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Background:
UPCAP has entered into a contract with the Upper Peninsula Health Plan (UPHP) to perform assessments, as well as care planning and on-going care coordination for designated individuals dually eligible for Medicare and Medicaid who are enrolled into the MI Health Link (MHL) Integrated Care Demonstration program.

The MI Health Link Program provides all services covered by Medicare and Medicaid through an integrated, managed care process, and includes primary, acute, skilled, long-term care and behavioral health care services.

All assessments must be performed by a licensed registered nurse, licensed bachelor's prepared social worker or limited license Master's prepared social worker.

Referral Process:

UPHP may refer the following five different service requests to UPCAP:

1. **Personal Care Service Assessment:** Determines if the MHL member is eligible to receive assistance performing Activities of Daily Living or Independent Activities of Daily Living
2. **Personal Care Supplement Assessment:** Determines if the MHL member is eligible to receive the personal care supplement payment for personal care services provided to members residing in licensed Adult Foster Care homes and Homes for the Aged
3. **Nursing Facility Level of Care Determination (NFLOCD) Assessment:** Determines if the member is eligible to receive Medicaid reimbursed long-term care services from a Medicaid-certified nursing facility or to receive services in the community through the MI Health Link Waiver program
4. **Level 2 Assessment:** Otherwise known as the InterRAI Assessment, used to determine waiver services for the member
5. **Community Transition:** Assessment and services for members residing in a nursing home who wish to return to the community but who are experiencing barriers that are beyond standard discharge planning and who have resided in the nursing home for at least 3 months

UPHP is responsible for identifying all members requiring assessment to UPCAP.

All referrals will be faxed to the UPCAP Case Tech at 906-217-3041 and to the UM fax intake 906-225-9259. The UPCAP CM Supervisor is responsible for distribution of the referrals to the appropriate office/target area.

Any contact or outreach related to the member is required to be documented and/or uploaded in Altruista to supply the data necessary to meet MHL reporting requirements tied to outreach attempts and assessment completion.

The UPCAP CM will then complete the CM-Personal Care Assessment Toolscript in Altruista. UPHP UM will review PCA and contact UPCAP CM if needed for discrepancies and/or clarification. UPHP UM will save decision letter in Altruista under documents, will mail to member and fax to UPCAP case tech.

Timeframes related to assessment and services:

Assessment/Service	Initial	Frequency	Results Due to UPHP
Level 2 (including all waiver associated materials – L2, PSCP, , Back Up Plan, Waiver Consent form, PCA if applicable)	Within 15 calendar days of referral	Annually or with a change in status * face to face evaluation is required every 90 days to assure there is no change in status and needs are being met	Within 7 business days of completion
Level 2 REASSESSMENT	Within 365 days from the date of the member's last Level 2 assessment.	Annually or with a change in status.	Within 7 business days of completion
NFLOCD & FOC	Within 15 calendar days of referral	Annually or with a change in status (ie member no longer meeting criteria or changes doors)	Within 5 business days of completion. UPHP is required to submit the LOCD into CHAMPS within 14 days of completion and upload supporting documentation within one business day if the LOCD is subject to a verification review in CHAMPS.
Personal Care Services	Within 12 calendar days of referral	Annually or with a change in status * face to face evaluation is required every 6 months to assure there is no change in status and needs are being met	Within 12 calendar days of the referral *if an exention is used, within 26 calendar days of the initial referral.
Personal Care Supplement	Within 12 calendar days of referral	Annually or with a change in status	Within 12 calendar days of referral

		* face to face evaluation is required every 6 months to assure there is no change in status and needs are being met	
Community Transition	Within 7 business days of referral	N/A	Within 7 business days of completion.

Unable to Reach Members:
A minimum of five contact attempts, at different times of the day, must be made before reporting an "unable to reach" outcome to UPHP. The UPCAP Care Manager is responsible for maintaining contact with the assigned Care Manager at UPHP to report difficulties in contacting the member and all contact attempts will be documented in Altruista by the UPCAP Care Manager.

Personal Care Services/Supplement Assessments:

Initial Assessment:
Personal Care Service/Supplement Assessment must be completed face to face within 12 calendar days of the referral utilizing the approved Personal Care Service/Supplement Assessments. Results will need to be entered into Altruista within 12 calendar days of the referral. If an exention is used, results will need to be entered into Altruista within 26 calendar days of the initial referral.

Continuity of Care Period:
For newly enrolled members previously receiving services through the Department of Health and Human Services (DHHS), UPHP will communicate to UPCAP the previously approved service amount that will need to be honored during the 90 day/180 day continuity of care period. For members receiving services from UPHP within the last 90 days – the amount of time on their previous assessment can be used during the continuity of care period. Hours can always be increased during the continuity of care period if supported by assessment, but not decreased.

If a member refuses to participate in the personal care services assessment, their worker may still get paid during the continuity of care period for time previously authorized by DHHS. This may happen in instances where the member is opting out of the health plan. It will need to be communicated to the member that their worker may be paid during this continuity of care period. In these instances, the UPHP Care Coordinator will send a payment voucher to the member to give to their worker. The worker will then need to fill out this form and fax the voucher to UPCAP for payment. If the member remains on plan outside of this time frame, an assessment will need to be completed to receive payment for services.

If the Personal Care Evaluation does not support the level of service authorized by DHHS, this is to be noted in the evaluation results. However, MI Health Link policy requires a continuity of care period following enrollment of 90 days for general members and 180 day for members receiving the Habilitation and Supports Waiver from the Pre-paid Inpatient Health Plan, during which time service plans may not be reduced unless requested in writing by the member.

Ongoing Requirements for Personal Care Services:
Members receiving personal care services require a face to face evaluation to be completed every six months for the members to continue to qualify for services. Notes need to be entered into the member's Altruista record supporting the continued need for personal care services and the findings of the visit along with completion of the CM-Personal Care Assessment 6 Month Assessment script.

Reassessments (completion of a assessment document) only need to be completed when:

- The member is due for their annual assessment,
- There is a change is status requiring a new assessment (an increase or decrease in service needs). If a member is choosing to utilize less hours then determined by the personal care assessment, a new assessment is not needed
- The member, provider, guardian or other legal representative is requesting a new assessment.

All assessment and reassessment results will need to be communicated to UPHP and documented in Altruista within 7 business days of completion. The work order should also be uploaded into Altruista under the Documents tab if the member is a c-waiver member also receiving personal care services.

UPHP is responsible for sending denial notices to the MHL members. The following scenarios require a denial notice to be sent by UPHP:

- A decrease in services
- Member not qualifying for any services
- Member requesting additional services above what is approved on the Personal Care Assessment without justification
- Members terminating services

UPHP is responsible for all hearing related activities. UPCAP CM staff may be required to participate in the actual hearing. UPHP will communicate to UPCAP/Northern Home Care Services the dates related to the denial notices so that services can be decreased or ended after the appropriate amount of time. UPHP Utilization Management sends Northern Home Care Services a copy of the denial notice that is sent to the member which includes service stop/decrease dates.

UPHP is responsible for all coordination related to personal care services including locating, providing and managing personal care services for UPHP MHL members.

UPCAP is responsible for completing the personal care assessment tool and providing the

member with a Northern Home Care Services employee application upon initial assessment.

Please refer to the MHL State Plan Personal Care Services document for any questions related to scoring or administering the benefit.

Ongoing Care for Personal Care Supplements:
The Personal Care Supplement is paid to licensed Adult Foster Care (AFC) homes and Homes for the Aged (HFA). It is a legislatively mandated payment made for personal care services provided to eligible individuals residing in AFC homes or HFAs. The personal care supplement amount is set by the Michigan legislature.

UPCAP will also be responsible to ensure the Resident Care Agreement is signed by the AFC (licensee), member/guardian, and UPCAP (Responsible Agency) Please add after signing "Personal Care Supplement Only".

To qualify for the Personal Care Supplement, the member must receive an ADL score of at least 2 on the Personal Care Assessment. If a MHL member residing in an AFC or HFA does not score a 2 on the evaluation, the UPCAP Care Manager must consult with the UPHP Care Manager. **If the person is receiving assistance with medications, per directive from MDHHS, the personal care supplement payment will continue.**

A face to face evaluation must be conducted no less frequently than once every six months. If there is no status change in the member, notes pertaining to the visit will be entered into Altruista by the UPCAP Care Manager. The UPCAP Care Manager is also responsible for completion of the CM-Personal Care Assessment 6 Month Assessment.

Coordination of Result Discrepancies:
There are occasions when the member reports different concerns to the UPHP Care Manager and the UPCAP Care Manager. In these instances, the expectation is for UPHP to reach out to the UPCAP Care Manager to review. Additionally, the member may need to be brought into a three way call if discrepancies cannot be resolved between the UPHP Care Manager and the UPCAP Care Manager. If the issue cannot be resolved, it should be escalated to supervisors at each agency for review.

Additions can be made to the assessment after completion if the member is in agreement. This will need to be documented. UPCAP does not need to drive to the members home for this and obtain a new signature.

Transition Services:

UPHP may send referrals for members that need transition assistance from the nursing home back to the community. Transition services may be referred for both members returning to the community with waiver services or without.

UPHP is responsible for identifying members that qualify for transition services and for notification of these members to UPCAP. UPCAP is responsible for conducting the initial face

to face transition interview with the member within 7 business days of referral as well as the development of the nursing home transition assessment . UPCAP will be responsible for uploading the nursing home transition assessment into the member record.

The original referral covers payment for all transition services related to UPCAP staff time and travel associated with the transition. UPCAP will supply UPHP's Assistant Manager with the requests for any additional non-reoccurring expenses related to the transition for authorization prior to purchase (please see the MHL Minimum Operating Standards for allowable transition costs). UPHP will provide written authorization of requested purchases prior to UPCAP proceeding with non-recurrent expeditures.

For those members meeting NFLOCD criteria and require HCBS Waiver serivces, the UPHP Care Coordinator will notify UPCAP when a discharge date is determinted via the referral form and UPCAP will conduct all associated C-waiver assessments as outlined in the HCBS Waiver Enrollment Process section of the MHL Minimum Operating Standards to include the completed Nursing Facility Level of Care tool, completed Freedom of Choice form, completed MI Health Link HCBS Waiver Application and Consent Form; and Level 2 assessment and submit the required documents to UPHP following the same process outlined below for waiver applicants in the Waiver Assessments/Referrals section. UPHP will be responsible for opening the case in the CHAMPS and triggering the member as a Nursing Facility Transition.

The UPCAP Care Manager will be responsible for documenting all progress related to the member's transition in Altruista.

For members not meeting NFLOCD criteria, an NFLOCD will still need to be completed with supporting documentation. UPCAP will conduct all associated transition assessments and communicate results back to UPHP and document transition progress in Altruista.

Current guidance does not require transitions to be entered into CHAMPS when the member does not meet the NFLOCD.

Waiver Assessments/Referrals:

Nursing Facility Level of Care Determination (NFLOCD):
Refer to the MHL Minimum Operating Standards as needed for instructions pertaining to filling out the NFLOCD Assessment and the specific required documentation to support the door in which the member scores.

Time Frames for NFLOCD completion are as follows:

- Completed face to face and within 15 calendar days of referral
- Completed annually or with a change in door status

UPCAP staff will upload the NFLOCD results and supporting documentation into Altruista as soon as possible after completion but no later than 5 business days after completion. Due to all Door 0 submissions being reviewed by MDHHS, UPCAP will submit the supporting

documentation for each Door 0 NFLOCD at the time they upload the NFLOCD into Altruista. All other NFLOCDs are subject to random verification review in CHAMPS. If the NFLOCD is randomly selected for verification review, UPHP will contact the UPCAP Care Manager and request the Level II assessment sections that support the NFLOCD and any other required supporting documentation. UPCAP will provide this supporting documentation within one business day and the UPHP Care Coordinator will upload into CHAMPS and submit it for review. If the UPCAP care manager is unavailable, the UPHP Care Coordinator will contact the UPCAP case management supervisor to request the documentation.

***As of June 22, 2018, MDHHS implemented CHAMPS systems changes which includes the elimination of NFLOCD temporary doors. All completed NFLOCD's will have an end date of 365 days from the conducted-on date to be completed annually, or with a change in Door status.**

Members that do not meet NFLOCD criteria:

For members that do not meet NFLOCD criteria (Doors 1-8):

- The NFLOCD assessment must still be returned to UPHP to be entered into CHAMPS. Please see the MHL Minimum Operating Standards for supporting documentation required when members do not meet criteria. An example of NFLOCD documentation for members that do not meet criteria is attached. Members who do not meet NFLOCD criteira are considered to score as a Door 0.
- Section 1 of the Freedom of Choice form must be signed by the individual who conducted the NFLOCD and dated with the date it was conducted.
- The member does NOT need to sign the Freedom of Choice form when they do not meet criteria. Section 3 of the Freedom of Choice form does not need to be filled out since it does not apply to the MI Health Link program.
- Freedom of Choice form **DOES** need to be signed by the UPCAP Care Manager completing the assessment.
- A Level 2 does **NOT** need to be completed for members who do not meet NFLOCD criteria.
- The supporting documentation for Door 0 includes a write up of the assessors observations for each door on the NLFOCD. This write up must be signed and dated by the assessor and uploaded into Altruista.

<u>Level 2 Assessments:</u>

Level 2 Assessments are required to be completed within 15 calendar days of referral to UPCAP. Results will need to be communicated to UPHP within 7 business days of completion unless the Level II assessment is required for a NFLOCD verification review. In this instance, sections of the Level II that support the NFLOCD would be required to be submitted to UPHP within one business day of the review notification. If the NFLOCD is indicated for a verification review, the UPHP Care Coordinator will reach out to the UPCAP Care Manager to request the Level II assessment. If the UPCAP care manager is unavailable, the UPCAP Care Coordinator will reach out to the UPCAP Care Mangement Supervisor to request the Level II assessment. If the

member is unable or unwilling to complete the assessment within 15 days of referral this will need to be communicated to UPHP. The UPCAP CM will document all attempts to schedule the Level 2 assessment in Altruista.

UPCAP will be responsible for uploading the following documents into Altruista within 7 business days of the assessment completion:

- Level 2 Assessment
- complete care plan
- signed Waiver Consent form
- Back Up Plan
- signed MHL HCBS Waiver Application and Consent Form

UPHP will be responsible for notifying UPCAP of the service authorization start date. Re-Assessments are required to be performed annually or with a significant change in status.

Coordination of Result Discrepancies:
There are occasions when the member conveys different concerns to the UPHP Care Manager and the UPCAP Care Manager. In these instances, the UPHP Care Manager will reach out to the UPCAP Care Manager to review the discrepancies. If UPCAP has different findings than reported on the UPHP referral or UPHP NFLOCD assessment, UPCAP should reach out to the UPHP Care Manager.

When necessary, the member will be brought into a three way conversation if there are discrepancies between what the member reports to UPHP and the UPCAP Care Manager. If the issue cannot be resolved, it should be escalated to supervisors at each agency for review.

Discrepancies between assessments will need to be resolved prior to any waiver submissions as MDHHS will not accept assessments that do not match without supporting rationale.

CHAMPS for Waiver Enrollment: For MI Health Link, MDHHS will make the final determination as to whether or not a member in MHL is eligible for a C-Waiver slot. UPHP is responsible for entering and managing the application in the CHAMPS system.

Once the Freedom of Choice, Waiver Consent, Person Centered Care Plan Report and the Level 2 Assessment are complete, they are to be uploaded into Altruista by the UPCAP Care Manager. The UPCAP Care Manager is to notify the UPHP CM that the documents have been uploaded via a message in Altruista.
Please note the NFLOCD will need to be sent prior to the application materials due to the 5 business day requirement (see NFLOCD section).

UPHP will review the application documents and upload according to the HCBS Enrollments and Dis-enrollments CHAMPS User Guide. Once documents are loaded into the system the application is considered approved.

The following documents must be uploaded to the CHAMPS portal by the UPHP Care Manager:

- Level I assessment (regardless of who completed it)
- Level II assessment
- Person-Centered Care Plan Report with specific requests for either State Plan Personal Care or Expanded Community Living Supports (ECLS) and any other services requested
- Completed MI Health Link HCBS Waiver Application and Consent Form
  - Member must sign this form stating he/she is consenting to participate in the C-Waiver and has been given information about various services and available providers
- Completed Nursing Facility Level of Care Determination tool (NFLOCD) including specific required documentation to support the door in which the member scores
- Nursing Facility Level of Care Determination Tool (LOCD) Guidance and Checklist-signed and dated by UPHP CM
- Freedom of Choice Form (signed by member and CM)
- Individual Integrated Care and Supports Plan (IICSP) signed by the member and CM
- Completed Provider Survey Tool for HCBS Residential and non-residential settings (for individuals wanting/needing LTCSS in an AFC or HFA residential setting or adult day care setting)
- Back up Plan
- Letters of Guardianship or activated DPOA if appropriate
- Current Medication List

At time of Waiver Application submission:

- UPCAP and UPHP will coordinate the anticipated start date for waiver services
- UPHP will enter the anticipated start date of services into CHAMPS at time of Waiver Application submission
- UPHP will notify UPCAP of official service authorization date via the CM-UM Referral/Referral/Service Notification form. This form will be sent to the UPCAP Iron Mountain office for distruibution to appropriate staff and will also be saved in Altruista
- UPCAP will begin waiver services per authorization start date. If there are any concerns related to start of service after authorization, UPCAP will be responsible to notify UPHP so that the Waiver Application can be updated as appropriate.

Since UPCAP will be responsible for purchasing waiver needed and approved services for MHL members in the same manner as MI Choice participants, all COMPASS data system applications will need to be utilized. COMPASS documentation will need to be uploaded into the UPHP Altruista care management system for inclusion in the MHL member's record. Required documents include:

- UPCAP Assessment Report InterRAI-HC (Level II) generated out of COMPASS **(Level II assessment must be dated)**
- Person Centered Care Plan Report

- Service Plan
- Back Up Plan
- Associated work orders for waiver specific services.

Imminent Risk

If the member is determined to be at imminent risk of nursing home placement, services are to start at the time the need is identified, or as soon as services can be started. The UPCAP Care Manager will notify UPHP of the service start date via phone call or message in Altruista. UPHP will then send a service authorization form using that date to UPCAP.

Imminent risk exceptions are indicated on the MDHHS MI Health Link HCBS Waiver Application and Consent/Eligibility Certification Form by checking the "At Imminent Risk of Nursing Home Admission" box.

Ongoing Care Coordination for approved Waiver Members:

For members that are already established with MHL Waiver Services, joint care coordination efforts will need to occur between UPHP and UPCAP Care Managers.

UPHP will be responsible for:

- The required monthly phone calls to the member for monthly care plan review
- Ongoing day to day care management of the members including all non-waiver related benefits (assistance with medications, service prior authorizations, non waiver DME, non-waiver medical transportation, etc.)
- All required hospital and nursing home transition requirements including notification to UPCAP via fax of member admissions and discharges.
- Status updates in CHAMPS –while in a nursing facility
- Denial notices

UPCAP will be responsible for:

- All care coordination related to waiver services and additional contract requirements including, nutritional supplements (when amount exceeds State plan benefit)
- Holding and re-starting waiver and PCA services for MHL members that are hospitalized
- Face to Face member follow up every 90 days for waiver service and provide specific documentation of each waiver service including member satisfaction in amount, type and scope in Altruista.
- Member follow up within 2 weeks of decrease, increase, or change in services (this does not have to be provided face to face). Documentation of the two week follow up will be documented in Altruista
- Communication of visits, status changes, and service changes to UPHP in Altruista

Service Arranging/Purchasing:

C-Waiver clients must have individualized care plans and corresponding service plans which

identify the frequency and duration of proposed services. Work orders for C-Waiver clients should be sent to selected providers in the same format currently used for MI Choice clients.

After initial service authorization is communicated by UPHP, UPCAP will be responsible for the ongoing arranging and ordering of waiver services and will follow the same requirements set forth for MI Choice clients. As such, UPCAP care managers will need to conduct an initial follow-up call within two weeks of starting services and for all subsequent additions or increases in service delivery and document this follow up in Altruista.

It is essential that any changes in service are communicated back to the UPHP Care Manager.

Disenrolllments:

UPCAP will be responsible to communicate to UPHP Waiver members that are no longer receiving waiver services or no longer qualify for waiver services.

UPHP will be responsible for submitting dis-enrollments in CHAMPS and denial notices.

Frequently Asked Questions:

Q: If a MHL member is receiving personal care services and moves into the waiver program are personal care services now considered a waiver service?
A: No, personal care services are not considered a waiver service. Personal Care evaluations will need to continue every 180 days and can occur at the same time as a C-Waiver visit.

Q: Does a member need to receive services for an ADL to receive services for an IADL?
A: No, the member must qualify for ADL services by scoring a 3 or higher for at least 1 ADL in order to qualify for IADL assistance but does not actually need to receive an ADL service.

Q: Can the same member receive Personal Care Services and ECLS services?
A: ECLS and Personal care Services may not both be provided for the same ADL or IADL at the same time during the day. It is ok for ECLS and Personal Care Services to be used for the same ADL or IADL during the same day, but at different times during the day.

Q: If a member is identified as qualifying for personal care services in conjunction with a C-Waiver assessment, does the waiver application need to be approved before starting personal care services?
A: No, personal care services are not waiver services and can therefore be started prior to the waiver application approval based on the personal care service processes.

Q: Can personal care services be approved for things other then what is listed on the personal care assessment i.e. care for pets, moving, yard work, assistance with paying bills, babysitting?
A: UPHP utilizes the personal care assessment and descriptions when approving services. UPHP is unable to approve any service not listed on the assessment.

Q: Why does an NFLOCD need to be completed on members that do not meet criteria?
A: MHL requires that all NFLOCDs conducted by Integrated Care Organizations, such as UPHP, or their vendors must be entered into CHAMPS regardless of whether the enrollee meets the NFLOCD criteria. Each NFLOCD, including those under Door 0, must be on record in CHAMPS.

When an enrollee fails to qualify under the NFLOCD criteria, an adverse action notice including enrollee right to appeal information must be issued. UPHP is responsible for entering the NFLOCD into CHAMPS and MDHHS is responsible for sending the adverse action notice.

ATTACHMENT

Example Supporting Documentation
Nursing Facility Level of Care Determination Tool for Door 0.

Member Name:
DOB:
ID#:

Summary of Findings….

Door 1- Activities of Daily Living. Member is independent with all his activities of daily living. Member informs he is able to move to/from lying position, turn side to side and position himself in bed. Member is independent with bed mobility, transfers, toileting and eating. Although member uses his lift chair, he states he doesn't require any assistance with transfers to/from bed, chair, or standing position. Member is independent using the toilet, with transfers on/off toilet, and is able to cleanse, and adjust his own clothes. Member is independent with eating.

Door 2- Cognitive Performance. Member's cognitive performance is intact. Member was able to recall words after five minutes. Member's decision making ability is assessed to be independent with member stating he is able to organize his own daily routine. Member is easy to have a conversation with and is understood clearly.

Door 3- Physician Involvement. Member does not meet the criteria for physician involvement with the 14 day look back period as he has not had any physician visits, nor order changes in the past 14 days.

Door 4- Treatments and Conditions. Over the past 14 days, member hasn't received any health treatments or demonstrated any health conditions. Member confirms he doesn't have any stage 3-4 pressure sores, doesn't use IV/parenteral feedings, or IV medications. Member doesn't require end stage care, nor daily trach, respiratory or daily suctioning cares. Member has not had pneumonia within the last 14 days, nor uses supplemental oxygen therapy. Member doesn't take insulin, nor is he on peritoneal or hemodialysis.

Door 5- Skilled Rehabilitation Therapies. Member hasn't had any skilled rehabilitation therapies in the past 7 days.

Door 6- Behavior. Member does not display any challenging behaviors during today's assessment, nor did member verbalize that he has any behavioral symptoms or problems over the past 7 days.

Door 7- Service Dependency. Member does not meet the qualification for Service Dependency as the member has not been a program participant in MI choice, Pace or a Medicaid-certified nursing facility for a one-year period.

Door 8- NF Level of Care Exception Review. Member does not meet any of the Exception Criteria. Member is able to perform ADLs in a reasonable amount of time. Member's weight is stable at 140lbs and he denies any recent falls in the past month. Member did not indicate any evidence of Frailty, Behaviors, or Treatments.