, displaying a question: "The member is currently in the Nursing Facility program. Do you still wish to continue?". Below the question are "OK" and "Cancel" buttons. The background form contains several fields and questions, including "Date of Admission/Enrollment" (12/01/2016), "Type of Facility" (Community), "Facility Contact Person" (Lynn), and various yes/no questions. A "LOADING..." spinner is visible in the center of the form area. The "Next" button is highlighted in the bottom right corner.

- Entering a Hospice enrollment for a beneficiary currently admitted to a SNF for the same date.
- Click Ok to continue the enrollment
  - *Note: The Nursing Facility admission will be end dated one day prior to Hospice enrollment date*

Provider Portal > Member Enrollment Admission List

NPI: [REDACTED] Provider Name: [REDACTED] Close

- Member Information
- Admission Information**
- Discharge Information
- Responsible Party Info
- Address Information
- Previous Facility Info
- Insurance Information
- Upload Documents
- Certification

**\*Date of Admission/Enrollment**  
08/01/2017

**\*Type of Facility**  
Nursing Facility

**\*Nursing Facility NPI:**  
[REDACTED]

**\*Nursing Facility Date of Admission:**  
08/01/2017

**\*Facility Contact Person**  
Carol

**\*Is the Individual Expected to Move to Community?**  
 No  Yes

**\*Is this Admission Likely to be 30 days or Longer?**  
 No  Yes

**Primary Diagnosis Code**  
[REDACTED]

**Attending Physician NPI**  
[REDACTED]

**\*Has this patient already been discharged from this facility?**  
 No  Yes

**\*Is the Individual Anticipated to have Out-of-Pocket Medical Expenses?**  
 No  Yes

**\*Nursing Facility Name:**  
[REDACTED]

**\*Facility Phone Number**  
(517) 555-1212

**\*Is the Individual Expected to Return Home within 12 months of Facility Admission Date?**  
 No  Yes

**Estimated Length of Stay (in Months)**  
Select

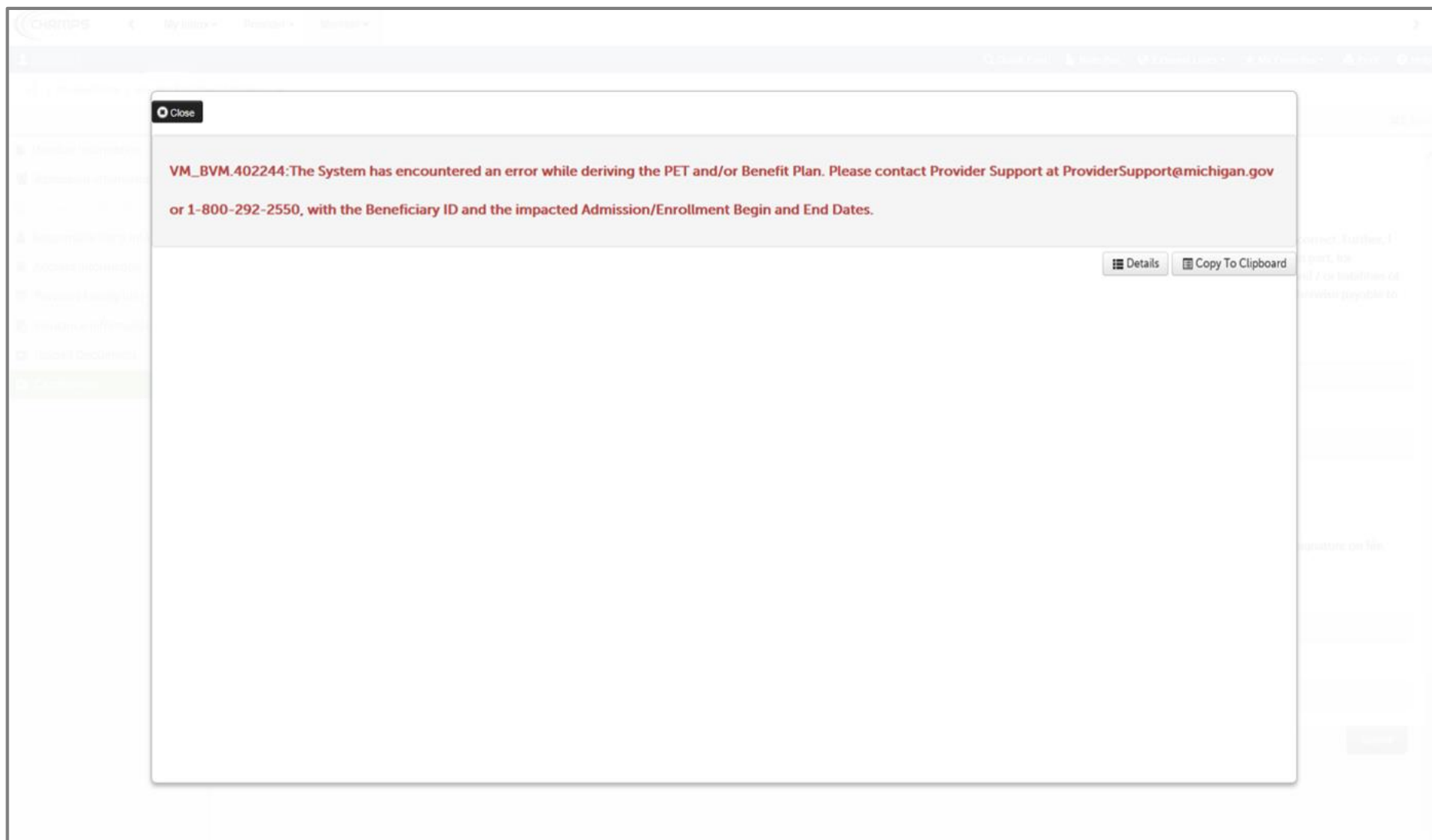
**Secondary Diagnosis Code**  
[REDACTED]

**Attending Physician Name**  
[REDACTED]

**Comments**  
[REDACTED]

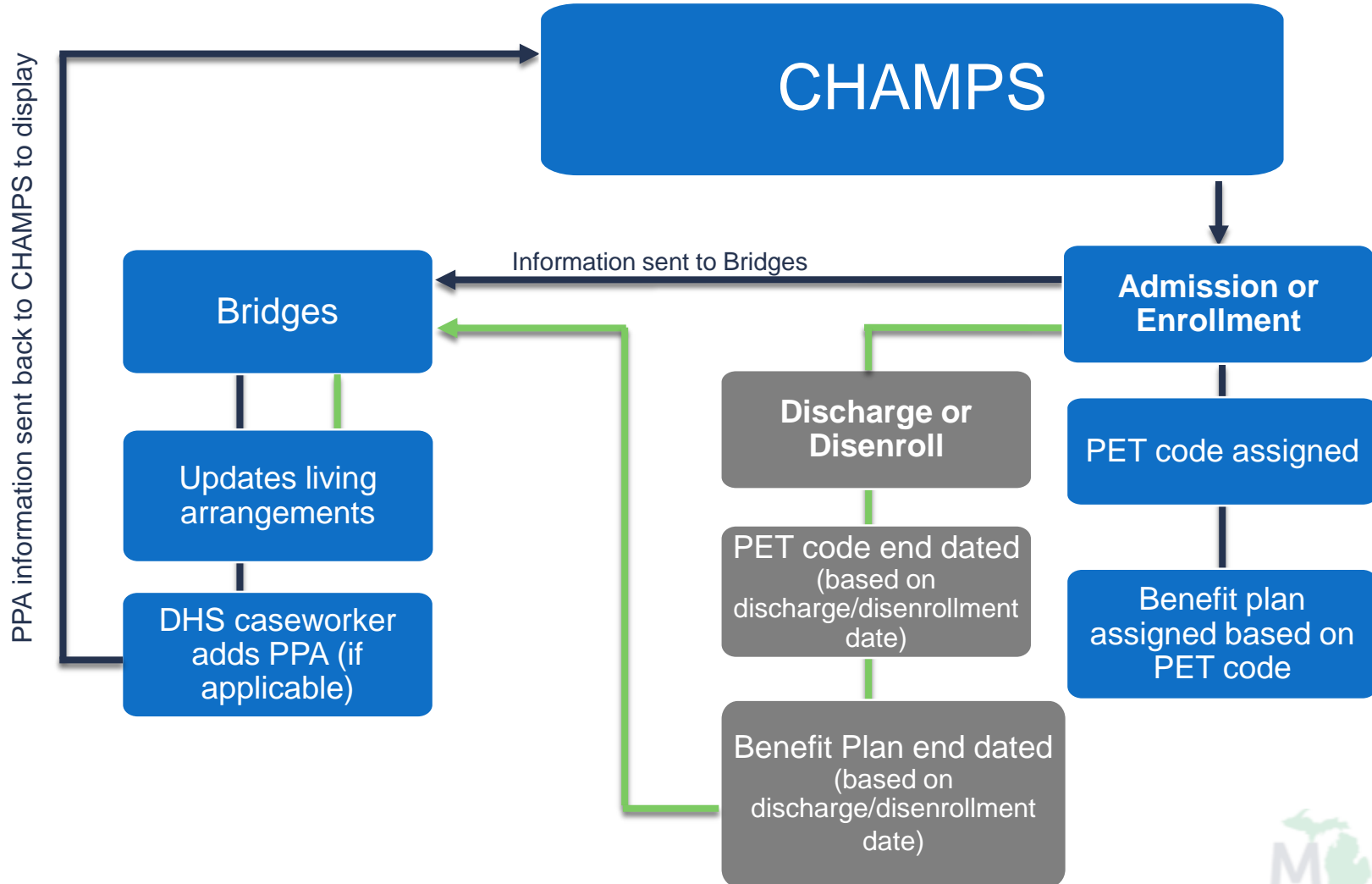
Next

- If Hospice is being provided in the Nursing Facility, it's the responsibility of the Hospice Provider to enter the enrollment and select type of facility "Nursing Facility" and enter that Nursing Home NPI number.



- There may be instances when there is an issue with the beneficiary ID attempting to be enrolled, in those instances providers will receive this error message.
- Contact Provider Support be sure to include the beneficiary number, dates of enrollment and NPI

# Visual Aid





# Upcoming Training Dates

## Virtual Training Dates

- MCC project overview:
  - November 16, 2017
- SNF and Hospice provider specific:
  - November 21, 2017
  - December 5, 2017
  - December 19, 2017

## In-person Training Dates

- SNF and Hospice provider specific:
  - November 28, 2017- Double Tree Detroit-Dearborn
  - December 12, 2017-Lansing Community College (LCC) West Campus

# Provider Resources

- \* Currently the State of Michigan is in the testing phase of MCC, screens are subject to minor changes prior to implementation.
- **MDHHS website:** [www.Michigan.gov/medicaidproviders](http://www.Michigan.gov/medicaidproviders)
- **We continue to update our Provider Resources, just click on the links below:**
  - [SIGMA](#)
  - [Listserv Instructions](#)
  - [Medicaid Alerts and Biller “B” Aware](#)
  - [Medicaid Provider Training Sessions](#)
- **Provider Support:**
  - [ProviderSupport@Michigan.gov](mailto:ProviderSupport@Michigan.gov) or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program