Care Management

and

MI Choice Waiver Program

Policies and Procedures

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Waiver / Care Management Policies

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UPCAP

Long Term Care Programs: Mission, Goals, & Objectives

Since 1974, mission and goals of UPCAP's Long Term Care (LTC) Programs have been centered around supporting adults to live independently for as long as possible in the setting of choice.

Providing information and assistance on home and community-based supports and services is key to the program's success. UPCAP believes that promoting a comprehensive array of these supports and services in the least restrictive setting enhances independence and quality of life for Participants and their supports.

UPCAP's LTC Programs use trained, professional Care Management staff and a comprehensive Community-Based Service Provider Network to deliver services across the Upper Peninsula.

- Based on standardized health and social needs assessments, **Care Managers** provide comprehensive, unbiased information and assistance to allow individuals to make informed long term care choices to address their individual needs. This process is based in the principles of Person-Centered Thinking and Person-Centered Planning that are designed to maximize Participant choice in meeting their needs in the least restrictive setting. The role of the Care Manager is to assist the Participant in this process to ensure they have control of their daily lives.

- UPCAP's network of **Community-Based Service Providers** share in the belief that quality supports and services should be designed and delivered in settings that provide the least amount of restriction and the maximum amount of independence and control. All Service Providers are required to demonstrate their commitment to the principles of Person-Centered Thinking and Planning, and to the guiding principle that the Participant is in control of their service plan to the greatest degree possible.

The following policies and procedures for Home and Community-Based LTC Programs have been established to guide staff and support UPCAP 's mission to assist Upper Peninsula residents in receiving supports and services in a setting of their choice and maximize independence.

Care Management Program Policies & Procedures

Section 1 - Program Overview

This manual is designed to assist UPCAP Care Managers in carrying out the goals and objectives of the **Upper Peninsula's Care Management (CM) Program.** The following policies, procedures, appendices, and amendments are based on requirements set in contracts with the Aging & Adult Services Agency (AASA)-funded **Care Management (CM)** program, and the Michigan Department of Health & Human Services (MDHHS)-funded Federal **Home and Community-Based Waiver Program (WA)**.

Section 2 - Outreach & Promotion

UPCAP will develop materials and organize outreach activities to promote the Care Management (CM) and the Home and Community Based Waiver (WA) programs throughout the Upper Peninsula. The outreach and promotion activities will target appropriate populations and referral sources. **All Care Management** staff are expected to participate in on-going outreach activities.

The goal of promoting the CM and WA programs is to generate inquiries and referrals for individuals interested in program services.

MDHHS, AASA, other funding and/or contractual sources, and copyrighted materials will be acknowledged in all printed, social media, web sites, video, and audio promotions.

Section 3 - Referrals

A "**referral**" represents any request for **participation** in either CM or WA program. Calls requesting **information** only are not to be considered a referral.

UPCAP's 211 Call Center is the referral site for CM, WA, and other LTC programs. Agencies and individuals must call 211 to make a referral. Referral-type calls received at local Care Management offices shall be directed to contact the 211 Call Center.

The paper work for each referral, whether eligible or not for program services, shall be saved for a minimum of three (3) years as required by MDHHS.

Section 4 - Pre-Screening

When the referral comes into the 211 Call Center, Call Specialists will complete the **Initial Referral Form** and the **MI Choice COMPASS Prescreen**.

- The 211 Resource Manager forwards the completed **COMPASS Prescreen** for those scoring **Level C thru E** to the appropriate CM office on a daily basis. **Section Q** and **nursing home** referrals are forwarded to the appropriate Transition Coordinator.
- Individuals scoring a **Level A or B** are not eligible for an in-person assessment. Call Specialists shall give these individuals an opportunity to discuss their needs via a phone call with an Options Counselor (OC), and may also suggest other community services that could meet their immediate needs. After Options Counseling activities are concluded, the OC shall mail an Adequate Action Notice to the individual reporting the results of the telephone screen and the person's right to request a fair hearing.
- The 211 Resource Manager is responsible for adding all referrals to the master Waiting List and the COMPASS Waiting List. The Resource Manager enters Initial Referral information into COMPASS for Section Q and nursing home referrals.
- Case Techs in each office are responsible for entering the Initial Referral information for referrals received into COMPASS prior to the Care Management assessment.

Section 5 - Scheduling

To ensure individuals with the highest acuity indicators do not seek nursing facility placement before they can be scheduled for a WA or CM assessment, assessments will be scheduled based on the following process - not by date received:

Screening Score	Priority for **Assessment**
D1	#1
E	#2
D	#3
C	#4

Assessments are assigned to staff on a rotating basis, taking into consideration the availability and/or time constraints of each RN and SW. Teams are expected to participate in a minimum of two (2) completed assessments per week. This should include assessments for the Veterans Program and MI Health Link.

All offices are **required to meet weekly** to review current referrals and all Care Manager schedules. If a scheduled assessment is cancelled or rescheduled, the Care Manager is responsible for promptly informing the Case Tech that they are available for another assessment. To maintain maximum case loads, it may be necessary to assign teams three (3) new assessments per week.

Assessments are typically scheduled for Tuesdays and Thursdays. However, in applying the principals of person-centered planning, preferences and considerations of the Participant and their responsible parties ***must*** come first. Care Managers may have to conduct assessments on days other than Tuesdays or Thursdays, **and** at times outside traditional work hours.

The Care Management Supervisor and/or Program Director shall be notified in the event a Participant or Responsible Party require that an **assessment be scheduled outside normal business hours.** Staff will be permitted to alter normal work schedules to compensate for meeting Participant/Responsible Party considerations. Changes in work schedules must be noted as approved by the Supervisor on the Care Manager's time sheet.

After scheduling has been completed, the Case Technician shall send a **confirmation letter** indicating: 1.) the agreed upon time for the assessment, 2.) a list of items which will be needed by CMs during the assessment process, and 3.) information about the Self Determination Program option and Person Centered Planning.

Section 6 - Assessments

The Assessment process is comprised of the following forms and documents:

- **Program/Process Review:** Program Explanation (included in CM Handbook), Consent Form, UPCAP Client Informational Folder, and Care Management Handbook Acknowledgement
- **COMPASS Assessment** (MDS-IHC)
- **Financial Eligibility** (MDS-IHC)
- **Functional Eligibility:** NFLOC & Freedom of Choice
- **Plan of Care** (COMPASS)
- **Post Assessment Recommendation** (Optional)
- **Internal Assessment Forms:** Cost Sharing Determination, Medicaid Contact Log, Medical Release of Confidential Information
- **Rugs, Caps, & Triggers** (Optional)

A. Assessment Preparation

On the day of the scheduled assessment, Care Managers shall call the prospective Participant ***before*** traveling to their home to verify that the person is still interested in participating in an assessment.

B. Program / Process Review

After greetings and introductions with the Participant and supports in attendance, Care Managers are to explain the CM process including, 1.) the **program explanation**, 2.) **eligibility criteria**, and 3.) the **formal assessment** process. The Care Manager must obtain the individual's signature acknowledging their Rights & Responsibilities in the Program and Bill of Rights documents were provided and explained to them.

- **Program Explanation & Eligibility Criteria**

  Upon first meeting the prospective Participant, the Care Management team shall explain the Care Management program and process, and briefly go through the Care Management Handbook, paying particular attention to the Rights and Responsibilities should the individual be determined eligible for enrollment and agree to participate. Participant or Responsible Party must sign Acknowledgement page of the CM Handbook, and it shall be maintained in the Participant case file, with the Consent & Authorization Form confirming program participation.

  During the first **re**assessment cycle, one or both CM team members are expected to conduct a much more thorough review of all aspects of the CM Handbook with the Participant. The purpose of this second review is to ensure that the Participant (or responsible party) is fully aware of all rights and responsibilities, as well as opportunities to have a voice in improving the quality of the care management and service delivery process. UPCAP acknowledges that the Participant and responsible party may be overwhelmed with information at the time of the initial assessment. This second review is intended to deepen their understanding of their rights and responsibilities and remind them of the opportunity to have a voice in improving the program.

- **Verifying Participant I.D. Numbers**

  The Participant's Social Security number shall serve as the Participant's identifying number for the State of Michigan. The Social Security number is to be "verified" at the time of the assessment and Case Tech notified if it is different from what is in COMPASS.

  If a Participant does not have a Social Security number, one must be obtained before the case can be opened. Social Security numbers are to be protected. HIPAA regulations allow for faxing of Participant information, but e-mails must be encrypted when confidential information is to be transmitted.

C. Functional Eligibility: Nursing Facility Level of Care (NFLOC):

MDHHS has determined that all individuals seeking long-term care (LTC) services, whether through an institutional setting or through the MI Choice Waiver Program, must meet Nursing Facility Level of Care (NFLOC) criteria as set forth in Policy Bulletin MSA 04-15, dated November 1, 2004. NFLOC assessments must be conducted in-person as directed in the MDHHS field guide. A current or potential Participant must meet the criteria in one of the seven "doors" in order to be deemed functionally eligible for enrollment into the MI Choice Waiver Program and/or the AASA-funded Care Management program.

All NFLOCs must be entered into the CHAMPS data system. This includes NFLOCs conducted for individuals who did not meet the eligibility criteria at the initial NFLOC or for individuals who no longer meet the NFLOC criteria at a subsequent reassessment. The NFLOCs must be in the CHAMPS system so UPCAP will receive its capitation payment for that Participant, and to facilitate the Participant's right to an immediate review by MPRO.

A copy of the NFLOC must be kept in the Participant case record.

1.) Conducting the NFLOC

When conducting the NFLOC with existing or prospective Participants, Care Managers use verbal ***and*** visual information of the individual as well as input from others who may have medical or caregiving knowledge of the individual. Failing to actually observe the individual in conducting activities being evaluated through the NFLOC, and not considering information from others may result in an inappropriate eligibility determination and a possible negative finding in an MPRO Retrospective Review or through an Administrative Fair Hearing.

Care Managers shall refer to the NFLOC Field Guide for policies and procedures pertaining to the completion of the NFLOC.

2.) Not NFLOC Eligible

Applicants not meeting the NFLOC criteria shall be given an **Adequate Action Notice** and advised of their right to appeal. Current *Participants* shall be given the **Notice of Adverse Benefits Determination** form. The NFLOC must be entered into the CHAMPS data system in the event there is an Immediate Review by MPRO or an appeal filed by the individual, and for UPCAP to receive its capitation payment. Those not eligible for UPCAP's LTC programs must be linked to appropriate community services.

- **Exception Requests to MPRO**

  Care Managers may request a "Frailty Exception" from MPRO for individuals who do not meet any of the eligibility criteria through the NFLOC whom the Care Manager believes needs Waiver services. NFLOC must first be entered into CHAMPS ***and*** an application for Medicaid must have been submitted and be on file with DHHS so that MPRO can access the MA number. The request for a **Frailty Exception** must be made the **same day that the NFLOC was completed** and entered into the State's on-line system.

  For Participants who are enrolled as a result of a MPRO Frailty Exception or an Immediate Review as requested by the Individual, eligibility for the MI Choice program exists only so long as the conditions under which MPRO granted the exception continue to exist. Should the Participant's abilities improve to where the frailty conditions no longer prevail, Care Managers need to complete a new NFLOC demonstrating that eligibility does not exist, provide the Participant with the Notice of Adverse Benefit Determination form, and advise the Participant of their right to appeal. Care Manager's documentation must support the decision and demonstrate that the conditions under which the exception was granted no longer exist.

3.) NFLOC Eligible

For Participants who meet the NFLOC criteria, a formal MDS-HC assessment shall be completed and the person enrolled into one of the two LTC programs. For Participants enrolled directly into the MI Choice Program, the results of the NFLOC must be **entered into the CHAMPS data system within fourteen (14) days** of completion of the NFLOC and enrollment into the MI Choice program.

- **Freedom of Choice Form**

  After completion of the NFLOC, the CM will have the Participant sign the "Freedom of Choice" form verifying the door they qualify under, and confirming the Participant's LTC setting choice.

- **Temporary Door (3, 4, & 5) Eligibility**

  If it appears the individual will be eligible through one of the temporary doors (3, 4, or 5), the Care Manager must review the requirements in the **NFLOC Field & Process Guidelines *and*** obtain approval from the current or potential Participant to contact medical/health care providers who have additional information regarding the relevant condition(s).

Therapies and treatments must be for "restorative purposes" as defined in the NFLOC Field & Process Guidelines. Care Manages must get **verification** of this from a medical/health professional and request **copies of any orders** for the treatments and/or therapies to support the temporary door eligibility. Such consultation is necessary to determine, among other things, the purpose or intent of such activities as oxygen usage, physical therapies, or other treatments and to ensure that any treatment, therapy, or physician intervention is for restorative purposes rather than maintenance purposes. It is also necessary should the Participant appeal the decision or in the event of an MPRO retrospective review.

Because a final eligibility decision cannot be made until the medical professionals provide the requested documentation, the Participant is not given a Freedom of Choice document at the initial meeting. If more than fourteen (14) days passes before this information is received, a new face-to-face NFLOC must be completed.

If the health care provider is unwilling to provide the requested orders or other supportive documentation, Care Managers must consult with the Program Director or CM Supervisor, and jointly make an objective decision based on the facts and evidence available as to whether the conditions for treatments and/or therapies are restorative in nature. Case notes should reflect the efforts to obtain information from the medical professionals as well as any reasons why requested information was not made available. Efforts must continue to obtain required documents, including contacting the agency supervisor and, if necessary, the Participant's physician.

Once an eligibility determination can be made, the Freedom of Choice form is to be completed and sent to the Participant along with any other materials not provided at the time of the initial assessment.

90-Day Eligibility Cycle for Temporary Doors: Participants found to be eligible for program enrollment through Doors 3, 4, or 5 shall be advised that their eligibility may be temporary. MDHHS policy requires that Care Managers must develop a discharge plan with the Participant which addresses their needs during the period of eligibility as well as for when the conditions under which eligibility was established no longer exist.

NFLOCs must be conducted and entered in to CHAMPS ***(within 14 days)*** **at least every 90 days** to evaluate if the qualifying condition still exists.

- Ongoing Temporary Door Eligibility

These NFLOCs need **not** be conducted in person and no Freedom of Choice form is needed ***if*** the Participant continues to qualify under a temporary door. **Copies of supporting medical documentation and orders must be collected for each 90-day cycle.**

- Becomes Eligible Under Non-Temporary Door

These NFLOCs must be conducted **in person** and a Freedom of Choice form issued.

- **No Longer NFLOC Eligible**

These NFLOCs must be conducted **in person**. A **Notice of Adverse Benefit Determination** and **Freedom of Choice** are issued along with information related to their rights to appeal the closure. Care Managers must implement the Discharge Plan.

- **Service Dependency Door (#7) Eligibility**

Participants enrolled through Door 7 or for those being considering for continued eligibility through Door 7, must also be in need of a Waiver service(s) that no other community resources can meet including the DHHS Home Help Program, Adult Foster Care settings, and/or the Participant's own resources.

Having been a Participant for one (1) year or more alone does not qualify someone for Door 7. Care Manager must specifically document the **service dependency** in COMPASS Progress Notes and why resources and services other than MI Choice are insufficient to meet the Participant's needs.

- **Waiver Program Enrollment**

The NFLOC must be completed prior to enrollment. The NFLOC is valid for fourteen (14) days and must be entered into the CHAMPS data system **within 14 days of completion.** If an NFLOC is older than 14 days before enrollment into the MI Choice program, a new NFLOC must be completed prior to establishment of the Waiver enrollment date and the enrollment date must correspond to the subsequent NFLOC.

The Waiver Enrollment date (From Date) cannot be before the NFLOC was completed in person with the Participant nor can it be more than 14 days after the NFLOC was completed.

- **Nursing Facility Transitions**

Waiver enrollment and subsequent services cannot begin until the NFLOC is completed. The NFLOC must be completed within 14 days ***before*** the NF Transition Resident returns to the community.

NFLOCs conducted in the nursing facilities cannot be entered until the individual has discharged.

- **Reevaluating Functional Eligibility**

  CMs are required to reevaluate a Participant's functional eligibility status at every assessment.

  - **No Door Change:** The NFLOC form does not have to be completed at every assessment, however, the COMPASS reassessment must validate which Door the Participant continues to qualify under. The "Door" must be written in the summary of the reassessment, or in the progress notes.

  > ***NOTE: NFLOCs must be completed and entered into CHAMPS annually and/or every 90 days for Temporary Door eligibility. <u>UPCAP will not receive payment</u> for any NFLOCs entered beyond those timelines.***

  - **Change in Doors or Functional Eligibility:** New NFLOC process must be completed for Temporary Door eligibility or when a Participant no longer meets functional eligibility. Such NFLOCs must be entered into CHAMPS.

- **Annual Requirements**

  NFLOCs must be completed and entered into CHAMPS **<u>at least annually</u>** for MI Choice Participants. A new Freedom of Choice does **<u>not</u>** need to be completed even if a Participant moves from one door to another.

- **No Longer Functionally Eligible**

  Current Participants no longer scoring under any doors must have a new NFLOC completed and entered into the CHAMPS system. They shall be given a new **Freedom of Choice** and the **Notice of Adverse Benefit Determinatio**n form.

- **Re-enrollment**

  When a Participant who had been closed to the MI Choice program (NF placement, etc.), a new NFLOC must be completed prior to any re-enrollment. The new NFLOC must be entered into the State's website **<u>within 14 days</u>** of re-enrollment. A new Freedom of Choice is required.

  For existing Participants returning from the nursing home, the Care Manager has **seven (7) calendar days from discharge** to <u>complete</u> the new NFLOC, and **14 days from date of discharge** to <u>enter</u> it in the State's website.

<u>Post Team Recommendation</u>

If, in the opin**i**on of the Care Manager, institutionalization is absolutely necessary, they must encourage the Participant to complete the assessment and make the

recommendation for such placement. If the person refuses to consider nursing home placement, the case may be opened, explaining to the Participant and Responsible Parties that the CM/WA program may not be able to meet all of their needs. Refer to **Section 11: 24-Hour Care**.

In the case where a Care Manager concludes that an individual requires nursing home placement and the Participant is making an "uninformed" decision, an Adult Protective Services (APS) referral must be made to the local DHHS office. The CM must work cooperatively with the APS worker to ensure that, 1.) appropriate placement is secured, 2.) that the Participant fully understands the consequences of their choice, and 3.) that the decision is an "informed" decision. However, prior to making such a referral, the CM must consult with the Care Management Supervisor or Program Director. See **Section 24: Advocacy & Protection.**
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This scenario is different from that in which, at the conclusion of a full assessment, the CM believes that a person's needs would be best addressed in an institutional setting. In this situation, the case would be considered open to Waiver until such time as placement is secured with the agreement of the Participant.

Care Managers must use their professional judgment in determining whether or not a mix of informal and formal services can adequately meet the needs of the Participant. If the demand for formal services exceeds the established ability of the program on its own, and the Participant's informal supports are insufficient to cover the balance of service needs, the Care Manager is responsible to verbally recommend institutional care.

The Participant can disagree with that professional judgment and can decide to live at home anyway within those limitations or they can appeal the decision.

D. COMPASS Assessment (IHC)

Each Participant seeking enrollment into UPCAP's Long-Term Care Program must first participate in the **MDS-IHC Assessment**. The assessment identifies problems and needs that may be barriers to the Participant's ability to remain at home. The assessment serves as the central component to validate Medical Eligibility for the MI Choice and Care Management Program. The assessment also validates the Nursing Facility Level of Care (NFLOC) determination process.

This component consists of the IHC assessment for RN Section and a SW section; both sections are to be completed by the RN/SW Care Managers by soliciting information directly from the Participant during a face-to-face assessment. Supervisory staff shall train each Care Manager on assessment procedures.

Social Workers are responsible for completing the SW section. The financial section is updated annually and should coincide with the annual Medicaid redetermination if

applicable. In addition, Social Workers are to describe financial problems or issues identified, and set an action plan into place for resolution and monitoring.

The Social Work Summary, (Section H) includes observations made during the assessment that will be addressed on the Plan of Care, highlighting issues with formal and informal supports, psycho-social behaviors, environmental concerns, financial status, etc.

The Nursing Summary, (Section T) documents observations made during the assessment that will be addressed on the Plan of Care, highlighting issues surrounding IADL's, ADL's, medication issues, etc.

Occasionally, Participants decide not to complete the remainder of the COMPASS assessment. The Care Manager should then offer other community resources that may be available to assist the Participant. The Participant Status Form shall be sent to the Case Tech with the outcome stating "***assessed, not opened***."

The Assessment Outcome

The MDS-IHC assessment is to be completed in the on-line COMPASS system, following the guidelines established in the COMPASS manual. At the completion of the assessment, the **Participant Status form** is sent to the Case Tech with the appropriate program enrollment and date of enrollment.

The "COMPASS Assessment" must be completed within two (2) working days of the face-to-face assessment with the Participant.

- Prior to the beginning of service delivery, each agency from whom services are to be accessed (either purchased or arranged), must be sent a copy of the completed COMPASS assessment with the intention of reducing duplicate assessments.
- Agencies using Vendor View will have access to the complete assessment. **See Appendix XI** for the current **List of Providers Enrolled in Vender View**.
- Paper copy of the assessment shall be mailed or faxed to agencies not enrolled with Vendor View. Care Mangers should print the assessment through the Report Portal in COMPASS selecting the "assessment without financials."

E. Financial Eligibility

Financial eligibility for individuals participating in the MI Choice Waiver program will ultimately be determined by MDHHS. A "Presumptive Financial Eligibility" is obtained by completion of section FS in the IHC Assessment and the Medicaid Application. Financial eligibility must be re-established annually. While ultimately the responsibility of MDHHS, Care Managers must assist Participants with the re-determination process to ensure that MDHHS has the materials and information necessary to establish on-going financial eligibility.

- **Application Process:**

  Following a determination of medical/functional eligibility, SW Care Managers shall complete the **Medicaid Application (1426)** with the Participant and mail it to:

  Health Insurance Affordability Program
  PO Box 30273, Lansing, MI 48909

  as directed in Step 6 of the application; or it can be dropped off at the local MDHHS office. Care Managers should obtain a date-stamped copy of the application cover page.

  Include all income and asset verifications along with the completed and signed **Form 1004.** The **MSA 0814 Waiver Enrollment Notice** shall be completed and attached to the Medicaid application, so MDHHS is aware of the program enrollment.

  Care Managers are also to complete Appendix C with the Participant signature, designating themselves as the "authorized representative" for the purpose of having future Medicaid information forwarded to the Care Manager.

  Care Managers are encouraged to check with their local MDHHS office regarding the changes in the application process. If the local MDHHS office will accept the **new 1426 Application and Form 1004**, deliver the application to the local office.

- **Waiver Pending**:

  If Presumptive Eligibility through completion of COMPASS SW Assessment, Section FS: Benefits & Insurance, and the MA application is determined, services should be started immediately after delivering to the local MDHHS office. Waiting for final MDHHS approval is not necessary. Note that a “Presumptive Eligibility” determination and formal enrollment cannot be made until the Medicaid application has been received by the local MDHHS office. It is recommended that the Care Manager obtain a copy of the date-stamped cover page from the local MDHHS office when the application is submitted.

  Social Workers are to track the MA application process to ensure that eligibility is determined in a timely manner. The primary Care Manager shall submit the Status report to the Case Tech with the program classification of Waiver Pending (WP) along with a copy of the **Waiver Enrollment Notice.** A copy of the Waiver Enrollment Notice must also be sent to the Administrative Services Manager in Escanaba.

  Follow-up contacts must be made with the local MDHHS office to ensure that the process is moving forward. Such contacts are to be noted in the Participant Progress Notes. Delays in processing the application should be reported to the Care Management Supervisor.

Participants currently MA eligible and have not divested in the past 5 years are automatically financially eligible for WA. However, if their needs can be met through participation in the Home Help Program or Hospice, without having to purchase a "Waiver" service, they should be placed in the Targeted Case Management Program (TCM). Ultimately, this will be a Participant choice issue and the individual must be given information enabling them to make the appropriate program choice.

Eligibility reports are run on a monthly basis by the Administration Office for all participants to verify MIChoice MC classification, and are distributed to Care Managers for review.

For individuals coming into the Waiver Program who are currently receiving services through the MDHHS Home Help Program, the local MDHHS office must be notified that the person is becoming a Waiver Participant. Care Managers shall instruct the MDHHS office to close the person from the Home Help Program on the day before enrollment, or to coordinate a different closure date because of Home Help payments.

- **Waiver Ineligibility - <u>Divestment Period</u>**:

  If a person gives away assets and resources in order to become Medicaid eligible, MDHHS may find that the person divested and is therefore ineligible for Medicaid financed long-term care services including MI Choice.

  The MDHHS is legally responsible for determining financial eligibility for Medicaid payments through the MI Choice Program. For individuals who are deemed by MDHHS to have divested for the purpose of becoming financially eligible, a penalty period may be established by MDHHS and if so, the person would be considered ineligible to receive Medicaid financed long-term care services.

  Per BEM 405, during the penalty period, MA will not pay for the Participant's cost for long-term care services, home and community-based services, Home Help, or Home Health. MA will pay for other MA Covered services.

  A person may be enrolled into the MI Choice Waiver during a divestment penalty period but must be classified as "WA-D" for the duration of the DHHS-established penalty period. (The WA-D case status, however, is not assigned until DHHS makes its determination.) During the Penalty Period, the person must meet the NFLOC criteria and must receive at least one Waiver service. Ultimately the person is responsible for paying for the cost of <u>all</u> necessary long-term care services, including the cost of Care Management during the divestment penalty period.

Individuals who have a divestment determination made against them, and therefore a penalty period, must be informed that during the penalty period, they are responsible for the cost of all Waiver services including Care Management that would normally be purchased or provided for using Medicaid resources.

The divestment determination may be delayed or established after a Participant is enrolled into the MI Choice Program. If, at the time of determining potential financial eligibility for the MI Choice program, a Care Manager becomes aware that the Participant has divested within the last five years or is currently working with an elder law attorney to set up finances for Medicaid eligibility, the Care Manager must inform the Participant that should a divestment penalty period be established, the Participant will be responsible for paying for all services (including Care Management) which may have been provided once the divestment period is finally established by MDHHS. Care Managers may project what these costs may be but the ultimate cost may not be known until after MDHHS makes its determination. In making this projection, Care Managers are to consider the monthly costs of services to be received by the Participant as well as the monthly cost for Care Management services, which is currently **$490.00 per month**.

Care Managers shall inform the Program Director when a Participant has an established penalty period or of someone for whom they suspect will be subject to a penalty period. This should be done via a secure e-mail. The Program Director will inform UPCAP's Accounting Department and an "Accounts Receivable" will be established. Care Manager must change the **fund code** from 100 to **221**. The Accounting Department will be responsible for sending monthly statements for the cost of Care Management services and authorized in-home services once the penalty period has been established. The selected service provider will bill UPCAP, as usual, for authorized services provided during the divestment period.

It is possible that a penalty period may be assessed by MDHHS after a person is enrolled into the MI Choice program. In those situations where a Care Manager believes that a divestment has occurred, they must discuss the implications of the divestment, including the requirements to pay for services and care management once the penalty period is implemented. In care planning, the Care Manager and the Participant should establish, at a minimum, a service plan that meets the basic requirement of receiving an on-going long-term care service throughout the penalty period. UPCAP will pay for services until MDHHS makes its divestment determination. From the time that MDHHS establishes the penalty period, the Participant will be responsible for paying for services in order to meet the conditions and intent of the penalty.

Failure on the part of the Participant to pay for the monthly cost of Care Management and in-home services will be reported to the MDHHS. MDHHS will be responsible for any recalculation of penalty periods. If the penalty period is to be retroactive to a date after enrollment into the MI Choice program and the Participant fails to pay for the cost of care management, UPCAP will take

whatever legal recourse is available, including, but not limited to, placing a lien on the individual's estate.

No Waiver resources may be used to purchase services during a divestment penalty period, regardless of when this period is established. Should the Participant decide to withdraw from the MI Choice program rather than pay for the cost of Care Management and in-home services, they may do so. The individual may opt to be classified as a Care Management Participant (60+) and receive grant funded services. However, in so doing, the person will not be deemed to be in a long-term care setting and the penalty period requirements will not be satisfied.

For situations where MDHHS makes a divestment determination after an individual has been enrolled into the MI Choice Program, and establishes a penalty period retroactive to the original date of Waiver enrollment, UPCAP will bill the individual for the full cost of services already provided, including the cost of CM. Since the provider will have already been reimbursed by UPCAP for services provided, UPCAP will bill the individual for the cost of those services.

- **Financial Ineligibility:**

  As indicated above, the MDHHS is ultimately responsible for determining financial eligibility for the MI Choice Program. This occurs when an individual initially applies for Medicaid and during annual redeterminations. Care Managers are expected to assist Participants and Applicants with the initial application and with annual redeterminations.

  Individuals determined financially ineligible for any reason other than divestment, **cannot** be enrolled into the MI Choice program.

  At Initial Assessment: If the person is found to be financially ineligible at the Initial Assessment, the process stops. The person may appeal with MDHHS.

  At Initial Determination: If the CM feels the person is financially eligible at the time of the assessment (presumptive eligibility), they should be classified as "Waiver Pending," and file a Medicaid application with MDHHS. If MDHHS later determines them to be not financially eligible, services must be terminated as described next paragraph. Expenditures are recoded to 105, and the Participant must be classified as Waiver Financially Ineligible = WA Fin-I.

  At Annual Determination: If MDHHS determines a Participant to be **financially ineligible at an annual redetermination,** the following procedures must be followed to close the case:

  - MDHHS is responsible for sending the Participant the official Notice of Ineligibility and provide that person with information on their right to appeal that decision.

- Upon notification from MDHHS that a person has been determined financially ineligible, Care Managers must consult with the Participant to discuss the MDHHS finding and to inform the Participant that Waiver enrollment and services must be terminated because ***financial eligibility*** is one of three requirements for Waiver enrollment and continued participation. Care Managers are to obtain a written statement from the Participant (or authorized representative) that they understand the reason for closure.

- A **Notice of Adverse Benefits Determination** shall then be issued and services terminated immediately.

- If the Care Manager is unable to discuss closure due to financial ineligibility, a **Notice of Adverse Benefits Determination** must be sent and services are to be continued for 10 calendar days.

If the Participant requests a fair hearing on the MDHHS determination within the 12 day standard of promptness, Waiver enrollment and participation is to be reinstated and continued until such time as the Fair Hearing has been conducted and the Administrative Law Judge (ALJ) issues a finding on the appeal.

If the ALJ rules in favor of the Participant, Waiver enrollment and services continue until no longer needed or until such time as any one of the three requirements are no longer met. Participant should be classified as "Waiver-Yes."

If the ALJ **upholds** the MDHHS determination, Care Managers are, again, required to meet with the Participant to discuss program closure and service termination, obtain the written statement indicating the Participant or representative understands the closure, and issue a **Notice of Adverse Benefit Determination** followed by service termination. This action is not appealable as it is based on a MDHHS determination and/or Administrative Law Judge ruling.

- **Married Couples and Establishing Eligibility:**

  MDHHS requires Waiver Agents to assist married applicants who have excess assets complete the **Initial Asset Assessment** (IAA) and to establish a ***continuous period of care.***

  Doing so grants the couple the right to protect a portion of their assets for the community spouse. When the protection of assets involves the creation of trusts or similar financial maneuvers, Waiver agents are required to work with the applicant's legal counsel in submitting the IAA to MDHHS. To comply with MDHHS requirements, the following procedures are to be implemented:

  BEM 402 requires that an initial asset assessment is needed to determine how much of a couple's asset are protected for the community spouse. For an asset assessment/asset declaration to be valid, the person needing long-term care

(the person who will be applying) must establish a "Continuous Period of Care" which is defined in BEM 402 as:

"a period of at least thirty (30) consecutive days where the institutionalized spouse/applicant has been, or is expected to be:

- *in a hospital, and/or*
- *in an LTC facility, and/or*
- *approved for the Waiver as defined in BEM 106*
- *approved for PACE as defined in BEM 167*

The period is no longer continuous when none of the above are true for 30 or more consecutive days."

BEM 106 defines "approved for the Waiver" as:

- *The agent conducted the assessment, and*
- *The person received, or expects to receive, supports coordination services from the agent with appropriate Waiver services for at least 30 consecutive days.*

Couples wishing to establish a continuous period of care must be enrolled in UPCAP's care management program and must purchase services using their own resources. They must also pay for the cost of the care management program.

For those individuals willing to pay the cost of these supports and services, Care Managers are to conduct the appropriate NFLOC and have the results entered into the State's CHAMPS web site. The person's eligibility is to be coded as Financially Ineligible. An appropriate person-centered service plan must be developed. The Waiver services deemed appropriate for the individual are to be ordered from the vendor selected by the person in the same manner as a traditional MI Choice Participant. The selected Provider Agency will bill UPCAP as usual for services provided throughout the period of continuous care. Fund code 221 will be used for these services.

Payment for the Care Management Program and appropriate services must be made by the person in advance of enrollment. This payment will be made directly to UPCAP after the Participant receives the statement from UPCAP. Once payment is received by UPCAP, the Care Managers can file the IAA assessment form with DHHS.

Should service provision be less than the presumed financial obligation for the service order, UPCAP will refund the balance to the Participant at the end of the 30-day period of continuous care.

The monthly fee for care management is $490.00. The cost of services will be dependent upon the service plan developed to meet the Participant's needs. The

service plan must be developed as if the person were an actual Waiver Participant based on the identified needs in the assessment. A service plan developed with a single Waiver service is inappropriate unless it is fully supported by the actual assessment.

Care Managers shall notify the local MDHHS that the person has been enrolled and classified as Waiver Ineligible as set forth in BEM 106. Likewise, if the person refuses to make payment as set forth in this policy, the local MDHHS is to be informed that the person has not been enrolled and therefore an initial period of continuous care has not been established.

For individuals working with legal counsel, Care Managers may share this policy with the legal firm so that they are fully aware of UPCAP's efforts to comply with State Medicaid Policy.

Section 7 - Referral Follow Ups

A. General Follow-Up Procedures

Original referral sources (except for self referrals) shall be notified in writing of the assessment outcome.

B: Follow Ups with Title III Subcontractors

Subcontract Agencies that receive AAA (Title III) funds from UPCAP who make referrals must be notified immediately (via phone call) of the outcome of the MI Choice COMPASS Prescreen and the date/status of the CM assessment. These agencies need not conduct their own assessment if a CM assessment is going to take place within ten (10) working days from the date the referral was made. Once the assessment visit is completed, the agency is to be notified of the outcome. This second notification shall be done by a phone call and followed by a referral outcome letter. If the case is not being opened to CM, the Care Manager should provide the referral agency with any pertinent information gathered at the assessment.

Section 8 - Waiver Status Effective Dates

Care Managers **must** establish the "Effective" dates for participation in either WA or CM.

- The "**FROM" Date** is the date the individual becomes a Participant and the case is considered "OPEN."
- The "**TO" Date** is the last day the Participant was on the program.

A person becomes a Waiver Participant on the day that the Care Manager becomes aware that the individual meets **all three (3) eligibility requirements:**

1 - Medical/Functional Eligibility (NFLOC);

2 - Financial Eligibility (presumptive eligibility at a minimum), AND

3 - has need for and accepts a Waiver Service.

- For Waiver Participants, the "**FROM" Date** may differ from the assessment date for one of the following reasons:

  - The Participant was assessed in the nursing home or hospital and placed in CM *(60 and over)* or LCM1 *(under age 60)* until discharge and then placed on the WA or LCM1. The **FROM Date** for CM is the date of assessment and the **WA FROM Date** will be the day of discharge, or the date approved for the WA.

  - The Participant was assessed but no WA slot is available. They are placed in CM until a slot becomes available. The **FROM Date** for CM is the date of assessment, and the **WA FROM Date** would be the date they received a WA slot.

  - The Participant was assessed but is not financially eligible for the WA. They are placed on CM *(60 and over)* or LCM1 *(under 60)* until assets are spent. The **FROM Date** for CM or LCM1 is the date of assessment and the **FROM Date** for WA is the date their assets are at or below the WA limits and a slot is available.

- For Waiver Participant, the **TO Date** will always be the last day they received any services from the program, except when entering a NF, then the **TO Date** is the day prior.

The established **FROM Date** is the date to be reported on the MIChoice Waiver Enrollment when opening a Waiver case. If the Participant is an active Home Help Participant, MDHHS must close the case prior to the effective **FROM Date** for the Waiver Program. If an effective **FROM Date** is established, but for some reason the case is not to be opened as scheduled, both MDHHS and The Case Tech must be notified.

The Administrative Services Manager must be notified of both the **FROM Date** and **TO Date** for each Participant. Separate notices are used for this purpose, and should be utilized whenever a Waiver FROM or TO Date changes.

- The **MI Choice Waiver Enrollment Notice 0814** cover sheet shall be used when submitting an Initial Notification of Waiver Enrollment with or without an Initial Application for Medicaid.
- The **MI Choice Disenrollment Notice 0815** coversheet shall be used when notifying the Administrative Services Manager of any case closure regardless of reason.

Section 9 - Waiting Lists

There are two types of waiting lists - the **Assessment Waiting List** and the **Waiver Waiting List**.

A. Assessment Waiting List:

The assessment waiting list is for all individuals, regardless of potential program classification, and may be established when the entire agency has reached its capacity to serve additional Participants or to conduct assessments.

If the capacity of a single Care Management office to conduct new assessments has been reached, but capacity exists in other offices, referrals received by the office at capacity are to be processed, and the assessment responsibilities turned over to the closest CM office. The case, if opened, is to be turned back to the local office within the first reassessment cycle.

When all UPCAP CM offices have reached their capacity to take on new Participants, referral sources are to be informed of the probable time an individual will be on the Assessment Waiting List. The referral sources are to be provided with options in terms of meeting immediate Participant needs. As always, after an individual is assessed, the referral source is to be notified in writing of the outcome of the assessment.

The applicant must be sent a **Capacity Action Notice** informing them of UPCAP's inability to assess them at this time.

The Program Director shall be responsible for notifying both the MDHHS and AASA that the agency has met its capacity to serve new individuals.

B. Waiver Waiting List:

The MDHHS requires the maintenance of Waiting Lists. All individuals screened who qualify for an assessment and are requesting enrollment into the Waiver Program, regardless of whether or not an assessment will be conducted, must be placed on the MDHHS approved **Referral (waiting list) Log**.

Enrollment into the MI Choice program based on the MDHHS Priority Ranking - not in the order in which the referral was received. This waiting list is established whenever there are more individuals requesting Waiver services than there are slots available. The list is kept by each office using the priority rankings established by the Program Director in line with Medicaid Policy for Waiting Lists. Applicants placed on the waiting list must be sent a **Capacity Action Notice** informing them of their status.

Office Case Techs are to offer a face-to-face assessment to Participants based on their Priority Ranking as assigned by the Program Director or designee. All offices must utilize the MDHHS Waiting List Policy when moving an applicant or Participant off of the Waiting List.

1st Priority - individuals transitioning from a Medicaid (MA) children's program who have on-going need for Private Duty Nursing.

2nd Priority - individuals currently in a Nursing Facility.

3rd Priority - a referral from Adult Protective Services (APS) or an imminent risk of Nursing Facility placement (Diversion candidates).

4th Priority - other community-based referrals that do not fit into any of the previous Priority groups.

- **Financially Eligible:** All referrals will be "assumed" to be financially eligible for the Waiver based on information obtained during the initial screening by the 2-1-1 Call Center until determined otherwise through formal assessment. This will ensure that individuals will receive their proper place on the waiting list. If a Waiver slot becomes available, but the financial eligibility of the first person on the list is still undetermined (including presumptive eligibility), then that person is skipped and the next person on the list receives consideration.

  If a Care Manager is certain a Participant on the list is financially eligible, but is waiting for final determination by MDHHS, the person can be given the slot under the Waiver Pending classification.

- **Financially NOT Eligible:** When one is found financially ineligible for the Waiver, that person's name is removed from the Waiver Waiting List.

- **Enrollment Slots at Capacity:** For all Applicants, regardless of age, who formally request enrollment into the MI Choice Waiver Program and for whom **access is denied** because of limited enrollment capacity, an **Adequate Action Notice - Capacity Notice** must be sent indicating that enrollment is not presently available.

  Individuals who are already Medicaid eligible must be informed of, and assisted with, the right to appeal our decision to place them on a waiting list. In such cases MDHHS Appeals Procedures (**Section 26: Participant Grievance & Appeals Procedure**) must be followed.

- **Waiting List Follow-Up:**

  All individuals awaiting assessment must be contacted no less frequently than once a month to determine continued interest in accessing the MI Choice Program and to determine whether additional referrals may be necessary to assist the individual until such time as an assessment and program enrollment can be provided. Case Techs shall be responsible for these contacts and for documenting the results of the contacts in COMPASS.

Waiver Waiting List and Individuals under age 60: Individuals under age 60 can only be assessed when a Waiver slot is available, or if they will be utilizing NFT funds (refer to Appendix Vv: NFT). They can be placed on the waiting list using their referral date and must be sent a **Capacity Action Notice** notifying them of their status.

Section 10 - Care Planning & Person Centered Planning (PCP)

A. Person-Centered Planning

Person-centered planning (PCP) is an on-going process used to develop a Plan of Care that focuses on the Participant's strengths and desires, as well as areas of everyday life where they may need and want assistance. The Participant directs the process and includes any and all goals, dreams, or desires that are relevant to them. The planning process should include all of the people identified by the Participant as being important and necessary to assist them in meeting their needs and reaching their goals.

The person-centered care planning process starts with information provided by the Participant during the initial screening and continues on with formal interventions by a Care Manager beginning with the assessment process by having the person describe what problems or issues they feel need to addressed in order for them to remain in the community. It is at this time that the Care Manager shall provide information to the Participant, in an understandable way, an explanation of the person-centered process. This discussion should include tools that may provide assistance to the Participant in deciding who is important in their life, which goals are most important to them, and how best those goals can be met. These tools include the Circle of Support diagram, Planning for Myself a Tool for My Circle of Support.

The Preplan Questionnaire can be used by Care Managers to document the PCP process, and validate that they are honoring the Participant's preferences in planning the meeting and focusing on issues important to the Participant.

Care Managers shall explain the types of services which may be available to the Participant depending on their financial circumstance, availability of a Waiver slot, and the limitations of the Waiver Program.

B. COMPASS Plan of Care (POC)

The Michigan Department of Health and Human Services (MDHHS) and Aging & Adult Services Agency (AASA) require that UPCAP utilize a standardized care plan. UPCAP implemented the use of the **COMPASS Plan of Care** that coincides with the COMPASS assessment. All problems and needs identified from the assessment must be addressed on the POC, regardless of payment source or informal service provision.

All formal and informal services planned are to be listed, including community services to be arranged and purchased, and those interventions provided directly by Care Managers. Direct CM interventions such as advocacy and/or limited counseling must be included in the plan.

In addition, all interventions must include the following:

- what the intervention is,
- who will carry it out,
- the frequency and duration of the service,
- Funding source for the intervention if applicable.

The POC should also include safeguards and support mechanisms to honor the Participant's choices and provide assistance when choices may cause risk to Participant's health.

Formal interventions include (but are not limited to):

- consultation with the informal support systems;
- arranging (purchasing) of agency staff to provide cueing to the Participant when appropriate as a component of in-home tasks;
- the purchase/installation of medication management equipment/devices;
- arranging for or purchasing the interventions of a Private Duty Nurse; and/or
- consultation with Participant's pharmacist and/or physician.

Care Plan Time Frames:

A Care Plan must be developed for every Participant whose case is to be opened, within five (5) days of completing the COMPASS Assessment. Formal service delivery must begin within seven (7) days of the assessment or indicate a plan to address Participant needs until such time as approved formal service delivery can begin.

Care Plan Approval:

The Participant must approve and sign the care plan before implementation. The Participant should sign the Care Plan signature sheet at the time of initial assessment if services were discussed, in order that services may start in a timely manner.

The Care Plan must be reviewed with the Participant at each reassessment and their signature is required to confirm their continued approval. The review should focus on the goals and expected outcomes from the service intervention and whether or not those interventions have had the intended outcomes in meeting the Participant's overall goals. The success or lack thereof should be noted in corresponding Progress Notes and adjustments to the Care Plan must be made to assure that the anticipated outcomes are achieved.

CMs should operate from the perspective of arranging *MINIMUM* formal services that support informal caregiver efforts, NOT from the perspective of providing as much as may be available in terms of service availability. The Medicaid Waiver is the payment source of last resort and all other 3rd party resources must be utilized before using waiver funds.

Care Management is not designed to replace family or informal supports, but rather assist them in their efforts and promote continued involvement with the Participant.

C. Arranging / Purchasing Services (See **Appendix IV: SD Program**)

Care Managers must establish both frequency and duration of service delivery as part of the care planning process. Care Managers must contact approved provider(s) to determine the Provider's capacity to meet Participant needs as well as to determine a formal start date. Care Managers must attempt to have service delivery begin within seven (7) days of the completed assessment or develop an alternative plan with informal supports to address Participant needs until formal service delivery can begin. The assessment must be completed and finalized before services can be arranged.

Work Orders are also to be used regardless of whether services are to be purchased or simply arranged by CM (DCH Requirement).

All Care Plans with Direct Service Purchasing (DSP) expenditures must be reviewed by the CM Supervisor who is required by CMS regulations to initial approval of all expenditures.

Care Managers may only purchase services as authorized in **Appendix XII: Attachment H – Minimum Operating Standards for MI Choice Waiver Program Services - of the MI Choice contract with MDHHS** *(sent to all staff by CM Supervisor on annual basis or as changes occur)*.

Work Orders:

Work Orders must be used to notify Providers and Case Tech of total units of service to be provided, time of day, day of week, start and stop dates, and changes in services.

- Work Orders must include information about risks related to health and welfare decisions made by Participant (i.e. DNR designations, living will information, etc), and any instructions related to those risks the Provider should follow in order to minimize risk to agency staff and/or Participant.
- Work Orders must include appropriate HCPCS codes for each service being ordered and the priority status of the Participant.
- Work Orders are to be written with specific instructions for each service requested and must include Participant instructions and/or wishes if applicable.
- Work Orders must be completed whenever service delivery is to stop unless a specific stop date is indicated on the original Work Order.

Two-Week Follow-ups:

CMs are required to contact new Participants **within two (2) weeks** of ordering their **initial services** to ensure their satisfaction with the service. This contact must be noted in the Progress Notes.

Vendor View:

Work Orders must be given to the appropriate Case Tech so they can enter in MICIS, which will generate the notice to a provider in Vendor View. Care Managers are to call Providers to confirm availability of providing a service before a work order is completed. For those providers registered in Vendor View, they must receive the service authorization (work order) in Vendor View before services are scheduled to begin. For providers not enrolled in Vendor View, work orders should be faxed to the provider following the confirmation call. It is not appropriate to send a work order without first talking to the Provider. This includes adjustments to previously accepted work orders.

Unauthorized Services:

When a Provider furnishes a service in excess of the authorization level, the Provider is essentially rendering a free service to the WA program and payment CAN NOT be made. CMS regulations require that all services must be authorized on Care Plans, and corresponding Work Orders. For this reason CMs must increase frequency, duration and/or units when a determination is made that a Participant needs and wants additional services.

UNDER NO CIRCUMSTANCES CAN A PROVIDER BE PAID FOR SERVICES NOT AUTHORIZED ON THE CARE PLAN! (MDHHS/CMS Standard)

Situations may arise where service provision is necessary which has not been authorized on the initial care plan or subsequent updates. Usually such events will take place when Care Managers are not available to discuss the situation with the Provider Agency (evenings or weekends). In such situations, if the provider agency is able to justify the extra hours, the Care Manager should approve the additional time. In such situations, the Care Manager shall be responsible for completing a **one-time only Work Order** via Vender View to the Provider and Case Tech.

Participant Not Utilizing Approved Services:

For Participants who have multiple instances where they fail to notify their Care Manager or the service provider when they are not home, or who regularly send provider staff home without service provision, Care Managers are to re-evaluate the need for the service and if appropriate, adjust the service plan with the Participant's approval. If the service plan remains appropriate to meet the Participant's needs, the Participant is to be sent a written notice indicating that future failures to notify either a Care Manager or the provider directly when absences continue, the provider will be authorized to bill the Participant directly for their efforts. A copy of this notice should be sent to the Provider as well, however the Provider must be told that this notice is not an authorization to directly bill the Participant.

If occurrences where the Participant is absent or sending staff away continue after the notice is sent to the Participant, the provider may be authorized in writing to directly bill the Participant for a missed visit. The Provider will need to have documentation of the good faith effort to provide service(s) as ordered and maintain a copy of the CM notice and CM authorization to bill. Each instance of Participant absence or service refusal will require a separate authorization to bill from the Care Manager. Additionally, this authorization does not allow a Provider to bill for hours provided over and above the work order authorization.

D. Hospital & Nursing Home Stays

If a Participant enters a **hospital** or will be temporarily **away from home** for **no more than two (2) weeks**, a service(s) can be placed on hold. The Care Manager must:

1.) complete a **Status Change** indicating the participant is in the hospital or away from home,

2.) notify the provider(s) immediately indicating the date to start holding the service, and

3.) complete a **Work Order** and submit to Case Tech.

Vendor View Providers will receive a Hold Notice and Care Setting Change via Vendor View. Care Manager shall fax Work Orders to providers not utilizing Vender View.

If the Care Manager is aware of the hospitalization, the Participant must be sent an **Notice of Adverse Benefit Determination** indicating that services are being temporarily suspended as a result of the hospitalization.

If the Participant enters a **nursing home**, all services must be stopped immediately. The Care Manager must:

1.) complete a **Status Change** indicating the Participant was placed in the nursing facility,

2.) notify the provider(s) immediately indicating the date services are to stop,

3.) complete a Work Order and submit to Case Tech, and

4.) send a **Notice of Adverse Benefit Determination** to Participant indicating that services are being suspended as a result of the placement. Vendor View providers will receive a Hold Notice and Care Setting Change via Vendor View. Care Manager shall fax Work Orders to the providers not utilizing Vender View.

For situations where a Care Manager knows that a Participant will be away from home at a certain point each and every month *(example: a medical procedure which requires the client to spend two to three days in a row in a hospital)*, services may be placed on hold using the above procedures. This procedure needs to be followed only once for both data entry and the Provider rather than on a monthly basis.

The "105" fund source code is to be used for Waiver Participants who enter a nursing home. On the date of actual placement, all services provided are to be coded with the "105" fund source code. When returning to the community, the Waiver "FROM" date is again the day of discharge and services provided can be coded to the "100" fund source.

Section 11 - Twenty-Four Hour Care

Twenty-four hour care is defined as the provision of care and/or supervision, continuously throughout a 24-hour period. Neither Care Management or the Waiver Program are designed to provide long-term 24-hour care when direct purchasing of needed services is required for the entire 24-hour period.

For individuals determined to require long-term 24-hour care and need the assistance of WA to purchase the care, the **Post Assessment Recommendation Form** should be completed with a recommendation for appropriate institutional care. (Optional Form)

If the Participant or responsible party wish to contribute to the cost of 24-hour care and are willing to provide informal support to the Participant, the CM may elect not to recommend institutional care.

"Short-Term" 24-hour Supervision/Care may be considered on a case-by-case basis. CMs must first consult with the CM Supervisor or Program Director to review potential benefits, service mix (formal and informal services), budgetary constraints, and the cost of the Plan of Care. "Short-Term" is defined as a period of time not to exceed fourteen (14) days.

Out-of-Home Respite Care must be considered as the primary option to in-home 24-hour care. The Care Manager must justify to the CM Supervisor why this option may not be in the best interest of the Participant and the cost effectiveness of the overall Care Plan.

At the end of the 14 days of the approved Short-Term 24-Hour Care, Care Managers shall review Participant status. If sufficient improvement is noted but a need remains for 24-hour care, the CM Supervisor or Program Director may approve continuation for an additional period of time.

If a Participant can pay the full cost of 24-hour care, or through a combination of private pay, service brokerage, and direct service purchasing, 24-Hour Supervision/Care may be arranged and included on the Care Plan for an indefinite period of time. (The implementation of 24-Hour Supervision/Care is ultimately limited by resource availability.)

Section 12 - Use of Physical Restraints or Seclusion

Under no circumstances shall a Care Manager recommend the use of physical restraints for a Participant or resort to the use of seclusion of a Participant. However, UPCAP and its employees cannot control the use of such restraints by family members, informal caregivers, or Service Providers who are acting upon the request of the Participant or responsible party. UPCAP prohibits Service Providers from utilizing physical restraints at the Provider's discretion and requires each Provider Agency to develop internal policies for staff when family members/responsible parties request the use of such devices.

Section 13 - Backup Plans

As part of the care planning process, the Care Manager shall establish a Backup Plan with the Participant and responsible parties. Backup Plans are automatically generated in COMPASS, pulling information from the assessment. Once the assessment is locked and a Work Order is entered, the Backup Plan can then be printed and given to the Participant and any others as authorized by the Participant. All agencies that utilize Vendor View will have access to Backup Plans.

The Backup Plan must be updated at least annually and reviewed when there is a change. Supporting documentation shall be included in the Participant file.

Backup Plans include the following information:

- Name and phone number of formal service providers
- Informal supports and who to call in case of an emergency
- Name and phone number of primary Care Manager
- Name and phone number of primary physician
- Type of assistance Participant will need in case of an emergency
- When and how the CM is to be contacted for changes or emergencies.
- That the hospital discharge planning team knows a Care Management is involved with this Participant.

In situations where services are limited or not available due to a Participant residing in a remote area and/or limited DSP staffing, the Participant must be informed of the risks and likelihood that not all identified needs will be met.

If no informal supports are able to supplement paid providers, the CM should note the unaddressed need(s) on the POC stating specifically which services will not be provided and that Participant is aware of risks.

The CM Supervisor must be informed of these situations in order that the lack of providers in a certain area can be communicated to the Quality Assurance Team and the Program Director.

When informal supports are delayed in to relieving DSP Providers, the informal supports must be instructed to contact the CM staff (or the provider when CM staff is unavailable). If the CM feels that uninterrupted services are necessary, they may authorize the extra time for the DSP Provider.

CM will conduct a case conference with the Participant and informal supports, should a pattern of tardiness or missed "shifts" develop. The focus of the conference is to be on the responsibilities of the informal support system. Care Managers must indicate that future lapses shall not be tolerated and that they will be responsible for paying the Service Provider agency for service provision beyond the authorized level.

Critical Incident Reporting: DHHS requires that an incident or event that brings harm or creates potential harm to a Waiver Participant be reported immediately. See **Section 24: Advocacy & Protection** for specific procedures on documenting and reporting a **Critical Incident**.

Section 14 - Case Classification

Care Managers designate a case status for each Participant at the time of Care Plan development. Consensus must be reached by both team members participating in the assessment, care planning, and reassessment activities in designating a case classification.

A. Active Classification

"Active" defines those cases with the most difficult, unstable, or complex needs which require intensive involvement. Care Managers classify cases as active when it is determined that the Participant requires a reassessment **at least every 180 days** by both team members or sooner when there is are significant changes in the Participant's health or functional status, or significant changes in the Participant's network of allies (i.e. death of a primary caregiver).

***All active Participants should be contacted by phone **every thirty (30) days or less** to closely monitor services and ensure outcomes and goals are being addressed. Documentation of contact Progress Notes should include satisfaction levels with the 1.) type, 2.) amount, and 3.) quality of services.

These contacts must be made with the Participant whenever possible. If the Participant is not able to communicate by phone, the reason should be noted in the Progress Notes and an approved alternate representative should be contacted. CMs should not use contacts with paid caregivers as a substitute for contacts with the Participant.

B. Maintenance Classification

- Under the "maintenance" classification, the physical, health, and social issues are more stable and less complex than those of individuals classified as "Active."
- Participants must remain active through at least the first reassessment cycle.
- Participants must be contacted at least **every 30 days or less**, with a complete reassessment conducted at least **every 180 days**.

"Maintenance" classification case status may be designated by the Care Manager for the following reasons:

- The Participant situation is currently stable but their level of frailty or illness may prompt the need to adjust the Care Plan within the next **four to six months**.
- The Participant has continued to refuse needed services, but the Care Managers perceive that services may be accepted by the Participant within the next **four to six months**.

- The Participant is institutionalized and may be able to return home with program assistance, within the next **four to six months**.

- The Participant situation is currently stable but continues to require Care Management to ensure stability and continuity to remain in home. Precise documentation, including CM's monitoring and level of intervention is required as well as problem identification which requires monitoring.

- The Participant situation is currently stable but continues to need the financial resources of Waiver funds to remain independent. In this particular situation, if the Participant has not been in the Waiver Program for at least one year, and does not meet the NFLOC requirements the case must be closed. Participants who have been in the Waiver for one year may continue to be eligible **under Door 7, service dependency. However**, Care Managers will need to document that the Participant's needs *cannot* be met through any other option and that closure may result in deterioration of the consumer and potential NF placement or the need for waiver program re-enrollment.

- A Participant case may remain classified as "Maintenance - **Care Management**" *(60 and over)* or LCM1 *(under 60)* (not "Maintenance – Waiver") for up to six (6) weeks maximum following the death of the Participant if the Care Manager can adequately document a need to keep the case open (i.e. CM will be providing direct interventions to assist the Participant's spouse in taking care of any loose ends following the death of the client.) Under no circumstances shall a Participant case remain open in excess of six (6) weeks following the Participant's death.

All case classification changes must be supported by appropriate documentation in the Participant's Progress Notes. When a Participant is to be changed from Maintenance back to Active, such a change must be supported by a formal Reassessment. This includes any situations where a Participant was classified as Maintenance because of a short term stay in a facility such as a hospital or nursing facility.

C. Closed Classification - Waiver

Care Managers must "close cases" when it is determined that program intervention is no longer necessary. A Waiver Disenrollment form must be completed and sent to the Administrative Services Manager. "**Closed**" status is used for the following situations:

- The Participant moves from the service area
- The Participant is institutionalized on a permanent basis
- The Participant terminated involvement with the program (i.e. refuses services)

- The Participant is no longer financially eligible to participate in the HCBS/ED Waiver
- Death
- The Participant is no longer medically eligible and does not meet the criteria for service dependency (See **Section 6.C - Functional Eligibility NFLOC**)
- The Participant is placed in an ICF/MR institution on a permanent basis.
- For cause as determined by the MDHHS.
- To implement the decision of a hearing officer in a formal grievance proceeding conducted by the State.

REQUIREMENTS:

- Reasons for changing a Participant from one classification to another must be clearly written in the Progress Notes. Simply documenting on one or the other is not sufficient per AASA/MDHHS requirements. A Status Change form must be completed indicating the date of closure and turned in to the Case Tech for data entry.

- Participants and/or responsible party must be informed of the decision to close their case and provided with instruction as to how to re-enter the Program if the need for intervention changes.

- Waiver Participants must be provided with a **Notice of Adverse Benefit Determination**, and provided with information as to how to appeal this decision (appeal procedures explained at the time of Participant enrollment will not meet this CMS/MDHHS requirement). MDHHS must also be notified.

- Waiver Participants who enter a nursing home must be sent an **Notice of Adverse Benefits Determination** informing them of their closure from the Waiver.

- Waiver Participants who are hospitalized must be sent an **Notice of Adverse Benefits Determination** advising them of the suspension of services during the hospitalization. The notice should also indicate that if the hospitalization is in excess of 30 days, participation in the MI Choice program will be terminated.

- All cases which were closed that require Program re-intervention must be counted as a new referral, a new screening, and a new assessment.

D. "WA-Pending" (WP)

"WP" status is only to be used if the person appears financially eligible as a result of the "Presumptive Eligibility" determination **and** the Care Manager is awaiting formal MDHHS approval of a submitted application, and Care Managers have determined a need to begin purchasing services prior to formal MDHHS notification. If the Participant does not want services during this period of time, the Participant is to be classified as a Care Management Participant *(60 and over)* or LCM1 Participant *(under 60)*.

NOTE - WA Pending: For potential Waiver Participants who meet the medical eligibility requirements but have excess assets above the allowable MDHHS level, such person(s) are to be classified as "Care Management" *(60 and over)* or "LCM1" Participant *(under 60)*, ***NOT*** "WA-Pending" even if the asset level will be reduced to the MDHHS limit within thirty (30) days.

MDHHS "CHAMPS" Requirements:

The Medical Services Administration (MSA) has determined that Waiver Agents **MUST** verify that the Waiver Enrollment Date assigned to an eligible Participant matches the date in CHAMPS, and that the appropriate PET/BP has been assigned. MSA is encouraging all Waiver agents to check the CHAMPS System monthly for all Participants. To meet the basic objective behind the MSA directive, the Administrative Services Manager will run an eligibility report on the first day of each month and notify Care Managers of discrepancies.

E. Targeted Care Management (TCM)

Individuals who can be classified as Targeted Care Management Participants (TCM) are individuals who meet the financial tests for Medicaid without Waiver eligibility rules applied, and whose needs can be addressed through Care Management intervention. Such individuals also represent that segment of the population who have opted to maintain their MDHHS Home Help worker as the primary caregiver.

TCM individuals may want to consider enrollment into Self-Determination if AHH is no longer sufficient. Care Managers will assist Participants in exploring Self-Determination as an option.

A Targeted Care Management Participant also represents an individual who may benefit from Waiver enrollment but given limited access to available slots, enrollment as a TCM Participant is necessary. TCM status in such situations is to continue until such time as the Home Help system, with coordination of services and minimal additional service purchasing from care management, no longer is adequate, and/or a Waiver slot is available.

If additional services are necessary, and if the person is over age 60, limited access to "202" resources may be available. The Care Management Supervisor must approve all use of 202 funds to purchase services.

For individuals under 60, TCM designation is not possible. Such Participants are to be classified as "LCM1." If additional services are necessary and need to be purchased on behalf of the individual, a request may be made in writing to the Executive Director for short term access to limited agency reserve funds. The request is to be addressed to the Executive Director and needs to explain the need, the volume of service to be utilized, and the cost of the service over the next six (6) months and a notation of other services which will be provided.

Individuals age 60 and over who may be eligible for traditional Medicaid, but through a spend down, and whose needs could be met through Home Help, grant funded services, or limited purchasing, can be classified as TCM.

- Care Management intervention may be used to assist in meeting the spend down. Each monthly face-to-face intervention by a Care Manager is a billable service and must be recorded both on the standardized Medicaid Log and in the Participant Progress Notes.

- Individuals for whom CM interventions will be used to meet spend downs are to be given the standard CM "bill" for a face-to-face intervention. The individual is to utilize the bill to meet all or a portion of that month's spend down as described in PEM 545 related to "Old Bills" (pp 2, 5, 6, 8, 12, 15, 18, 24, and 25).

- Only one face-to-face intervention may be used per month for the purpose of assisting an individual in meeting a spend down.

Monthly Requirements:

For any Participant classified as a TCM Participant, UPCAP is authorized to bill the Medical Services Administration for its Care Management activities. Billable services include one monthly face-to-face contact with TCM Participants for the purposes of conducting the initial assessment, reassessments, care planning, and service monitoring. ***NOTE***: Face-to-face contacts used to assist with spend downs are not billable.

Care Managers will maintain documentation for each contact. Documentation includes completion of the standardized Medicaid Log and progress notations of face-to-face contacts.

All contacts (except those used to meet spend downs) are billable regardless of which CM makes the contact. However, in compliance with CMS rules, all documentation of face-to-face contacts by social workers must be co-signed by an RN.

Copies of Medicaid Logs must be submitted monthly to the Escanaba Office so that billing activities can be accomplished within time frames set by AASA.

Any face-to-face contact with a Targeted Care Management (TCM) Participant must be recorded on the AASA-approved "Medicaid Log" indicating the purpose of the contact and initialed by the individual making the contact. A corresponding description of the contact must also be recorded in the Participant's Progress Notes. An RN Care Manager is required to co-sign or initial any contact made by a SW Care Manager. This is a CMS requirement. (RN must initial both the MA Log & the Progress Note corresponding to the contact.)

The Medicaid logs serve as the "billing" tool for the Escanaba office in preparing monthly bills for "case management" services provided to Medicaid-eligible Participants (excluding Waiver Participants). Copies of the Medicaid logs must be sent to the Escanaba office during the last week of each month, with the visits for the month to be billed for highlighted in yellow. The original log is to remain part of the Participant's case record.

When utilizing Care Management interventions to assist a Participant in meeting the MDHHS spend-down, such face-to-face visits must also be recorded as described above and flagged as a non-billable visit on the MA log.

F. Participant Classifications & Managed Care Capitation Process

Effective October 1, 2013, the MI Choice Waiver Program is classified as a **Pre-paid Ambulatory Healthcare Program (PAHP).** Under this new classification, all MI Choice Waiver Agents are reimbursed on a "per member per month" managed care system. Through this managed care system, UPCAP is paid a flat rate per day for each MI Choice Participant. In turn, UPCAP is expected to meet all of the needs of the Participant regardless of the care plan costs. UPCAP expects its Care Management staff to continue developing services plans as they have in the past; based on a person-centered focus of needs and desires as identified in the functional assessment.

The capitation system of payments is based on a CMS-approved, actuarially sound system which classifies Participants by three (3) age groups and by two (2) resource utilization groups within each age group based on certain acuity factors triggering higher service need and utilization. MDHHS makes the final determination of this classification based on Participant algorithms from the functional assessment. The acuity-based classifications are entitled **"NSSP" (Non-Significant Support Participant)** and **"SSP" (Significant Support Participant)**, and are intended to acknowledge that certain

Participants, regardless to age group, have higher than average long-term supports and services needs. The NSSP and SSP system replaces the previous process of **Memorandums of Understanding (MOU's)** and **Special Memorandums of Understanding (SMOU's)**.

UPCAP expects Care Managers to continue their high level of accuracy in assessment/reassessment activities and to record Participant abilities and deficits as identified during the assessment process. However, it is important that Care Managers know that MDHHS will be utilizing the following methodology in making the NSSP and SSP designations:

- All individuals transitioning from a nursing facility will be classified as an "SSP" Participant.
- Individuals for whom SMOU's were previously obtained will also be classified as "SSP" Participants.
- In place of the SMOU process, MDHHS will be evaluating assessment results for all other non-Transition Participants in deciding a NSSP or SSP designation.

For a MI Choice Participant to receive a designation of "SSP," the Participant must qualify as follows:

1. **Not NFT** (NFT and CSHCS age-outs who require PDN are automatically put in SSP category)
2. **WA-Y** status during relevant dates

Non-NFT SSP Criteria: To meet criteria, the Participant must qualify for **3 or 4**, and both 5 and 6 below:

3. Cognitive Decline

a. Section E: Daily Decision Making = moderately impaired, severely impaired, or no discernible consciousness **AND** either b, c, or d below

b. Section E: Memory Problem in either short term, procedural, or situational **OR**

c. Section B: Left Alone = Less than 1 hour or 1-2 hours **OR**

d. Section F: Making Self Understood = Sometimes Understood or Rarely/Never understood

4. Diseases/Diagnosis

a. Section I: Disease Diagnosis = score 1 or 2 in any of i-iii below ***or*** b ***or*** c ***or*** d

i. Any of the Cardiac or Pulmonary listed, **OR**

ii. Any of the Neurological listed, **OR**

iii. Any of the Other listed (renal failure/cancer/diabetes)

b. Primary diagnosis of ALS (335.xx) MD (359.xx) Huntington's (333.4) MS (340.xx), or AIDS (042), **OR**

c. Section J: Health Conditions, Instability of Conditions, End-state disease = YES, **OR**

d. Section Q: Treatment scored 3 for both a & b
   i. Ventilator or Respirator
   ii. Suctioning

5. **Functional Status** – any listed are scored 4 or higher
   a. Section P: Transferring OR Transfer Toilet
   b. Section P: Toilet Use
   c. Section P: Bathing
   d. Section P: Eating
   e. Section P: Bed Mobility

6. Service Utilization

a. Section Q: Formal Care Personal assistants/aides = 5 or more days & at least 2,400 minutes, OR

b. Section Q: Formal Care Home Nurses = at least 1,800 minutes/week, regardless of days, OR

c. Section Q: a + b above equal at least 2,100 minutes/week and at least 180 of those are **VN (visiting nurse)**

MDHHS will be responsible for reviewing COMPASS data and for assigning the SSP designation for Non-NFT individuals meeting the above criteria. UPCAP staff may request MDHHS to review and evaluate a particular Participant case record when they believe the MDHHS has not assigned the SSP designation to a Participant that the Care Manager believes meets the criteria. This request must be made first in writing to the Program Supervisor. The Program Supervisor will be responsible for review of the most recent assessment and to document in writing that the Participant does in fact meet the requirements as set forth above. This will then be forwarded to the Program Director who will submit a formal request to the MDHHS Contract Manager for a formal review of the Participant. (Program Director may have the Supervisor submit the request for review directly to the MDHHS Contract Manager, depending upon the circumstances of the particular request)

Section 15 - Re-Assessment Requirements & Schedules

A complete reassessment for each MI Choice Participant is required **within 90 days** of initial enrollment, and **every 180 days thereafter.**

AASA Care Management Participants should be on the **same schedule** as MI Choice Participants.

Only one CM is needed to perform reassessments. Progress Notes should reflect that they conferred with the appropriate SW or RN discipline as needed and at a **minimum of one time per month**.

Reassessment Guide:

- NFLOC eligibility must be confirmed
- Outcomes on Plan of Care must be updated
- All follow up as described in previous Plan of Care must be documented
- CMs should confirm Participant's possession of Care Management Handbook
- CMs must review the CHAMPS Eligibility report sent by the Administrative Services Manager for any "Status Match" or "Status Mismatch" cases that require investigation or correction.

Section 16 - Waiver Ineligible Categories

Eligibility for the MI Choice Waiver Program is based on three primary eligibility criteria – 1.) Financial Eligibility, 2.) Functional Eligibility, and 3.) the need for and receipt of Waiver Services on a continuous basis. The following represent situations where a person may be deemed **Waiver In-Eligible**:

A. Hospitalizations

When a Waiver Participant enters a ***hospital***, the WA case does not have to be closed if the stay does not exceed 30 days. The following procedures must be followed (per MSA/AASA):

- All services must be put on hold.
- The Waiver case is closed when a Participant stay exceeds 30 days.
- The WA closure date occurs after the 30 day waiting period (Day 31). In this situation, WA closure cannot be retroactive to the first day of hospitalization.

- The **Notice of Adverse Benefit Determination** is sent to the Participant on Day 19 of the hospitalization stipulating that if the hospitalization is over 30 days, the Waiver case will be closed and Waiver services will be discontinued. Case may remain open as a Care Management (60 and over) or LCM1 (under 60), case classified as "Maintenance."

B. Nursing Facility Placement

When a Waiver Participant enters a ***nursing home***, they **MUST** be closed to the Waiver program on the **day prior to actual placement**. The case may be reclassified as a Care Management (60 and over) or LCM1 (under 60), during the institutional placement period.

C. Swing Beds

Swing Beds are not considered nursing home beds if Medicare pays for the bed, therefore, the person does not have to be closed to the Waiver.

If, however, Medicaid is the payer for a Swing Bed stay, the case must be closed.

- The CM must send t a **WA Closure Notice** to the Administrative Services Manager.
- The Participant must be sent a **Notice of Adverse Benefit Determination**.
- The official "closure date" for someone entering a nursing home is the day prior to admission.
- Upon returning to the community and the program, the Administrative Services Manager must be sent the **WA Open Notice**.
- Any services provided on the day of admission must be re-coded as fund source “105," and the Participant case must be kept open as Waiver-Ineligible for the actual day of admission/placement.

D. Out-of-Service Area

While UPCAP’s contract with the MDHHS is to provide services to individuals residing in the **15 counties of the Upper Peninsula**, Participants may occasionally need to travel out of the service area for special occasions, events, or other circumstances.

Care Managers must seek prior approval from:

- Program Director (who may consult with the MI Choice Program Manager at MDHHS), and the
- Service Provider / Paid Caregiver

before services may be arranged and purchased for a Participant while they are **temporarily be out of the service area**.

Participants who are away from the State of Michigan for more than thirty (30) consecutive days lose their Michigan Medicaid status, and are therefore no longer eligible for the MI Choice Waiver program.

Care Managers must contact the Participant or responsible party **15 calendar days** after the Participant has left the State to determine the planned date of return. If the planned date of return goes beyond the **next 15 calendar days**, the Care Manager shall obtain a mailing address **so as to send a Notice of Adverse Benefit Determination.** If the Participant has not returned to their place of residency by the 30th day following departure from the State, the case shall be closed and all providers notified of service termination.

Upon return to the Upper Peninsula, the Participant may request readmission to the MI Choice Program. If this request is made within the same fiscal year during which the case was closed, the person shall be entitled to their former Waiver slot. A new assessment and corresponding NFLOC shall be completed, and if functional eligibility is confirmed, the person shall be reinstated into the MI Choice Program. If the person requesting readmission departed the Upper Peninsula during one fiscal year and returns in a different fiscal year, the request for enrollment shall be treated as a new request following policies and procedures for enrollment and wait list placement.

Section 17 - Direct Service Purchasing (DSP)

This system was created to alleviate service access issues experienced by both MI Choice Waiver and AASA-Care Management Participants. It involves the purchase of needed services from Service Providers selected from a competitive pool. The ability or inability to access services for Participants is the key to determining when to direct purchase.

Requirements:

A. CMs must explore all other payment options including all third party sources such as, private insurance, Veterans Benefits, Medicare, Medicaid funded services separate from the Waiver, and private pay. For Care Management Participants, Older American Act Grant funds from local providers must also be explored before directly purchasing services.

B. It is the stated goal of UPCAP's Long-Term Care Programs (the MI Choice Waiver & AASA-Care Management Programs) to develop cost effective alternatives to institutional placement. To this end, CMs should strive to implement care plans that will meet the needs of Participants in the most cost effective way.

C. CMs must obtain approval from the CM Supervisor before implementing initial care plans.

D. CMs are not required to obtain supervisor approval for increases to care plans. The exception being Home Modifications.

E. All LTC Participants can choose to participate in the Self Determination program component. This program option allows the Participant more choice and control over who will provide services and when. They may choose a family member or friend, versus an agency from the DSP provider pool, to care for them. (See **Appendix IV: SD Program**)

F. Care Managers may only purchase services as authorized in **Attachment H**: **Minimum Operating Standards for MI Choice Waiver Program Services** - of the MI Choice contract with MDHHS *(sent to all staff by CM Supervisor on annual basis or as changes occur)*, or those services authorized in the Area Agency Annual Implementation Plan. CM must have prior authorization before attempting to access a needed service for a Participant.

G. For purchasing for AASA-CM Participants, Care Managers are also to follow requirements for NAPIS as indicated in **Appendix I: NAPIS** - Use of 202 Funds.

H. Any provider utilized to purchase services on behalf of a Participant must have an agreement in place before services may begin.

Direct Purchasing for Care Management Participants:

As a matter of last resort, Care Management Participants (non-Waiver) may be assisted with paying for some services. This includes use of the Self Determination Process. To make certain UPCAP's limited funds are spent on those individuals who are most in need and unable to pay for their own services, the following priority groups are established:

Group #1: Participants with savings and liquid assets up to or above the current Medicaid asset limit <u>but</u> at or below $5,000 with net incomes that are not adequate to meet necessary household expenses and the cost of care. This group also includes married couples with liquid assets at or below $7,500 with household incomes insufficient to meet household expenses and the cost of the Participant's needed care.

Group #2: Participants with incomes and/or assets adequate to pay privately for services, <u>and</u> Participants who chose not to disclose financial information. Care Managers are to consider all resources above the Medicaid limit as available to this group to pay privately for services when developing the care plan, and in considering whether or not the option of direct purchasing is to be included.

In situations of extreme hardship, CMs may request a Waiver of this rule from the Program Director.

A limited amount of resources may be set aside each year (providing such resources are available) for the purpose of assisting individuals who do not meet the financial eligibility requirements of the MI Choice Waiver program, yet whose income and/or assets are not sufficient to privately pay for needed in-home services.

Whenever Title III resources are to be used to directly purchase services for Care Management Participants, two criteria must be considered:

1.) The person must be **at least 60 years of age** *and* a Care Management Participant.

2.) As required by AASA, a **NAPIS Enrollment form** (See **Appendix I**) shall be completed for any Care Management Participant whether UPCAP pays for services or arrange services.

The **NAPIS Enrollment form** must be completed even if the individual is classified as CM for a short period of time prior to MI Choice enrollment. This form **must be completed** for anyone UPCAP is purchasing services for using the “202" fund source code &/or arranging services for grant funded services through an annual contractor.

If services are only being arranged on behalf of a Care Management Participant, the **NAPIS Enrollment form** must still be completed as described above and entered into the NAPIS system. A copy of the Registration form must be forwarded to the Service Provider along with the Care Management assessment for the Provider's records.

NAPIS **Caregiver Registration form** must also be completed for any Care Management Participant receiving Adult Day Care or In-Home Respite. This form is on NCR paper.

- The original signature page must be given to the Caregiver
- Copy to the Case Tech for data entry
- Copy to the Service Provider

All NAPIS forms shall be forwarded to the appropriate Case Tech for data entry into NAPIS system.

Section 18 - Provider Selection

To ensure that CMs remain service neutral, the following procedures must be followed:

- If a Participant indicates a specific choice of Provider, and the Provider is enrolled into UPCAP's DSP system, the CM is to access that Provider.
- If the individual specifically requests information regarding enrolled providers, such information may be provided in the form of a generic overview. Provider Agency brochures are not to be used. If the Participant still does not have an agency preference, all things being equal, the CM should access services from the agency who charges the least amount. No recommendation of provider is to be made to the Participant.
- In the event all agencies in the area are charging the same amount, and the Participant does not express a specific choice of Provider, the Care Management office should set up a mechanism to rotate provider selection.
- If a Participant wishes to hire their own employees or have family members be paid for providing their care, they must be enrolled in the Self Determination Program. (See **Appendix IV: SD Program**)

To ensure continuity of care and continued availability of services from enrolled providers, if an employee of the selected Provider leaves that agency's employment, the agency shall be granted the opportunity to assign a new employee. If the agency is unable to provide an acceptable replacement, then the Participant shall be offered the choice of another enrolled Provider. This procedure ensures that Participants are not caught up in agency battles to increase service case loads by luring employees away from another agency.

CMs must work with the Participant to allow adequate time for the new employee and the Participant to become acclimated with one another. If after sufficient time (two week minimum) has lapsed and the Participant remains unsatisfied with the new employee, Care Managers may offer additional choices in service providers.

CMs must discuss with their Participants the possibility of employees moving from one agency to another and UPCAP's policy regarding such moves. This should be done through the Person Centered Planning process, both by phone at the time the initial care plan authorization is received, and at the time when the Participant actually signs the Care Plan. Care Managers are also encouraged to discuss this policy with other responsible parties so that they are aware of the process.

During the implementation of the care plan and on-going service provision, should problems occur, CMs shall attempt to resolve the problem with the provider initially selected. If the problem(s) cannot be resolved to the Participant's satisfaction, CMs can access a new service provider.

Section 19 - Direct Interventions

Care Managers are involved in a number of direct interventions designed to assist the Participant in meeting personal goals and objectives as well as to assist in reducing potential risks which may result from activities and/or behaviors engaged in by the Participant.

Counseling interventions are provided directly by Social Workers and Nurses to Participants and caregivers as defined in Care Plans. Such interventions are intended to be short-term and provided only when such interventions cannot be arranged or purchased from the formal network. Further, counseling efforts are not intended to serve as treatment of long-term psycho-social disorders. The following issues are appropriate for direct counseling interventions:

- Refusal of services crucial to independence - Includes addressing issues or activities which place the Participant at risk such as non-compliance with physician orders, misuse of medications, refusal to allow service providers to carry out Work Orders, etc.
- Conflicts in relationships which threaten continued independence.
- Adjustment difficulties experienced by Participants regarding illness or modifications in service delivery (i.e. coping abilities, wants vs. needs, etc.)
- Increasing the involvement of informal caregivers.
- Assistance with financial or budgeting issues to ensure maximum use of resources for needed care.
- Address risks associated with unsafe medication management.

Social Workers and Nurses are to provide advocacy as necessary for entitlements, financial issues, and social services. Nurses provide advocacy focused on health-related issues and services.

All CMs must continually strive to increase their knowledge regarding regulations of various service programs, and are to seek advice or assistance as needed.

Section 20 - Case Reviews

A. CM Supervisory Review

All new cases shall be reviewed by the CM Supervisor to ensure that the assessment and associated paperwork are complete, and that the Care Plan is appropriate to meet identified needs. Suggestions for change or improvement are written on a standardized form and given to the CMs to make corrections.

CM must get approval by the CM Supervisor before purchasing services for a new Participant with Waiver funds. This can be done in-person or via phone/fax/secure email before the services actually begin. The CM must complete the ***DSP Care Plan Review*** form and send it to CM Supervisor for approval. This form must be maintained in the Participant chart.

B. Peer Reviews

CM staff also participates in the on-going review process through intra- and inter-office Peer Review sessions. Each CM professional discipline conducts reviews of their counterpart's case work utilizing a standardized review form. When significant problems or issues are identified, they are to be presented to the CM Supervisor and/or the Program Director. Reviews are conducted no less frequently then **bi-monthly** at all Care Management sites. A random sample method shall be used, with the sample size based on 10% of the current open caseload.

Requirements:

1.) Cases reviewed must be composed of all case classifications (AASA-CM, TCM, Waiver, private CM, active, maintenance, closed, etc.).

2.) Assessment Teams cannot conduct a review of their own cases and must alternate reviews among various teams.

3.) After completion of the review, the Peer Review form must be sent to CM Supervisor for review. This form will be kept through the current fiscal year and then shredded.

4.) A **Quality Indicator Report** will be generated for each Care Management office to review the report to identify additional issues that may require person-centered planning efforts.

5.) Inter-Office Peer Review will include drill down activities, if needed, related to the Quality Improvement Goals established in the overall Quality Management Plan.

Section 21 - Participant Privacy & Confidentiality

Disclosure of Participant information is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All communication received from the Participant, whether verbal or written, is to be considered confidential under the law and UPCAP Employee Policy 1.6: Confidentiality. All LTC staff receive HIPAA training upon hire and then annually.

Participants shall be given a copy and brief verbal overview of UPCAP's **Notice of Privacy Practices** at assessments. Participants are required to sign an **Acknowledgment of Receipt form** stating that they have received the written privacy practices document.

***All Participants will be asked to sign a **Program Consent & Authorization** and **Confidential Release of Information** form **annually**. Each CM must develop a reminder system of when newly signed forms are due.

Prior written consent to release information is required from the Participant when sharing their information except for the purposes of treatment, billing, health care operations, or quality assurance activities. CMs are mandatory reporters of suspected abuse, neglect, or exploitation, therefore, no release is needed in such instances.

In approved sharing situations, CMs must provide only what is "minimally necessary" for the receiving person or organization to perform their function. For example, financial information is only to be shared with entities that require such information as a condition of eligibility for their goods or services.

Faxing of Participant information is HIPAA compliant. All faxes must include a cover sheet clearly stating to whom the document is intended, and the actions unintended receivers should follow.

Emailing, Texting, Document Sharing:

Emailing and texting are not secure methods of communicating. Sensitive information of any kind should **not** be in the **subject line or body of an email**.

Document sharing through email or web applications (such as DropBox) is prohibited. In order to be HIPAA compliant, email attachments containing sensitive information must be encrypted ***and*** password protected, or transmitted through secure file exchange applications such as Zix, COMPASS, or Altruista.

Participants who have difficulty communicating via telephone have the right to request unencrypted email communication with Care Managers. The **Participant Consent Form for Email Communication** shall be used to inform Participants of the risks of using this communication method. All such requests must be approved by the Program Director. The form shall not be used as a standard consent allowing for the use of e-mails with all program Participants.

- The Email Consent Form is time limited and must be reauthorized annually.
- A copy of the fully executed Email Consent Form must be sent to the Participant with the original maintained in the case record.

HITECH Act: Security Breach Notification Law

All LTC Staff are trained upon hire and annually to report any attempted or successful unauthorized access, use, disclosure, modification, or destruction of private or secure information.

Staff shall immediately report any occurrence, discovery of, or suspicion of a security breach (*successful or attempted*) to the UPCAP Privacy Officer (LTC Program Director) and/or Security Officer (UPCAP CEO).

The Privacy or Security Officer is required to perform a risk assessment considering:

1.) the nature and sensitivity of the PHI accessed, disclosed, or destroyed, and the likelihood that it could post a significant risk of financial, reputational, or other harm to the individual;

2.) if the PHI was unsecured (not encrypted or password protected);

3.) if the person(s) who received or accessed sensitive information is a Covered Entity or Business Associate, and if motives for willful intent exist;

4.) whether PHI was actually viewed or acquired (i.e. what was on a lost laptop);

5.) whether the risk has be satisfactorily lessened or mitigated.

If it is determined that a security breach occurred, the Privacy or Security Officer must promptly notify affected individuals. Breaches impacting **fewer than 500 individuals** are reported to the HHS Secretary on an annual basis. Breaches affecting **more than 500 individuals** requires immediately notifying the HHS Secretary and the media.

All submissions must be reported using the web portal at: www.hhs.gov

Section 22 - Case Records Maintenance

CMs must establish and maintain a file for each Participant served. The file must include, but is not limited to, the following information:

- Initial Referral & Initial Assessment
- Nursing Facility Level of Care Determination
- Freedom of Choice
- All Assessment Forms (COMPASS)
- Notices of Adverse Benefit Determinations / Action Notices

- Care Plan (COMPASS)
- Person Centered Planning materials
- Follow-up Letters to Referral Source(s)
- Work Orders
- Status Changes
- Copies of Waiver Open and Closed Notices.
- Consent Forms
- Post-Assessment Recommendation (optional),
- Cost-Sharing
- Progress Notes (COMPASS)
- Reassessments (COMPASS)
- Medicaid Contact Logs (TCM Participants only)
- Any correspondence pertaining to the care of the Participant.
- All documentation pertinent to the Participant case.
- Emergency Plan
- See Appendix IV: Self Determination Case records.

All forms must contain either the signature or the initials of the person completing such forms. Participant signature is required by MSA and AASA Performance Criteria on the Care Plan (initialing the COMPASS Plan of Care is accepted as meeting this requirement), and any release of information forms as well as the Program Consent and Authorization form.

To protect the privacy of Participants and referrals:

- Participant files are not to be stored out of the office.
- File cabinets or office door must be locked at the close of the working day.

Case records, including referrals, are to be **saved for a minimum of ten (10) years** as required by MDHHS.

Section 23 - Quality Assurance

A. Quality Assurance (QA) Team Reviews

An independent evaluation of eligibility and compliance is to be conducted by UPCAP's Quality Assurance Team. The QA Team is to be composed of professional staff with a preferred background in long-term care and the aging process. The QA Team's review of Participant records corresponds to the QA monitoring of providers and Participant

satisfaction. The QA team is required to conduct face-to-face interviews with randomly selected Participants as part of their monitoring protocols. In preparation for the agency audit and Participant visits, QA team members are to review the case records of the randomly selected Participants. This review is to be conducted to determine that assessment/reassessments are current, that care plan goals and objectives are current as well as documentation related to Participant participation and satisfaction and continued program eligibility.

The Quality Assurance Team will develop internal protocols for communicating findings of CM case records and/or through face-to-face interviews with Participants, to the CM Supervisor and/or Program Director.

CM Supervisor and/or Program Director shall further investigate findings and respond to Quality Assurance Team actions taken to address findings. This response shall be in writing and include plan for staff improvement activities if necessary. Investigation of findings and response to QA Team shall be completed within 30 business days of receipt of the QA findings.

B. Quality Assurance - Participant Satisfaction Survey Process

Participant Satisfaction Surveys are conducted to ensure that the services being provided to Care Management and MI Choice Waiver Participants are appropriate to meet their needs and are being provided in a Quality manner. Surveys are also conducted to assist UPCAP and its providers in continually improving the way business is conducted.

Participant Satisfaction Surveys are conducted through mailings, one-on-one phone contacts, or through in-person visits with program Participants. The results are shared with UPCAP Care Managers and service providers in an ongoing effort to improve service delivery. Survey results are also reviewed at the quarterly participant-directed Quality Management Collaborative meetings.

The survey process begins following a person's enrollment into either UPCAP's AASA-funded Care Management, MI Choice Waiver, or VA Program.

Initial Survey:	State mandated survey will be mailed to every new enrollment approximately one (1) month after their enrollment date.
Six-Month Survey:	Is designed to measure satisfaction levels after services have been put into place.
Annual Survey:	Measures satisfaction levels after the Participant has been with the program for one year.

MDHHS oversees the survey process for all MI Choice Waiver Participants statewide. The same survey process is performed internally for Care Management and VA Participants.

C. NFLOC Eligibility & Quality Reviews

To ensure that all Participants enrolled into the MI Choice Program meet the Nursing Facility Level of Care criteria, the CM Supervisor will review each completed **initial NFLOC** as part of the review and authorization of each new case. The CM Supervisor will compare the results of the NFLOC with the results of the functional assessment to ensure that the assessment supports the results of the NFLOC. Any contradictions will be highlighted and referred back to the Care Manager and enrollment will be placed on hold until the discrepancy is resolved.

On an on-going basis, through intra- and inter-office peer reviews, the continued NFLOC eligibility for program participation shall be reviewed to ensure on-going reassessments and documentation support continued eligibility.

To promote continuity in the NFLOC process, each Care Manager will participate in at least one NFLOC quality review practice each year. Case scenarios will be developed by Supervisory staff reflecting real case situations. Care Managers will have 5 working days to review and score the scenario and return it to the Program Director. Results are to be discussed at the next joint Inter-Office Peer review or monthly staff meeting. Supervisory staff will work with Care Managers who do not score the scenario correctly to ensure consistency with Participant eligibility.

D. MPRO Retrospective Reviews

The MDHHS has contracted with the Michigan Peer Review Organization to conduct retrospective eligibility reviews. MDHHS randomly selects a sample of program Participants that have received services through the MI Choice program. MPRO sends notification of selected Participants for review to UPCAP. Care Managers are responsible for development of all materials requested by MPRO for the retrospective review and for assuring that the documentation is sufficient for MPRO to conduct the review and that all materials are submitted to MPRO within the time frames established.

Section 24 - Advocacy & Protection

A. Reporting Suspected Abuse, Neglect, & Exploitation

As stated in the **Adult Protective Services (APS) Act,** P.A. 223 of 1983:

> *"Care Managers must report immediately any suspected abuse, neglect, and exploitation to the appropriate authorities. The Care Manager does not have to substantiate the suspected abuse or investigate the suspected abuse*."
>
> *"A person...who is employed...to provide...social welfare...or other human services...who suspects or has reasonable cause to believe that an adult has been abused, neglected, exploited, or endangered, shall make immediately, by telephone or otherwise, an oral report...."*

Call the MDHHS – Adult Protective Services Department at (855) 444-3911

Call 911 if the individual has a safety/health risk

B. Identifying Elder Abuse, Neglect, & Exploitation

Elder Abuse is defined as the abuse, neglect, or exploitation of the elderly. **There are 3 basic categories of elder abuse:**

1. **Domestic Abuse**: The mistreatment of an older person by someone who has a relationship with the elder.
2. **Institutional Abuse:** Abuse of an older person who resides in a nursing home, group home, or care facility.
3. **Self-Neglect:** Behavior by an older person that places their safety at risk.

   * This does not include a situation in which an older person makes a conscious choice to place their health and safety in jeopardy.

Types of Abuse:

- **Physical Abuse:** Any physical injury inflicted on an older person by someone who has custody of the elder, or provides care. Characteristics may include: hitting, scratching, improper use of restraints, forced feedings, and improper use of medications.
- **Psychological/Emotional Abuse:** The treat of injury, unreasonable confinement or punishment, or verbal intimidation/humiliation which may result in mental anguish such as anxiety or depression. Characteristics may include: threatening the elder with punishment if they do not behave, talking to the elder as if they were a child, yelling or screaming at the elder.

- **Sexual Abuse:** Sexual contact that is forced upon an elderly person. It occurs whenever an older person is involved in sexual activities to which they have not consented or is incapable of giving consent. Characteristics may include: unwanted touching, any sexual activity that occurs when one or both parties cannot or do not consent.
- **Financial Exploitation**: Is the illegal or improper use of an elder's funds, property and assets. Characteristics may include: stealing an older person's money or possessions, forging an elder's signature, misuse of guardianship, conservatorship, or power of attorney.
- **Neglect**: Is the refusal or failure to provide the necessary care to an elder by someone who has assumed that responsibility. Characteristics may include: failure to pay for necessary care, failure to provide food, shelter, water, medicine and other necessities for daily living.

Types of Neglect

- **Passive Neglect:** The deprivation of goods or services without conscious intent. Characteristics may include: forgetting to fix a meal, not adhering to safety precautions, or the person responsible for care is incapable or lacks adequate knowledge or skills to provide the necessary care.
- **Active Neglect:** The willful deprivation of goods or service which are necessary to maintain physical or mental health. Characteristics may include: purposefully withholding food, or other items, not assisting an elder who knowingly needs help with feeding, not providing needed personal care.

C. Critical Incidents

***__A Critical Incident Report__ is defined as any actual, alleged or suspected, event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Waiver program Participant. Types of critical incidents include:

- Exploitation**
- Illegal Activity in the Home **
- Hospitalization or emergency treatment resulting from a medication error
- Hospital and ER visits within 30 days of a previous hospitalization
- Injuries requiring medical treatment
- Medication Error
- Missed visits for Priority One Participants / other CIs involving enrolled providers
- Neglect **
- Physical Abuse **
- Provider No-Show
- Sexual Abuse **
- Suicide attempts
- Suspicious Death **
- Theft
- Use of Restraints, Restrictive Interventions, or Seclusion
- Verbal Abuse **
- Worker Drugs/Alcohol

__** must be reported to APS__

MDHHS policy states that Waiver Agents have first line responsibility for identifying, investigating, evaluating, and following up on critical incidents that occur with program Participants.

When a critical incident occurs, Care Managers must investigate and evaluate the incident within **2 business days** becoming aware of a situation. Care Managers must continue to investigate the critical incident until the situation is resolved and the Participant is no longer in danger. Per MDHHS policy "Cases can only be resolved when the Participant is as safe as possible."

The Administrative Services Manager arranges for each Care Manager's access to the Center for Information Management's (CIM's) **Critical Incident Reporting Portal**. Care Managers shall enter information regarding the Critical Incident into the CI Reporting Portal, and then notify the Program Director by e-mail that a Critical Incident has occurred and has been entered into the CI Reporting Portal. **The Program Director has 30 days** from the date of the incident to approve and submit the Critical Incident Report to MDHHS. State policy also requires the reporting of a suspicious Participant death **within 48 hours.**

During the investigation period, the Critical Incident shall be classified as "Unresolved" in the CI Reporting system. If during the course of the investigation the Care Manager determines that a Critical Incident did not occur, the case must be re-classified as "Unsubstantiated." Once the investigation is completed and all parties agree the situation has been resolved, Care Managers shall change the case status to "Resolved" and notify the Program Director. The Program Director will review all activities throughout the investigation, and release the report to MDHHS once the case is resolved (or classified as unsubstantiated). Documentation of the event and the activities taken by the Care Manager to resolve the Critical Incident, shall be maintained in the Participant file.

D. Durable Power of Attorney for Health Care & Guardianship

The Care Manager's goal is promote the general welfare of all Care Management Participants by establishing a system which permits persons who are "incapacitated" to participate as fully as possible in all decisions which affect them. The definition of "Incapacitated" means an individual whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that they are partially or totally unable to manage their financial resources or meet essential requirements for their physical health and safety.

On admission to the LTC program, the Care Managers review with the Participant whether Advanced Directives have been completed. If the Participant has not addressed this issue, the Care Managers provides the Participant and/or approved representative with the necessary information to complete this information. Information about the importance of designating a Durable Power of Attorney for health care is provided.

* The Participant is in charge of decision-making until they voluntarily delegate responsibility, or until the court grants that responsibility to another individual. (Note - the designation of someone as a Power of Attorney does not, but the designation itself, give the person decision making authority. **The DPOA must be activated** before such authority is granted.)

Per MDHHS, *"Waiver agents are to have policies and procedures detailing steps to follow before pursuing guardianship or other mechanisms that take authority away from Participants."* Thus, when Care Managers determine a Participant's poor decision-making abilities and/or behaviors are not the result of a basic lack of knowledge that can be addressed through education and teaching, the Participant's ability to understand the consequences of their decisions or behaviors, i.e. competency, must be examined. A person has the right to make bad decisions as long as they understand the consequences of those decisions. This follows the principles of personal choice, and self determination.

When it has been determined that competency is in question, efforts to ensure Participant safety and security should be accomplished using the least restrictive mechanism possible so that the person is able to retain as much of their autonomy and dignity as possible.

The first appropriate step would be suggesting a comprehensive cognitive assessment by a specialist to validate the deficit, identify the level of severity, and obtain a physician's medical treatment plan. At a minimum, Care Managers should complete the standardized mini-mental exam on any Participant they suspect may have problems with cognition. For cases involving obvious and severe endangerment of the Participant, a referral to **MDHHS Adult Protective Services** shall be made.

Care Managers shall approach responsible parties about helping with cueing, providing structure/routine, or assisting with IADLs/ADLs before seeking a surrogate decision maker.

Activation of a DPOA for health care or other matters would be the next least restrictive step if deemed necessary. Two physicians or one physician and a psychologist must attest to the fact that a person is no longer competent to make their own medical decisions in order to activate a DPOA for health care. Representative Payees and Conservatorships to assist with financial matters, and are considered less restrictive than guardianship.

Finally, there are several forms of limited guardianship available that are considered less restrictive than full guardianship. Full guardianship should be considered ~~explored~~ as a last resort for the most severely impaired.

Care Managers are required to inform CM Supervisor anytime they feel the pursuit of Guardianship is necessary and the CM Supervisor must contact the Program Director. The Participant's case will be evaluated by the Program Director, CM Supervisor, and Quality Assurance Supervisor to ensure that all other options have been explored. The Participant's case may also be flagged for a "Peer Review" giving other Care Managers an opportunity to offer alternative suggestions or options other than Guardianship.

It shall not be the responsibility of UPCAP or its employees to initiate any Guardianship activities. If, after consultation with CM Supervisor, it is determined that Guardianship is appropriate, Care Managers will be directed to contact the local DHHS office to request Guardianship procedures be initiated. DHHS will not pursue Guardianship if they do not agree with the CM's recommendation. UPCAP staff are expected to fully cooperate with MDHHS staff and, if requested, testify to their knowledge of the case during the formal Guardianship process.

Section 25 - Case Conferencing - Service Providers

Each Care Management Office shall establish an internal process of ensuring that there is regular and on-going case conferencing with local service provider agencies occurring no less frequently than **once a month** with each service provider, regardless of utilization.

A specific day of each month shall be set aside to meet with provider agency representatives.

Provider Case Conferencing shall be used to:

- discuss the provision and quality of service,
- address any questions related to the Work Order or Work Order adjustments,
- address Backup Plan developed by Care Manager,
- address provider no-shows in an effort to reduce or eliminate the negative impact on Participants.
- inform providers of risks related to health and welfare decisions made by Participants.

In the event a specific office is having difficulty finding agencies to provide service in a particular service area, the provider meetings should be used to gather all agencies together at the same time that serve that area, to discuss ways to share referrals in order to better utilize agency staff, and most importantly, to ensure that the needs of Participants in a particular area are met.

Provider meetings that pertain to Participant-specific issues must be documented in the Participant Progress Notes. Documentation pertaining to general issues may be maintained in the form of meeting notes by the office Case Tech or by the Care Managers themselves. Such notes must be maintained for review by MDHHS and/or for the purpose of Quality Assurance reviews.

Section 26 - Participant Grievance & Appeals Procedure

Participants wishing to challenge an **Adverse Benefit Determination** may file an **Appeal**. An Adverse Benefit Determination would include reduction, suspension, or termination of services, or denial or termination of program participation. Appeals start with **UPCAP's Internal Appeal Process** and gives rights to an **External State Fair Hearing**.

Applicants not meeting NFLOC criteria, placed on the MI Choice waiting list, or not enrolled in MI Choice for any reason shall be given an **Adequate Action Notice** that gives the right to proceed directly to a **State Fair Hearing** (bypassing UPCAP's Internal Appeals Process).

Participants and Applicants displeased with all other service-related matters *(that are not Adverse Benefit Determinations or Adequate Actions)* may file a **Grievance**. Grievances can be filed at any time.

A. Participant Grievance (Complaint) Process

Participants, Applicants, their caregivers, supports, guardian, or Appointed Representative (OMB #0938-0950 form) expressing dissatisfaction with a service-related matter ***other than*** an Adverse Benefit Determination, may file a Grievance.
If Care Management Staff believe the dissatisfaction stems from incorrect or lacking information, they may attempt, with interventions of the Care Management Supervisor, to resolve the matter with the Participant/Applicant or those authorized to provide and receive information on behalf of the individual. Details shall be documented in COMPASS Progress Notes.

If, however, this intervention does not quickly remedy the situation, the individual shall be advised to proceed as follows:

By Phone, In-Person, or In Writing:

Advise person to contact UPCAP's Grievance & Appeals Committee comprised of Administrative Services Manager and LTC Operations Manager or an alternate as designated by the LTC Program Director.

Assigned Committee member will:

1. document details of the Complaint or request they be submitted in writing depending on seriousness or complexity

2. issue **Notice of Receipt of Appeal/Grievance form** within three (3) business days of the in-person meeting, a call, or receipt of the written complaint

3. investigate or research the issues identified in the grievance/complaint

4. respond in writing within 30 calendar days of receipt of grievance/complaint. The letter will summarize results of the investigation and any action that will be or has been taken, and/or recommendations/options that would be helpful for the Participant/Applicant in addressing their issues.

Grievances do not give rights to State Fair Hearings, but may proceed to **UPCAP's Internal Grievance Process.**

All documents, notes, records, letters shall be maintained by the Grievance and Appeals Committee.

B. UPCAP Internal Grievance Process:

Grievances that cannot be resolved satisfactorily with the UPCAP Grievance and Appeals Committee, may proceed to UPCAP's Internal Grievance Process. All Grievance Response Letters shall include instructions for next steps (if any) in the Grievance Process.

1. The appropriate individual shall submit the Grievance to the LTC Program Director in writing within **30 calendar days** of the Grievance and Appeals Committee's final response. The Program Director shall respond in writing to the grievance within **ten (10) business days**.

2. Those not satisfied with the response of the LTC Program Director may forward their grievance in writing to the UPCAP CEO, within **ten (10) business day**s of receipt of the LTC Program Director's response. The UPCAP CEO shall respond in writing within **ten (10) business days** of receipt of the grievance.

3. Those not satisfied with the response of the UPCAP CEO may forward their grievance in writing to the UPCAP Executive Committee within **ten (10) business days** of the UPCAP CEO response. The UPCAP Executive Committee shall review the appeal at its next regularly scheduled meeting.

4. A request for the continuation of service(s) being grieved must be received within **ten (10) business days** of the Participant/Applicant receiving notification that the services will be denied, suspended, reduced, or terminated. Exceptions to this include situations where funds do not exist for the service continuation or in cases where there is a danger to the individual. In situations where there is reasonable cause to believe that the individual is endangering their well-being, a referral must be made to the appropriate MDHHS Adult Protective Services (APS) Division.

C. UPCAP's Internal Appeals Process

Participants, their designees, appointed representative (OMB #0938-0950 form), or providers acting on their behalf, may challenge an **Adverse Benefit Determination**.

Participants have the right to appeal decisions made by UPCAP Care Management staff, whether it is related to an initial screening, eligibility, care plan reduction, service delivery, service(s) termination or suspension, and/or termination (case closure) from the program. Individuals shall be informed of this right at the time of initial screening or enrollment into the program, and anytime a Care Manager makes a service-related determination.

To replace the former Adverse and Advanced Action Notices, Care Manages shall now only issue a **Notice of Adverse Benefit Determination** with an addressed return envelope that gives *Participants* twelve (10) calendar days notice that services will be reduced, suspended, or ended, or that program enrollment will be terminated or denied. This Notice shall also be used upon learning of an event or action that occurred that would adversely impact services and program participation.

Appropriate individuals have **sixty (60) calendar days** to file an appeal in writing. Those expressing a verbal appeal shall immediately be instructed on how to submit the written appeal, and that the process is as follows:

1. Appeals must be sent to UPCAP's Grievance and Appeals Committee within **sixty (60) calendar days** of the date the Notice is issued. The Appeal must include in writing unless an Expedited Resolution is requested:
   - Full contact information for the Participant
   - Fill contact information for any approved representatives
   - Date of the Notice of Adverse Benefit Determination
   - Reason why the Determination is being challenged.
   - Signed and dated

2. Assigned Committee member shall issue **Notice of Receipt of Appeal/Grievance form** within **three (3) business days** receipt of the written Appeal

3. Assigned Committee member shall schedule a hearing within **fourteen (14) calendar days** of receipt of the Appeal, and investigate or research the issues identified in the appeal.

4. The Committee has **30 calendar days** from the date of the Notice of Receipt of Appeal/ Grievance form to issue either a **Notice of Appeal Approval form** or **Notice of Internal Appeal Decision-Denial form**. During the 30 day period, Committee members shall review evidence from the Care Managers and the Participant and conduct the hearing with the parties involved.

5. Participants have **120 calendar days** from the date of the Notice of Internal Appeals Denial to request a formal State Appeals Hearing. (See Section D below)

Expedited Request

Participants can, verbally or in writing, request an Expedited Request if it is felt that the standard resolution time frame would seriously jeopardize the enrollee's life, physical or mental health, or the ability to attain, maintain, or regain maximum function.

Approved requestors must justify the need for Expedited Request.

- If the Request is approved, the Committee has 72 hours to resolve the appeal. The Participant may request a fourteen (14) calendar day extension.

- The UPCAP Grievance and Appeals Committee may extend the response deadline by a fourteen (14) calendar days by promptly notifying the Participant verbally and in writing within two (2) calendar days. Both communications shall inform them of their right to file a grievance regarding the extension.

- If the UPCAP Committee denies the Expedited Request, the timelines revert to the regular appeals process.

Continuation of Services

Participants appealing the reduction, suspension, or termination of previously authorized services, must file for continuation of services within 12 calendar days of the Notice of Adverse Benefit Determination.

D. External Appeals Process - State Fair Hearing

The **Notice of Internal Appeal Decision - Denial** form (include mailing envelope) has instructions for *Participants* to request an External State Fair Hearing with the Michigan Administrative Hearing System within **120 calendar days** from the mailing date of the **Denial Notice**. Requests to continue services, however, must be made within **12 calendar days** of the Denial Notice.

Applicants must request a State Fair Hearing within 90 calendar days of the date on the Adverse Action Notice.

Processing Hearing Requests:

Upon receipt of a hearing request from a Participant/Applicant, the Administrative Tribunal will assign a docket number and fax a copy of the request to UPCAP. The LTC Program Director will notify the CM Supervisor who will be designated as the "Hearings Coordinator." The Hearings Coordinator shall be responsible for identifying the responsible staff to participate in the hearing and for the completion of and forwarding of the hearing summary to both the Administrative Tribunal and the Participant/Applicant. This process must be accomplished within **14 calendar days** of receipt of the hearing request from MDHHS.

Hearing Summary is prepared in cooperation with CM staff knowledgeable about the case and who will also be involved with the hearing.

In preparing the Hearing Summary, all case identifiers and notations on status must be complete. The Narrative must include all of the following:

- A clear statement of the action and/or decision being appealed, including all programs involved in the action.
- Facts which led to the action or decision
- Policy which supported the action or decision
- Correct address of the Participant/Applicant or Authorized Hearing Representative (AHR)
- A description of the documents UPCAP intends to offer as exhibits at the hearing.

The Participant/Applicant or AHR has the right to review the case record and obtain copies of documents they feel are necessary to make their case. UPCAP staff are expected to assist approved individuals with reasonable requests for information.

A copy of the hearing summary and all documents intended to assist UPCAP in making its case in the appeal must be forwarded to the Participant/Applicant or AHR at least **seven (7) calendar days** before the scheduled hearing.

The Hearings Coordinator shall cooperate with the Administrative Tribunal and participate in any and all pre-hearing conferences. Pre-hearing conferences with the Administrative Law Judge may be scheduled at the discretion of the Administrative Law Judge, or at the request of the parties involved in the dispute. The designated Hearings Coordinator shall ensure that all appropriate Care Management staff also participate in such pre-hearing conferences.

The Hearing:

The Administrative Tribunal will set the date for the actual hearing. UPCAP staff with knowledge of the appeal are expected to be at the hearing regardless of previous commitments (unless the CEO authorizes an exemption).

At the hearing, UPCAP's Hearing Coordinator (CM Supervisor or Program Director)will be responsible for presenting the agency's case unless it is determined that the primary CMs would be more appropriate. Following opening statements by both sides, the hearing summary (or highlights) is to be read into the case record. The following are to be included in preparing for the case presentation:

- An explanation of the action(s) taken including all programs involved (if other than HCBS/ED Waiver).
- The facts which led to the action by the Care Manager.
- A summary of the policy or laws relied upon to take the action (usually found in MDHHS's Waiver Manual or the actual approved Waiver, if not found in MSA policy manuals)
- Any clarifications by staff of policies or laws relied upon in making the decision being appealed.

Only the Administrative Tribunal can deny a request for a hearing. The UPCAP Care Manager may attempt to convince a Participant/Applicant to proceed through UPCAP's appeals process first before filing a request with MDHHS, however, a Care Managers may not tell a Participant/Applicant they may not appeal an action taken by Care Management.

If a Care Manager believes that a request for an appeal hearing is inappropriate or if the request was filed beyond the required deadline, the Care Manager, with the Hearings Coordinator, may complete the Hearing Summary indicating that the

request should not be heard and state the reasons, or that the request was received after the required deadline for filing. It will be up to the Administrative Tribunal to make a final decision as to whether or not to proceed following review of the Hearings Summary.

While UPCAP is unable to impact whether or not the process moves forward, the Participant/Applicant or AHR may request that the appeal be withdrawn at any time. Should a Participant/Applicant wish to withdraw their request, the Care Manager is to assist the process by providing the person the "Hearings Withdrawal Form" and providing the appropriate postage-paid envelope addressed to the Administrative Tribunal.

The withdrawal request must clearly state why the Participant/Applicant or AHR has decided to withdraw the request. All identifying case information must be contained on the Withdrawal form.

Rehearing / Reconsideration:

If the appeal process goes to an actual hearing, and the results of the hearing are disputed by the Care Manager, the Hearings Coordinator must discuss the case with the Program Director (if other than the Program Director). A decision will then be made, in consultation with UPCAP's MDHHS Contract Manager in Lansing, as to whether or not to file for a rehearing or a reconsideration. The request must be made in writing. It will be up to the Tribunal to decide whether or not to grant a reconsideration or a rehearing based on a number of criteria, including newly discovered evidence that has a direct impact upon the case, or a convincing argument that the manual policy was misinterpreted and led to a wrong conclusion.

To proceed with a request for a rehearing or a reconsideration, it will be the responsibility of the CM to bring the necessary evidence to the Hearings Coordinator and the Program Director. Care Managers will be expected to comply fully with the decision of the Administrative Law Judge and to continue to treat the Participant/Applicant with the utmost respect.

Appendix I

Care Management Participants

NAPIS Registration Requirements & USE OF TITLE III (202) FUNDS

All Care Management Participants (60 and over) ***must*** be registered in the NAPIS data base in order for UPCAP to bill for Care Management Services.

Complete the one page **NAPIS Registration Form** as follows:

Form Section	Information to be Entered
1. Service Provider:	UPCAP Services
2. Senior Center:	Primary Care Manager
3. Intake Date:	Date of the referral to Care Management or the date of the assessment
4. Participant Information:	Complete and answer the questions
5. Care Recipient:	Check Care Recipient

6. "**Service Information**" section, check only those services which are to be purchased and enter the start date for service delivery. Observe the following additional instructions.

   Service Clusters:

   a) Check Services: Only services that UPCAP is going to pay for and date when the service will begin

   b) CM Designation: Check "Care Management" - date would be the date of the CM Classification

   c) Arranged Services: *Do not check any boxes for Arranged Services* – the specific agency responsible will place the date next to services they will provide

7. Complete Nutrition Health and Risk Score and check Nutrition Risk box. Complete ADL/IADL information. Be sure to put CM name or initials at the top of the page indicating who completed the enrollment form. Case Techs are to date stamp form following data entry into NAPIS data system.

Appendix II

Coordination with Medicare / Medicaid Hospice Programs

Participants enrolled in either the Waiver Program or the CM Program can be dually enrolled in a Medicare or Medicaid Hospice Program. The Hospice Program is considered the primary payer of services, with the Waiver or CM Program the secondary payer. Duplication of services shall be avoided through early and ongoing communication and coordination between the Care Manager and the Hospice Agency.

When a Waiver Participant, with an established Care Plan in place, is newly enrolled into a Hospice Program, a case conference shall be held to determine which Hospice Services will be put into place and which corresponding Waiver Services will be reduced or terminated. This communication will ensure the Waiver Program does not duplicate Hospice Program Services. The Care Manager shall send the Participant the required MDHHS **Notice of Adverse Benefit Determination** form specifying that certain services previously provided by UPCAP and its enrolled Provider(s) will now be provided by the Hospice Program.

MDHHS/MSA has additional regulations in place for persons dually enrolled in the Waiver Program and a Hospice Program:

1) The Participant remains classified in CHAMPS as "MI Choice MC" even if dually enrolled in a Hospice Program.

2) Hospice services must be used to the fullest capacity before Waiver services are initiated. If inappropriate (i.e. duplicate) services were provided, MSA will seek restitution from the Waiver Agent, not the Hospice Program.

According to MDHHS/MSA Hospice Policy, the Hospice Agency is responsible for addressing all care needs related to the terminal diagnosis. Waiver services can only be used to meet needs not directly related to the terminal diagnosis per MDHHS/MSA policy.

Despite MDHHS policy, local hospice agencies may not be able to meet all of the care needs of an individual and may request Waiver services in addition to Hospice services. CMs shall request a copy of the Hospice Agency's Plan of Care as well as a written statement or letter from the Hospice Agency as to what service it normally provides if not available to the Waiver Participant, along with the reason why, before using Waiver funds to fill in the gap.

Appendix III

Prior Authorization:
Durable Medical Equipment (DME) & Medical Supplies

Before Waiver funds can be used to purchase any type of equipment, supplies, or items, CM's are to seek payment from Medicare, the State Plan, Medicaid, or any other insurance the Participant might have.

The medical equipment/supply company of the Participant's choice will be able to determine if the needed item is billable to any of the Participant's insurances. Unless it is customary for the DME Company to obtain a physician's order (Rx), the CM shall contact the doctor's office to request the order along with directions to fax or mail the Rx to the DME Company, depending on the standard operating procedure of the physician's office and/or the DME Company.

Waiver policy states that the Waiver Agent must obtain a copy of the Medicare/Medicaid denial of payment from the DME Company before Waiver funds can be used to purchase the item. If a DME Company is unwilling to provide this required denial, then Waiver funds cannot be used to purchase the service/item on behalf of the Participant unless a Waiver is granted by MDHHS. Care Managers must thoroughly document all conversations with DME companies related to requests for DME or other Medicare/ Medicaid reimbursable services.

CMs should reference the current HCPCS Codes to verify an item is billable to the Waiver or whether it is a State Plan item that requires prior authorization before purchase.

When purchasing a **lift chair**, UPCAP requires the DME Company bill Medicare and Medicaid for the lift mechanism. UPCAP may purchase the lift chair using Waiver funds only after the DME Company receives the denial for the lift chair. Care Mangers must use the lift chair Work Order giving instruction to the DME Company to bill Medicare and Medicaid first. The DME must send the denial to UPCAP along with the bill before UPCAP will pay for the chair.

Appendix IV

Self Determination Program Option

The Self Determination (SD) Program option is central to implementing Self Determination policy and practice in the MI Choice Waiver. It is also an option for AASA-Care Management Participants. It allows Participants in the Waiver and Care Management to direct and manage their services. The Participant and their supports work with the CM to determine the appropriate level of services (based on the Care Plan) utilizing the person-centered planning process. Participants may choose to use a **Fiscal Intermediary (FI)** or an **Agency with Choice (AWC)** model to implement the SD option.

Both FI and AWC options allow Participants to directly employ workers or contract directly with chosen Providers. Service and support arrangements controlled by the Participant may range from one specific service to all of those in the Care Plan. The Participant chooses whether to manage some or all of their services.

A. Participant Requirements

All Waiver Participants are eligible to participate in SD Program. All LTC Program Participants must be given information about the Self Determination Program so they can decide whether or not to participate.

Participants can choose a Representative to assist them in the process of managing their own services. This Representative, however, cannot be a paid caregiver.

If a Participant has a diagnosis of dementia and is not able to make decisions on their own (as determined by at least two physicians), the Self Determination option is still available to them if they have an activated Durable Power of Attorney (DPOA) in place. The DPOA must be willing to act as the Representative for the Self Determination option and, therefore, cannot be a paid caregiver.

B. Fiscal Intermediary Option

A FI is an independent legal entity that acts as the fiscal agent for the Waiver Agent and as the employer of record when the Participant directly hires their workers. The Fiscal Intermediary

- ensures financial accountability for the funds in the budget,
- receives the funds comprising the Participant's budget,
- makes payments as authorized by the Participant and approved in the budget, to Providers of services, supports, or equipment;
- acts as an Employer Agent when the individual directly employs workers.

Participants choosing the FI option must:

- be willing and able to manage employees and a monthly budget,
- be willing to utilize the services of an FI to disperse funds in their budget,
- be willing to develop their individual budget or service plan using the principles and practices of person-centered planning,
- design an emergency back-up plan in the event paid providers or caregivers are not available,
- require workers to maintain daily documentation of services and supports provided, including the amount of time required to complete necessary and assigned tasks,
- (with their supports) understand the legal responsibilities in managing LTC funds - particularly Medicaid funds and the legal ramifications of Medicaid fraud.

CMs who feel a Participant is not able to direct or manage their services, or feels family or friends are trying to convince a Participant to choose this option for their own benefit, must address these concerns with the Program Supervisor or Program Director.

If the CM continues to feel this option is not in the best interest of the Participant, their only recourse is a formal denial, in writing, giving the Participant the right to appeal. (See **Section 26: Participant Grievance & Appeal Process**) This should be the action of last resort after all other attempts to rectify the situation have been explored.

Fiscal Intermediary Services Process

The Fiscal Intermediary (FI) acts as an employer agent and assists SD Participant meet state and federal requirements for hiring home care workers. The FI charges a monthly fee to perform these functions and this fee is taken out of the Participant's budget.

The FI will pay, out of the Participant's budget:

- all the Participant's SD Employees,
- Workers Compensation for each employee,
- Employer Taxes, and
- Agencies that provide in home services under the Self Determination program. An example would be an Agency that serves as a back-up in the event a Participant's SD Employee is not available. Vendors must be instructed to bill the FI, and not UPCAP for services or goods provided to a SD Participant. All Vendors must have a signed contract with UPCAP.

- goods and services purchased by the Participant that are not reimbursable under traditional Waiver funds. (Not a CM option.)

After the CM completes the Care Plan and receives approval for the budget from their supervisor and the Participant, they must:

- Complete the **Participant Registration** form online at the FI's website.
- Print copies of the Employee Application (one for each employee) or let each employee know they can fill it out on-line at the FI's website.
- Contact the FI and finalize the budget. The FI will complete the budget template and e-mail a copy to the CM and the CM Supervisor. The CM should know the approximate number of employees that will be used and the hourly pay rate for at least one of the employees. This will enable the FI to calculate if there will be an excess dollar amount in the budget. The FI will also calculate the maximum hourly rate the Participant can pay their employees.
- Schedule the meeting between the FI and the Participant. All SD Employees must be present at this meeting.

The FI will bring all necessary forms and documents to the meeting including Employee Time Sheets.

Before the Participant can begin utilizing the funds in their budget, all SD Employees must have completed the necessary paperwork for both the FI and UPCAP. **There are no exceptions to this policy.**

The FI will inform the CM and Participant of the budget start date. This date must be written on the Enrollment Agreement, signed by the CM and Participant, and a copy sent to the CM Supervisor.

The CM Supervisor will sign the Budget template giving final approval and mail a copy to the FI, CM, and UPCAP's Accounting Department.

UPCAP will send 1/12 of the annual budget amount to the FI so they can begin paying the SD Participant's Employees.

Employee Requirements

Care Manager shall assist SD Participants interested in hiring their own workers in determining the types of tasks and services they would want the SD Employee to perform. This will ensure that a Participant does not expect an SD Employee to perform tasks they are not capable of. It also helps the Participant determine an hourly rate of pay for the SD Employee, i.e. they may wish to pay more for personal care and specialized services, than housecleaning and chore services.

Care Managers shall also meet with SD Employees to review documentation requirements.

Participants shall to choose the SD Employees they want to hire, however these workers must meet the following requirements:

- Must be at least 18 years of age
- A US citizen or Legal Alien
- Must be in good standing with the law and agree to a criminal background check
- Cannot have been convicted of abuse, neglect, or exploitation of any person
- Cannot be a legally responsible relative (spouse) or legal guardian
- Cannot be the Participant's Representative for the Self Determination Program
- If performing personal care tasks, must be trained in CPR, First Aid, and Standard Precautions. The CPR requirement can be waived by the Participant if there is a written "Do Not Resuscitate" order
- Must be willing and able to maintain written documentation related to services and supports provided and the time requirements for completing assigned tasks

C. Agency With Choice Option

Those Participants choosing the **Agency with Choice (AWC) option**, will be approved for services on a weekly basis as with the traditional agency arrangement. They will receive an annual budget based on the approved weekly hours. Participants will choose the workers and set the hourly wage. The AWC will employ those individuals and act as the employer of record with the Participant acting as the co-employer. The Agency is considered the employer for IRS reporting purposes. The AWC will send the Participant a Monthly Spending Report that shows the actual hours used for the month.

Agency with Choice Process

The Agency with Choice (AWC) option allows Participants to hire their own workers through a traditional home care agency that has agreed to allow Participants to choose their own staff and direct their care. The AWC serves as employer of record and directly hires staff of the Participants choosing. The AWC completes all necessary paperwork as they would for any employee with the exception of the Employment Agreement that is signed by the Participant, employee, and AWC. This Agreement sets rules and policies the Participant wishes the employee to follow as well as specific hiring criteria like criminal background checks that the AWC requires. It includes the agreement of the hourly wage for the employee and number of hours allowed each week.

- CMs contact the AWC of the Participant's choosing and directs the Participant's providers/workers to contact the AWC for enrollment as an employee of the AWC for the Participant.
- All paperwork must be completed before the Employees can begin work.
- Each AWC have its own procedures for hiring and meeting with the Participant.
- CMs complete the annual budget (DSP Budget form) and send to CM Supervisor for approval.
- CM Supervisor signs budget and mails to Participant for their signature.
- CMs have Participant sign SD Enrollment Agreement with start date of budget and send to CM Supervisor.

D. Budgets / Billing / Purchasing

Budgets

All Participants in the Self Determination Program will be allocated resources to purchase needed services in a monthly budget. The budget will be determined based on the hours of services needed each month or week to meet the needs of the Participant. The CM, along with the Participant and their supports, will through the person-centered planning process, decide on what services can best meet the needs of the Participant, and set the frequency and duration for each service.

If a Participant is currently receiving traditional Waiver services and those services are meeting their needs, the budget (amount of service hours) will not be increased because they choose the Self Determination option.

For Participants whose current level of traditional Waiver services are not meeting their needs, the CM along with the Participant will determine the appropriate number of service hours.

All budgets must be approved by the CM Supervisor before implementation.

Participants must sign a copy of their Plan of Care acknowledging their approval of the budget.

The recommended hourly wage/rate to be used by Care Managers in developing budgets is $9.50 per hour. All budgets are zero-based budgets. The recommended wage/rate was established at $9.50 to be competitive with the going agency rate. The maximum hourly rate when benefits and FI expenses are included should be lower than the going rate for agencies because the employees of Self Determination Participants will not incur the overhead expenses of an agency. This hourly rate can only be changed with approval from the Program Director or Program Supervisor.

When the Participant replaces an employee with a new employee, the new employee is to begin at the minimum $9.50, unless approved by the CM Supervisor and the Participant, and if the Participant's budget can support the higher rate.

Wage Increases

All wage increase requests must be authorized by the Program Director **in writing**. A revised Work Order must be completed noting the wage increase and submitted to Data Entry.

The rate will be negotiated individually for each AWC based on the employee wage and administrative costs incurred by the AWC.

Services that can be self directed are:

- Chore services
- Community Living Supports
- Fiscal Intermediary Services
- Goods and Services (gaps services under traditional Waiver, not available for CM Participants)
- Homemaker
- In-home and Out of Home Respite
- Home Modifications (not for CM Participants)
- Personal Care
- Private Duty Nursing
- Transportation: Medical & Non-medical
- Workers Compensation

The **fund code** for self directed services is 108 (202 for AASA Care Management Participants).

The service (HCPCS) code for the **FI is T2025**, with a standardized remark of 8500 Fiscal Intermediary Services, per month.

There is no specific service code for the AWC. CMs are to use the HCPCS code for the service being provided by the employee as with a traditional agency. Fund code is 108.

Work Orders written for SD services are for the use of data entry and the FI or AWC. Participant SD Employees do not receive a written Work Order, but sign an Employee Agreement.

Billing for SD Participants

The FI shall bill UPCAP on a **bi-weekly basis.**

All AWCs shall bill on a **monthly basis**.

The FI will complete a Monthly Expenditure Report for each Participant, and send a copy to the Participant and the CM.

The CM must review the report. Participants may occasionally over or under spend their budget for the month. These discrepancies should not be of concern to the CM or FI unless there is a pattern of over spending, or if an item or service appears on the report that the CM did not approve. The CM should then contact the Participant and FI immediately.

The AWC will contact the CM anytime an SD Employee submits a timesheet that is over the approved hours in order to obtain approval before payment is made to the employee

Neither the FI, AWC, or Participant can purchase a service not approved on the Care Plan or approved in the budget.

Goods & Services

Individual directed goods and services are services, equipment, or supplies not otherwise provided through the Waiver, Medicaid State Plan, other 3rd party, or community resources.

Goods and services can be approved when they meet the following requirements:

- The item or service would decrease the need for other Medicaid services; and/or
- promote inclusion in the community; and/or
- increase the Participant's safety in the home environment; and
- the Participant does not have the funds to purchase the item or service.
- must address an identified need in the Care Plan.
- are designed to meet the Participant's functional, medical, or social needs and advances the desired outcomes in their Care Plan.
- are not prohibited by State or Federal law.
- are purchased from the budget.
- must be documented in the individual Care Plan and authorized prior to purchase.

When a Participant wishes to purchase goods or services under the SD/FI option the CM must contact the FI and tell them, 1.) what is being purchased, 2.) the cost, and 3.) name of Vendor.

The Vendor must have a signed contract with UPCAP in order to be reimbursed by the FI.

The CM's shall send a **Work Order** to the FI and Vendor for their records. When completing the Work Order, the CM shall:

- write the name of the FI in the space for "agency," and
- write the name and address of the Vendor in the Comment Section.

***Participants using the AWC option will be able to purchase Goods and Services using a traditional provider agency.

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* Required Forms *

Fiscal Intermediary Option:

- **Employee Agreement** (one for each employee) - signed by Participant and employee
- **Self Determination Enrollment Agreement** - signed by Participant, CM, and representative (if applicable)
- **Budget Template** - signed by CM Supervisor
- Updated **Plan of Care** with cost of SD services - Participant signature required
- **Medicaid Provider Agreement** - signed by employee and CM Supervisor
- **Person Centered Plan** - copy for Participant
- **SD Program Requirements for Personal Care Workers** - signed by Employee
- **Back-up Worker Agreement -** signed by Participant

Agency with Choice Option:

- **Enrollment Agreement** - signed by Participant, CM, and Representative if applicable. Copy to Participant, AWC, and CM Supervisor
- **Employment Agreement** - signed by AWC, Participant, and Employee - AWC will supply copy to Participant, Employee, and CM
- **Annual Budget** (DSP form) - sent to CM Supervisor
- **Person Centered Plan**

Forms for Participant to use with Employees:

- **Hiring & Managing Personal Care Workers**
- **Employee Job Description**
- **Employee Work Documentation** form

Special Self Determination Rules for AASA Care Management Participants

The Aging & Adult Services Agency (AASA) allows the Self Determination option to be made available for Care Management Participants using Older American Act and Older Michiganian Act resources. However, only those services approved in the Area Agency's Annual Implementation Plan may be purchased using the Self Determination process.

Because UPCAP's reserve of Older American Act resources (202-fund code services) is extremely limited, Self Determination may only be used as an option to meet gaps in traditional service delivery (i.e. agency does not provide evening or weekend service and this is a Participant need). Participants must utilize personal resources and grant funds through traditional service delivery must be accessed and utilized before the SD process is implemented. For Care Management Participants, Self Determination may not be the sole option for meeting the Participant's needs unless approved by the CM Supervisor or Program Director, and then only when based on the absence of traditional service delivery options for the Participant.

All other aspects of the Self Determination process must be followed as set forth in this policy manual and/or by the MDHHS or AASA.

Veteran Directed Home & Community-Based Services

UPCAP has contracted with the Veterans Administration to administer their Veteran Directed home care program. Referrals for this program will come directly from the Veteran's hospital in Iron Mountain to the local CM office where the Veteran resides.

Assessments for this program will be scheduled like all referrals in the order they are received and as time permits. When receiving the referral from the VA staff, Case Techs should make every effort to give the VA an approximate date of when the assessment can be scheduled.

The VA staff will fax pertinent information about the Veteran to the local CM office.

CMs will use the same assessment and care planning protocols as with all UPCAP Participants with the exception of determining eligibility. The VA staff will determine eligibility for the program - the CM's responsibility is to assist the Veteran in determining what services are needed and the frequency.

CMs will use COMPASS for the assessment, they are not required to complete the Compass POC *unless* they are going to request from the VA that client is only **reassessed every 6 months instead of every 90 days**. The assessment summary for each discipline must be completed and include all issues and services that will be provided to the veteran.

UPCAP will only serve those Veterans who choose to direct their services through the Self Determination option. If a Veteran decides at the assessment or after not to direct their care, the CM should contact the VA staff and refer the Veteran back to the VA.

UPCAP is authorized to purchases services for the Participant up to $2,315.00 per Participant per month for any Participant enrolled prior to April 1, 2013, and to bill $525.00 per month per Participant for Case Management and Administrative Services. The total monthly cost of the Participants Care Plan cannot exceed $2,840.00 per month which includes the administrative fee.

The Veterans Administration will establish a specific dollar amount for use in developing the SD budget based on an internal evaluation of the Participant’s needs and a pre-defined case mix reimbursement system. If the Veteran’s needs appear to be greater than can be arranged through the SD process based on the assessment, Care Managers are to contact the VA Representatives responsible for the SD program and discuss the assessment findings. Only upon written approval from the VA may a budget be developed greater than the dollar amount specified by the VA in its case mix reimbursement contained in the original referral.

Care Managers must document all activities pertaining to CM interventions with the Veteran the same as if the Veteran were enrolled into the AASA Care Management program or MI Choice Waiver Program. Additionally, time spent working with a Veteran must be properly allocated when completing bi-weekly payroll time sheets.

Participants can choose either the FI or AWC option to administer their budget.

Participant contacts and reassessments will be on the same schedule as all CM Participants.

Copies of assessments, reassessments, and Care Plans must be mailed to the VA for their records.

CM must get prior authorization and/or contact VA Staff if:

- Participant requests DME, skilled nursing, or home modifications (prior authorization)
- Participant enters hospital
- Participant requests nursing home placement
- CM feels Participant should be terminated from SD program*
- CM feels a reduction or suspension of services is needed*

* Care Manager must send a **Veteran Adverse Action Notice** so that the Veteran can exercise their right to appeal to the VA.

For Status Form: Participant type - **VETERAN**
Fund Source code - **450**
Waiver eligibility - **NO**

Participants of the VD-HCBS will not be applying for Medicaid coverage or enrollment into the MI Choice program.

Case Mix Reimbursement Fees (Effective 2-1-17)

Maximum Budget

Case Mix Category	Michigan Veterans	Wisconsin Veterans
Level L	$1,066	$1,172
Level A	$1,475	$1,621
Level B	$1,678	$1,845
Level C	$1,970	$2,164
Level D	$2,036	$2,237
Level E	$2,243	$2,465
Level F	$2,313	$2,542
Level G	$2,386	$2,622
Level H	$2,691	$2,958
Level I	$2,763	$3,036
Level J	$2,945	$3,236
Level K	$3,432	$3,772
Level V	$16,643	$18,289
Assessment Fee	$ 629.00	$ 676.00
Monthly Adm. Fee*	$ 450.00	$ 495.00

(*fee is included in the overall case mix rate, not a separate fee)

Self Determination Program:

Self Determination Participants utilize a monthly budget. Variations in the amount spent each month are allowable.

CMs will receive a monthly expenditure report from the Fiscal Intermediary for each Participant choosing the FI option. CMs are required to review the report and discuss any discrepancies in the report from what was approved, with the Participant to ensure that services are being provided and meeting the Participants needs.

If Participants are consistently over or under spending their budget, CMs should review the budget with the Participant and make changes as needed.

CMs should contact the Fiscal Intermediary or Agency with Choice when changes in the budget are made or when the Participant, for any reason, will not be receiving services for an extended period of time.

Bills for Self Determination Participants received from the Fiscal Intermediary will be sent immediately to CM's for review.

For SD Participants choosing the AWC option billing will be the same as with any traditional agency.

Appendix V

Nursing Facility Transition Services (NFTS)
& Nursing Facility Diversions

Nursing Facility Transitions Services (NFTS)

The Nursing Facility Transition Services is a component of the MI Choice Waiver program designed to assist nursing home residents to overcome existing barriers to discharge and allow the individual to transition back into the community. Individuals with an active discharge plan and an expectation of returning to the community are not considered NFT participants. Such individuals would be placed on the MI Choice Wait List and be given a Priority 2 ranking for assessment purposes. NFT participants are also given a Priority 2 ranking for assessment once barriers are addressed and removed.

Individuals classified as Transition Clients must be registered with the State in the Transition Portal. MDHHS provides Waiver Agents with additional resources to address and overcome barriers. The State has developed specific standards for transition activities along with corresponding revenue limitations. These are found in Attachment L of the MI Choice Waiver Contract.

UPCAP Transition Coordinators may begin working with a resident before he/she qualifies for Medicaid in order to expedite the transition. However, to obtain any reimbursement from MDHHS, the resident must be an **active Medicaid recipient for at least one (1) month prior to the date of transition**.

Transition Coordinators may work with residents who are not Medicaid eligible. Residents who have the resources to cover the cost of their transition services are expected to do so. UPCAP will not be reimbursed for expenditures for non-Medicaid residents. If the individual is functionally eligible via the NFLOC, they may be enrolled into AASA's Care Management program (60 and over) or LCM1 (under 60), and offered services via Older American Act resources or as coordinated by the Transition Coordinator or Care Manager using the individual's own resources.

To be eligible for Transition services, the Resident:

- Must meet the Nursing Facility Level of Care (NFLOC) criteria for enrollment into the MI Choice Program *and* that a barrier exists keeping the resident from returning to the community.
- may have been a former MI Choice Participant whose participation ended prior to the current fiscal year. Individuals who were active Participants during the current

fiscal year who are placed into a NF may return to active participation without utilizing the transition process.

- must be 18 years of age or older - if under 65, must be declared blind or disabled according to Medicaid rules.
- must be a legal resident of Michigan.
- must be an active Medicaid recipient at the time of discharge, however transition activities can and should begin before such eligibility is reached.
- may reside in a Wisconsin facility provided they have a residency in Michigan to return to with the advance approval from MDHHS.

Nursing Home Residents who do not meet the NFLOC criteria or whose needs can be met through the MDHHS Home Help Program should be referred to the Superior Alliance for Independent Living (SAIL) for transition assistance.

Transition Process/Standard of Promptness:

- Transition activities begin upon referral from any referral source through the 2-1-1 Call Center. If the referral source is a nursing facility complying with the MDS Section Q policy requirements, Transition Coordinators must respond within the time frames established by MDHHS/MSA:
    - Follow-up phone call with Resident within **3 business days,**
    - If requested, face-to-face meeting with resident within **10 business days**.
- For all other referrals for individuals currently residing in a nursing facility, a Transition Coordinator should be scheduled to begin transition activities within **14 business** days of the referral.
    - Transition activities include:
        - Initial Transition Interview/Barrier Identification
        - NFLOC (unofficial) Evaluation
        - Transition Plan
        - Formal COMPASS Assessment with formal LOCD prior to actual discharge.
- Transition Coordinators must complete the Nursing Facility Transition Notice (NFTN) and forward a copy, along with the Nursing Facility Admission Form (obtained from nursing facility) to the Administrative Services Manager.
- Transition Coordinator will assess the resident in the nursing home and determine the appropriateness of using Nursing Facility Transition Services (NFTS).

- Once it has been determined the resident meets NFTS requirements, the following information should be forwarded to the Administrative Services Manager:
    - Nursing Facility Transition Notice/Exception Request (both sections must be completed), rationale for requesting exception. Be specific about the condition of the individual, the types of services you think they will need post-transition, and the estimated cost for transition.
- A formal COMPASS assessment is not required to begin transition activities, however, the Transition Coordinator must complete the Initial Transition Interview and conduct an informal NFLOC before formal enrollment procedures are implemented.
    - If an individual does not appear to meet NFLOC criteria, or does not want to enroll into the MI Choice Waiver, or for where the needs of the resident can be met without Waiver enrollment, the case is to be transferred to Superior Alliance for Independent Living (SAIL) for their registration of the individual.
    - UPCAP Transition Coordinators may continue to work with the resident based on discussions with SAIL staff, utilizing the internal contract between UPCAP and SAIL.
- A formal COMPASS Assessment and an official NFLOC must be completed prior to the actual transition home. The NFLOC must be entered into CHAMPS the day of the Transition so that needed in-home services may begin on that date.
- When Resident is transitioned home and placed in the Waiver program, the status report is changed to reflect the transition date and changed to Waiver-Y Transitioned.
- NF Transition Team is responsible for implementing a person-centered care plan with the resident and for the development and implementation of that plan immediately upon discharge. Care Planning activities actually begin prior to transition and must be formalized and approved by the resident prior to the actual date of transition.
- The Transition Coordinator shall be responsible for all Care Management activities on behalf of the Resident/Participant through the first reassessment cycle, after which the case should be transferred to a local WA/CM team in the UPCAP office serving the Participant's particular community.
- The time for completing a transition will be dependent upon each individual case. **If transition activities are to take longer than 6 months,** the NFTS designation may have to be reauthorized. NF Transition Team must consult with the Program Director to ensure that a reauthorization is sought and secured on behalf of the Participant.

Transition Outreach Activities:

UPCAP Transition Coordinators are each assigned a specific number of nursing facilities throughout the region that they will be responsible for. Transition Coordinators are required to have a physical presence in their assigned facilities no less frequently than once a month.

Monthly visits are to be used to interact with interested residents, family members, facility staff for the purpose of identifying individuals who may be interested in returning to the community.

UPCAP will support the activities of Transition Coordinators by providing public service announcements and advertisements calling attention to the availability of transition services. UPCAP will continue to use its sponsorship of the Nursing Facility Best Practices Conference as an opportunity to promote transition services.

UPCAP Transition Coordinators shall meet with SAIL Transition Coordinators and Outreach Specialists in person or via conference call on a weekly basis for the purpose of coordinating transitions, problem solving, and to coordinate outreach activities.

Exception Requests / Diversions

Transition agencies may submit NFT Program Exception requests to MDHHS through the NFT Portal. The purpose of an exception request is to ask MDHHS for permission to utilize additional criteria to authorize services to meet the unique needs of an individual.

MDHHS allows Waiver Agents to apply for Nursing Facility Diversions. A Diversion Request can be made when a current Care Management Participant is on the waiting list for the Waiver but who will have to enter a nursing home if not placed on the Waiver immediately due to the need for extensive services, services are not available because the Participant does not have the resources to pay for them, and no other funding source is available. The CMs must complete the MDHHS Imminent Risk Assessment with the Participant. The Participant must meet the Imminent Risk criteria to be considered a diversion. If the Participant meets the criteria, the CM should review the diversion request with the CM Supervisor or Program Director. The CM must complete a Nursing Facility Transition Notice/Exception and a Diversion Request.

For complete instructions, see Page 32 - E: Exceptions - Attachment L in the MI Choice Waiver contract.

Transition Program Purchasing Protocols

All items needed by Participants to successfully transition must be indicated on the Transition Interview and indicate who is responsible for obtaining these items (Participant/Responsible Parties/transition program, etc.)

Work Orders must be completed for purchases and approved by Waiver Program Director or Supervisor. Work Orders are vendor specific so several Work Orders may be necessary.

Home modifications requiring structural work require a minimum of two (2) bids from licensed contractors and can only be performed in a home owned by the Participant.

Modifications cannot be made to rental units or to homes owned by other family members. Exception Requests may be made to the State to modify homes owned by family members.

Adaptive equipment items must be specified in the Plan of Care with estimated costs and have corresponding Work Orders indicating each item from each vendor.

Household goods such as groceries must be itemized with receipts for verification. Participant verification of receipt of goods is also required. Company credit card may be used to purchase such household goods. Transition Coordinator must arrange to meet with an UPCAP staff person authorized to use the credit card. Transition Coordinators are not to use the company credit card independently.

Work to be done on a resident's home must be completed by a licensed contractor who has a Purchase Agreement with UPCAP. No work can be initiated until the Purchase Agreement has been completed.

Refer to Attachment L for specific details and cost constraints related to transition activities.

Appendix VI

Residential Services Option

The Residential Services Option of the Community Living Supports (CLS) Service Standard allows for MI Choice Waiver Services to be provided within a licensed Adult Foster Care (AFC) Home or licensed Home for the Aged (HFA).

This option is primarily intended to expand housing options in order to facilitate nursing facility transitions, but may be used for individuals who are considering nursing home placement from their current home or apartment, or for individuals currently residing within an AFC or HFA.

Only those AFCs and HFAs who have entered into a Purchase of Services Agreement with UPCAP are available when implementing this option. If a Participant would like to reside within an AFC or HFA that does not have a Purchase Agreement, a Transition Coordinator will work with the selected home in an attempt to reach agreement for entering into a formal Purchase of Services Agreement. Residential Services may not be provided until agreement has been reached between the selected home and UPCAP and payment is not retroactive to the date of admission.

Each participating AFC or HFA will be required to indicate the daily assistance provided to residents through its "Usual and Customary Services" provision of licensure. This baseline of Usual and Customary services is to serve as the baseline for all care and service planning activities. The MI Choice Waiver Program ***cannot pay for room and board or for the cost of the usual and customary services. This is the responsibility of the Waiver Participant***. Residential Services are supplemental services needed by a Participant over and above what the home is required to provide by its individual license.

MI Choice Participants will be expected to pay the home's traditional room and board costs. This may limit some homes as options based on the private pay rate of the home, unless the home accepts Medicaid payments.

To utilize Residential Services, a person must meet the admission criteria for the MI Choice Waiver program and agree to enrollment.

Care Managers are to conduct their assessment as usual and establish a level of service intervention needed and wanted by the Participant. The total hours of service needed on a daily basis, as determined by the care manager through the assessment process, is then compared to the "usual and customary" care level of the selected facility. The difference between the Participant's total need and the amount of care provided by the facility is the amount of service to be purchased by the MI Choice Waiver Program. To

determine the amount of care being provided by the home, the Care Manager is to review Progress Notes or other documentation provided by the home. It may be necessary to obtain a release from the prospective Participant in order to view this documentation. It is not sufficient to simply take the word of the facility staff as to the level of assistance being provided.

Example: Care Manager determines Participant needs 4 hours of assistance daily. The selected home provides 2 hours of assistance daily through its license as usual and customary service. The difference of 2 hours is what UPCAP would be responsible for purchasing on behalf of the Participant through the Residential Service option.

Each participating facility will establish an hourly rate for services as well as the base line of usual and customary services. This information will be maintained by UPCAP's Contract Manager and made available to each CM office.

Residential Services are reimbursed on a monthly per diem rate. The per diem rate will likely be different for each Participant based on their overall care needs.

After developing an overall Service Plan, Care Managers are to complete both their traditional Work Order and the document entitled "Summary of Resident Services & Per Diem Rate." This document establishes what UPCAP will reimburse the home on a monthly basis for services provided to the Participant.

To complete the "Summary of Resident Services and Per Diem Rate" document, Care Managers are to multiply the number of Residential Service hours to be provided on a daily basis by the home's established hourly rate. This total is then multiplied by 30.4 which represents the average number of days in a month over the course of a year. This is the amount that UPCAP will be responsible for paying the home for each month that the Participant resides at the home.

There are **three exceptions** to the monthly Per Diem rate:

#1. If the Participant enters the AFC/HFA after the 10th day of the month for the first month of residency, Care Managers are to multiply the hours of care by the unit rate by the actual number of days remaining in the month. In such cases, complete both lines on the "Summary of Resident Services & Per Diem Rate" sheet, the first line indicating payment for the first month, the second line indicating payment for the subsequent months of residency.

***Example**: Participant enters AFC Home on the 16th of January. There are 16 days remaining in the month (including the day of entry). The hours of care are to be multiplied by the unit rate and by 16.*

#2. If a Participant is hospitalized or away from the AFC/HFA for **5 days or less**, UPCAP will continue payment as established in the "Summary of Resident Services and Per Diem Rate" document.

If the Participant is hospitalized or away from the AFC/HFA for **more than 5 days**, payment will be based on the actual number of days the Participant resides at the home similar to the first month of participation.

#3. If the Participant resides at the AFC/HFA for **21 days or more during the final month of participation**, UPCAP will honor the full Per Diem rate.

If the Participant resides at the home for **20 days or less**, cost settlement will be based on the actual number of days the Participant resided at the home during the **final month**.

Participating AFCs/HFAs are required to immediately notify care managers of any hospitalization, leave of absence or death of the Participant. Care Managers need to review documentation during reassessments to ensure that the home has in fact provided proper notification as required as well as to ensure that services are being provided as set forth in the Work Order. This includes a review of the Weekly Service Log the participating AFCs/HFAs are required to maintain for each Waiver Participant.

Under all circumstances except one, the MI Choice Waiver Program is the payer of last resort. For facilities that accept Medicaid payments within their homes, Medicaid pays a Personal Care supplement in addition to the person's SSI payments. When such individuals enroll into the MI Choice Waiver Program, the Waiver Program becomes responsible for paying the personal care benefit which normally is approximately $192.38, plus the cost of the additional care to be provided through the Residential Services benefit.

In such situations the Care Managers are to establish their Care Plan/Service Plan as usual and UPCAP will be responsible for paying for the entire Care Plan within the facility. The individual will still be required to pay the cost of room and board utilizing their available income as if they were nursing facility residents. If the person is an SSI recipient, the State will pay the home for room and board based on the facility's negotiated agreement with MDHHS. The AFC/HFA must be given a copy of the final Service Plan or the Care Manager may sign the home's MDHHS authorized Service Plan.

If, at the time of assessment, the Care Managers determine that the individual meets the NFLOC criteria but the level of service intervention is being satisfactorily met by the AFC/HFA through the provision of usual and customary services, the individual is not to be opened to the MI Choice program since the third criteria for eligibility – t*o need and*

accept a Waiver service – would not be met. For example, the assessment indicates a person needs 2 hours of assistance daily. The home/facility provides 2 hours of assistance as its usual and customary service. There is no additional need for service so there is no need for a Waiver service. The third condition of eligibility is not met.

Some AFCs/HFAs have indicated that they are not interested in entering into a Purchase Agreement with a Waiver Agent but will allow an outside provider to enter their facility to provide for the additional service needs of the Participant. In such situations the Participant is responsible for paying the traditional room and board rate. Care Managers are responsible for establishing their Care/Service Plan and to subtract from this plan the usual and customary care provided by the home. The balance is then purchased from a traditional in-home service provider enrolled into UPCAP's Service Purchasing Pool or through a self-directed process with the Participant identifying a caregiver who will be responsible for providing the needed care.

Transition Coordinators will be responsible for negotiating a three-way agreement between the home, UPCAP, and the in-home service provider. The agreement holds UPCAP and the AFC/HFA "harmless" to any acts by the Service Provider that endanger the health and well being of the Waiver Participant or other residents of the home. It also holds UPCAP and the Service Provider "harmless" from any acts that endanger the health and safety of the Service Provider employees.

This Service Agreement must be in place <u>before</u> UPCAP can purchase services on behalf of the Participant.

When a third party will provide services within the AFC/HFA for an individual who is an SSI recipient, the home will not be paid the personal care supplement and UPCAP will be responsible for paying for all of the care provided to the Participant.

Brief Review of Roles:

TC: Negotiate purchase agreements with AFCs & HFAs
Establish usual and customary service provision levels
Initiate all nursing facility transitions; assist with transition activities

CM: Conduct assessment and establish eligibility - financial & functional
Develop care/service plan
Establish monthly per diem rates
Conduct reassessments and review documentation

Beginning in Fiscal Year 2014, Residential Services will utilize the Community Living Supports (CLS) service classification and corresponding codes.

Appendix VII

Staff Training / Licensure / Continuing Education

All Care Management staff are expected keep current on issues and innovations that directly impact their profession and Participants with whom they work.

This includes increasing knowledge of the various cultural differences of the Participant population to ensure that individual cultural backgrounds and beliefs are respected in all aspects of care management activities. To assist in this process, all Care Managers will participate in planned in-service training sessions that will coincide with the semi-annual inter-office Peer Review sessions. Training topics may include, but not limited to:

Alzheimer's Disease	Dementia
Cultural Diversity & Sensitivity	Disability Sensitivity
Elder Abuse and Neglect	Person-Centered Thinking

MDHHS requires that Care Managers be licensed Registered Nurses and Licensed Social Workers in the State of Michigan. UPCAP's professional staff must maintain their licensure and/or certification and, as set forth in UPCAP's Personnel Policies, are responsible for presenting documentation of their license or certification prior to employment and at those times when license or certifications are renewed.

UPCAP will make every effort to assist staff in meeting their licensure and/or certification requirements by working with staff to facilitate attendance in conferences or other forums where CEUs needed for licensure or certification are offered. The cost of obtaining CEUs shall be the responsibility of the employee, however, on a case by case basis and upon approval of the Executive Director, UPCAP may share in the cost with the employee or provide assistance to the employee in attending training and/or conferences which lend themselves to supporting the mission of the organization, improving job related skills, and assisting the employee in meeting CEU requirements.

As a designated, full functioning Aging & Disabilities Resource Center (ADRC), UPCAP has access to the ADRC Technical Assistance Exchange. This web site periodically has information on on-line webinars and training sessions with a specific emphasis to Cultural Sensitivity. From time to time staff will be assigned to participate in these on-line webinars and to submit proof of attendance for inclusion in individual personnel files.

Appendix VIII

Participant Financial Responsibilities

Participation in the MI Choice Medicaid Waiver requires that Participants meet specific financial eligibility requirements. However, that does not mean that Participants do not have resources to pay for some of their care. It is the philosophy of UPCAP's Care Management Program that, whenever possible, Participants contribute to the cost of their care. However, the MDHHS prohibits the use of any cost-sharing formula or format. Therefore, it is up to the Care Manager, in conversation with the Participant, to identify those situations where the Participant may be able to contribute to the cost of the desired item or service, and to reach agreement with the Participant as to whether or not the Participant will utilize their resources towards those goods or services.

Participants who receive SSI payments are exempt from any cost sharing activities unless such Participants and families requests to participate in this process.

Any co-payment or cost sharing on the part of the Participant shall be paid directly to the Service Provider.

The co-payments are voluntary and the WA program is required to provide services to the Participant regardless of their willingness or ability to pay for services.

COST SHARING

As a condition of UPCAP's contract to provide state-funded Care Management services to individuals who do not meet the financial requirements of the MI Choice Waiver program, such Participants must be "billed" for the Care Management services received.

Care Managers are to determine each Participant's (CM only) cost sharing amount as part of the care planning process. Cost Sharing is required as part of Care Management's participation in billing Medicaid for "Case Management" services. The Centers for Medicare/Medicaid Services (CMS) has determined that billing for "Case Management" for Medicaid recipients is not allowable if the service is provided without fee to the rest of the target population. Furthermore, the Michigan 1990 Budget Reconciliation Act provides for a "fee-for-service" system to be developed when only State Dollars are funding the particular service. Non-Waiver Care Management is funded with 100% State revenues, therefore, the Cost Sharing component of Care Management is to be viewed as a fee-for-service.

Participant Cost Sharing is a quarterly fee for participation in Care Management. The initial Cost Sharing fee is for the purpose of the assessment and initial care plan. Each successive quarterly fee is for the provision of on-going care management and re-assessment of needs.

Spousal income and assets are not factored into the cost sharing process.
The Participant Cost Sharing fee is determined by establishing a Monthly Income Rate and an Adjusted Monthly Asset Rate. The Monthly Income rate is the Participant sub-total in Section C-1 on page 3 of the MI Choice Participant Information form.

The Adjusted Asset rate is determined from Participant sub-total in Section C2 Assets, of page 3 of the MI Choice Participant Information form. Subtract $2,000.00, MA allowable asset limit, from the Participant sub-total line. This total is then matched to the "Adjusted Income/Asset Range" scale on the worksheet with the corresponding "Quarterly Contribution" amount entered at the bottom of the worksheet.

COST SHARING - Example:

Monthly Income Determination - Participant Income Sub-Total is $1,500.00. Participant Asset Sub-Total is $2,500.00. Subtract $2,000.00 (MA allowable asset limit) from this amount for a total of $500.00. Divide this amount by 12 for a total adjusted asset level of $42.00 (Round up to the nearest whole number).

Add $1,500.00 plus $42.00 for a total of $1,542.00. Refer to Income/Asset Range on Cost Sharing Form - Participant Quarterly Contribution is $35.00.

Enter $35.00 at the bottom of the Cost Sharing Form as indicated.

Net Income will be the amount the Participant quotes as monthly income.

Allowable deductions from this net amount include guardianship fees paid to a guardian and health insurance premiums paid by the Participant. An additional $60.00 may be deducted. This is the amount the State currently allows NF residents for monthly personal needs.

Spousal Impoverishment rules may be applied for diverting assets to the non-CM spouse before factoring assets into the cost sharing format.

Should the Participant refuse to divulge income and asset information when developing the Cost Sharing Statement, CMs are to assume that the Participant's income and assets are equal to or greater than Level 16 on the sliding scale of the worksheet.

Care Managers are to explain to the Participant that this is a quarterly fee for their participation in Care Management and that they will be sent a statement following their first three months of participation in the program. Further, the Participant is to be told that a new statement will be sent every three months thereafter following each 90 Day Reassessment visit.

The CM shall sign and date the form after presentation to Participant. A copy of the cost sharing is mailed to the Escanaba office, and a copy to the Participant.

Appendix IX

Healthy IDEAS Depression Screening

Purpose: UPCAP's mission is to assist individuals needing long-term care supports and services in their homes. Depression can be a major barrier to accomplishing this goal. Depressive symptoms, like all other Participant issues, concerns, and problems, should be identified, included in the Participant's care plan, and monitored over time. To overcome potential barriers to continued community-based living that may result from depression, UPCAP has adopted an evidence-based program to identify and address depression as part of our overall Care Management process.

This evidence-based program is known as ***Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors***). Healthy IDEAS builds on the established Participant relationship to empower at-risk older adults to address depression and other basic care concerns so that they can remain at home. The following procedure's effective date is October 1, 2013.

Procedure:

1. During the in-person re-assessment (for existing Participants or at 6 months for new Participants) the CM will administer the Two-Question Depression screening as follows:
    a. ***During the last two weeks, have you often been bothered by having little interest or pleasure in doing things?***
    b. ***During the last two weeks have you been bothered by feeling down, sad, or hopeless?***

2. If the answers to both questions are "no," the result is negative. With the Participant's permission, leave educational materials on depression with the Participant.

3. If the Participant answers "yes" to either or to both questions on the Two-Question Depression Screen, the following steps shall be taken:
    a. If the CM administering the Two-Question Depression Screen is the primary Care Manager:
        - Administer the Geriatric Depression Scale (GDS) to assess the severity of symptoms and the need for medical treatment; and Quality of Life Questions related to pain and social functioning
    b. If the CM is the secondary Care Manager:
        i. The CM will provide the Participant with information regarding Healthy IDEAS and other materials pertaining to depression;

ii. The CM is to consult with the Primary CM about the results of the Two-Question Depression Screen

iii. The Primary CM shall call the Participant within 5 working days to schedule a face-to-face meeting during which the Geriatric Depression Scale (GDS) is to be administered to assess the severity of symptoms and the need for medical treatment; and Quality of Life Questions related to pain and social functioning

4. For a **GDS score of 0-5**, the CM will provide educational information on depression.

5. For a **GDS score of 6 or higher**, the CM will conduct a Suicide Screen.
    a. If the Suicide Screen is positive follow the COA suicide prevention protocol.
    b. If the Suicide Screen is negative, continue with the process.

6. The Primary Care Manager educates Participant on depression symptoms, treatment, and self care. If the Participant is agreeable, treatment options are explored. Treatment options include:
    a. Medication
    b. Mental Health Treatment (linkage and referral)
    c. Self Care (Behavioral Activation)

7. The Care Manager discusses the Healthy IDEAS Behavioral Activation program and asks if the Participant wishes to participate.
    a. If the Participant does not wish to participate in Behavioral Activation, offer education and process ends.
    b. If the Participant is agreeable to participate in Behavioral Activation, continue with process. The Behavioral Activation steps are to be performed at the next in-person visit scheduled within two to three weeks.

8. Behavior Activation steps:
    a. Explain the connection between mood and activity
    b. Assess current levels of activity and rate mood. Use the Healthy **Idea #1** – Record Daily Activities and Rate Mood (***T-26***) to identify activities the Participant is currently doing and how much pleasure those activities provide.
    c. Identify behaviors and activities. Use the **Healthy Idea #2** – Identify Pleasant Events and Meaningful Activities (***T-27***) to identify the number and type of activities the Participant is participating in and whether the activities make the Participant happy.

d. Help the Participant set goals.

    i. The Checklist of Activities (***T-28***) can be used to brainstorm and help the Participant choose an activity or goal that is pleasant, meaningful, helps solve a problem, or provides a sense of accomplishment.

    ii. Use the **Healthy Idea #3** – Identifying Activities with Steps to Take to Help Feel Better (***T-30***) to help the Participant choose a specific activity that is observable and measureable. This form allows the CM and Participant to consider the necessary steps to accomplish the goal and identify help that might be needed.

e. Follow up to support the Participant's efforts. The CM role is to monitor progress toward goals, help adjust goals as needed, and reinforce positive behavior. It is very important to support and encourage any action that the Participant has taken.

    - Within one (1) week, the CM contacts the Participant by phone to determine progress towards goals.

f. Maintain ongoing contact to review depressive symptoms, review accomplishments, set new activity goals, and evaluate progress.

    - The CM contacts the Participant by phone every two to three weeks until the next in-person visit.

9. The CM completes an in-person visit at 90 days (for PSP, this is the quarterly visit). The GDS is re-administered.

    a. If the Participant's score has not improved or has worsened, pursue further medical or mental health consultation. Some Participants may need more time to do the intervention, so use knowledge of the person's progress to judge what the next step should be. Consult the team leader if needed. Continue Healthy IDEAS interventions for an additional 90 days.

    b. If the Participant's score has improved but is still indicative of depressive symptoms, the CM will determine how to best support his/her continued behavioral activation. The CM will review accomplishments with Participant and encourage the Participant to maintain gains and to add more or new goals if applicable. Continue interventions for another 90 days.

    c. If the Participant's score no longer indicates even mild depressive symptoms, prepare the Participant for self-directed maintenance of gains. The CM will determine if the Participant can identify depressive symptoms, then agree upon a follow up plan. Discontinue active Healthy IDEAS interventions but review for recurring signs of depression at all subsequent reassessments.

Agency Outcome Measures

- When CM identifies Participant who wishes to participate in Healthy IDEAS Program they notify CM Supervisor.
- Supervisor begins tracking outcomes by adding Participant name to T-6 tracking form.
- CM will document interventions and Healthy IDEAS steps in POC or Progress Notes.
- CM Supervisor will check PICK progress notes and POC monthly to verify CM following Healthy IDEAS steps.
- CM Supervisor will record progress on T-6 form.
- CM Supervisor will follow-up with CM as needed to clarify progress for each Participant.
- If after 90 days Participant is not seeing improvement in mood/depression CM will contact supervisor to review Healthy IDEAS protocols and determine next steps.

Required Forms for Healthy IDEAS:

Geriatric Depression Scale (GDS)

Suicide Screen

T-24: Depressed Mood & Symptoms Diagram

T-25: Better Mood & Fewer Depressive Symptoms Diagram

T-26: Recording Daily Activities & Rating Mood Log

T-27: Identifying Pleasant Events & Meaningful Activities Log

T-30: Identifying Activities with Steps to Feel Better

Optional:

T-17: Readiness Ruler

T-28: Checklist of Life Activities or Events

T-31: Positive Events Planning & Tracking Chart or

T-32: Yes I Can! Calendar

Suicide Protocol

For LTC Participants Demonstrating Suicidal Tendencies

This Suicide Protocol is to be used by UPCAP staff with Participants who are exhibiting suicidal tendencies or for individuals who are threatening suicide during an assessment, reassessment, or during any in-home encounter with a Participant. The Protocol is designed to coincide with UPCAP's 2-1-1 Call Center Protocols for such situations.

If a Participant answers "yes" to both suicide risk questions during an assessment or subsequent reassessment, or if a person is demonstrating suicidal tendencies during a subsequent home visit, the following steps shall be taken:

1. Ask the following questions:

   "Over the last 2 weeks, have you had thoughts that you would be better off dead or that you wanted to hurt yourself in some way?" **Yes / No**

   "Do you feel these thoughts are a problem for you or something you might act on?" **Yes / No**

2. Explore the following with your Participant:
   a.) Does the individual have a plan to commit suicide? If so, when and how?
   b.) Is the means/method available to the suicidal individual?
   c.) Is the individual alone?
   d.) Has the individual ever attempted suicide before?
   e.) Is the individual under the influence of drugs or alcohol?

   Remember that lethality increases with each affirmative answer, and it increases as the plan becomes more specific and immediate

3. For individuals who answer "Yes," begin a conversation that asks about the issue of intent. If they <u>volunteer</u> other information, use when reporting to emergency services.

4. Call the local CMH Crisis line and explain the current situation. (If unable to access the local CMH office, call 2-1-1 for access and linkage to the local emergency response/crisis assistance entity in the Participant's local area.)

5. Advise CM Supervisor or Program Director of the outcome of the call including the next steps to be taken or required.

In addition to accessing the U.P. 2-1-1 Call Center, the toll-free National Suicide Prevention Lifeline is available 24-hours a day, seven days a week, at 1-800-273-TALK (1-800-273-8255)

Appendix XI

COMPASS Portal - Vendor View 2018

Active Vendor View Vendors

Agent: 11 - UPCAP AREA AGENCY ON AGING

Vendor	Assess Report Type	Internet/Fax	Fax Number
ACOA ALGER COUNTY COMMMISSION ON	Expanded	Internet	
AMCB AMCAB	Expanded	Internet	
AH00 ARCADIA HEALTH CARE	Expanded	Internet	
ANGELS ARMS OF ANGELS, INC.	Expanded	Internet	
GV00 ASPIRUS GRAND VIEW LIFELINE	Expanded	Internet	
ASPIRU ASPIRUS HELP AT HOME	Expanded	Internet	
CCGI ASPIRUS HELP AT HOME/CARING	Expanded	Internet	
AHCINC AT HOME COMPANIONS, INC.	Expanded	Internet	
AVANTI AVANTI SUPPORTIVE HOME CARE	Expanded	Internet	
BLSC BARAGALAND SENIOR CITIZENS CTR	Expanded	Internet	
BELL BELL MEMORIAL LIFELINE	Expanded	Internet	
CM00 CAA - HUMAN RESOURCES AUTHORITY	Expanded	Internet	
CCHD CHIPPEWA COUNTY HEALTH	Expanded	Internet	
CC00 CHIPPEWA-LUCE-MACKINAC CAA	Expanded	Internet	
POHR COPPER COUNTRY SENIOR	Expanded	Internet	
CST CRITICAL SIGNAL TECHNOLOGIES	Expanded	Internet	
CD00 DICKINSON IRON CSA	Expanded	Internet	
GO00 GOGEBIC/ONTONAGON CAA	Expanded	Internet	
GTRACK GT INDEPENDENCE	None	Internet	
GUARD GUARDIAN MEDICAL MONITORING	None	Internet	
HHCP HOME HEALTHCARE PROFESSIONALS	Expanded	Internet	
KLIN KLINE MEDICAL SUPPLY	None	Internet	
LSHADC LAKE SUPERIOR ADULT DAY SERVICES	Expanded	Internet	
MOMS MOM'S MEALS - PUR FOODS LLC	Expanded	Internet	
NWHN NORTH WOODS HOME NURSING	Expanded	Internet	
NHCS NORTHERN HOMECARE SERVICES	Expanded	Internet	19067895951
NMHH NORTHERN MICHIGAN HOME HEALTH	Expanded	Internet	
LGSC ONTONAGON COUNTY COA/LAKE	Expanded	Internet	
TC00 PORTAGE HEALTH HOME SERVICES, INC,	Expanded	Internet	
SCINC SUPERIOR CAREGIVERS, INC.	Expanded	Internet	
UPPD U.P. PRIVATE DUTY	Expanded	Internet	
WPIN WHISPERING PINES/GREAT NORTHERN	Expanded	Internet	

Total Active Vendors: 32

Appendix XI: Acronyms

A

a	Before
@	At
A.A.	Alcoholics Anonymous
AAA	Area Agency on Aging
AAAAM	Area Agency on Aging Assn of MI
AACIL	Ann Arbor CIL (Ann Arbor area)
AAL	Aid Association for Lutherans
AARP	Amer Assn of Retired Persons
AASA	Aging & Adult Service Agency
Abd. or abd.	Abdomen
ABT	Antibiotic
a.c.	Before Meals
ACA	Affordable Care Act
ACL	Admin. for Community Living
acct.(s)	Account(s)
AD	Alzheimer's Disease
ADA	Americans with Disabilities Act
ADAAG	Amer. w/Disabilities Act Guidelines
ADAPT	Amer. w/ Disabilities for Attendant
ADC	Adult Day Care
ADCS	Adult Day Care Standard
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyper Disorder
Ad lib	As desired
ADL	Activities of Daily Living
adm	Admission
admn.	Administrative
ADP	Adult Day Program
ADRC	Aging & Disability Resource Ctr
ADS	Adult Day Service
AFC	Adult Foster Care
AG	Attorney General
AH	Administrative Hearings
AHH	Adult Home Help
AILS	Adult Independent Living Svc
AHR	Authorized Hearing Rep
AIM	**A**ging in MI (OSA Publication)
AIP	Annual Implementation Plan
AIS	Aging Information System
ALF	Assisted Living Facility
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclerosis
4AM	Area Agencies on Aging Assn of MI
A.M. or a.m.	Morning
AMA	Against Medical Advice
AMAP	As much as possible
AMCAB	Alger Marquette Community Action Board - now CAAM
A & O	Alert and Oriented
amt	Amount
AmLeg	American Legion
Ans	Answered
AoA	Administration on Aging
AP	Assistance Payment
appl.	Application
appt.	Appointment
APS	Adult Protective Services
ASA	Aspirin or AmerSociety on Aging
ASAP	As Soon As Possible
ASHD	Arteriosclerotic Heart Disease
ARC	Advocacy Org for Parents
ASL	American Sign Language
ASM	Autism Society of Michigan
ASW	Adult Services Worker
AT	Assistive Technology
ATT	At This Time
avail	Available

B

b\4	Before
B or bro	Brother
BAMC	Bay Area Medical Center
BCBSM	Blue Cross/Blue Shield of MI
BCHH	Baraga County Home Helpers
BCHC	Baraga County Home Care
BCMH	Baraga County Memorial Hospital
BEAM	Bringing the Eden Alt. to the Midwest
BFD	Barrier Free Design
BI	Brain Injury
BIA	Bureau of Indian Affairs
BIA	Brain Injury Association
b.i.d.	2x day or Twice a Day
BKA	Below knee amputation
BM	Bowel Movement
BMH	Bell Memorial Hospital
BP	Blood Pressure

Appendix XI: Acronyms

BR	Bathroom
BS	Blood Sugar
BSC	Bedside Commode
BSHN	Bay Shore Home Nursing
BSW	Bachelors in Social Work
BWCIL	Blue Water CIL (Port Huron area)

C

C	Centigrade
c	With
CA, Ca	Cancer
CAA	Community Action Agency
CACIL	Capital Area CIL (Lansing area)
CAD	Coronary Artery Disease
cap	Capsule
CAP	Community Action Program
CAPS	Client Assessment protocols
CAR	Case Assessment Review
cath	Catheter
C.B.C.	Complete Blood Count
CBC	Citizens for Better Care
cc	Cubic Centimeters
CC	Care Conference
CC	Clinical Coordinator
CC	Community Connections
CCC	Credit Counseling Center
CCHD	Chippewa County Health Dept
CCMHS	Copper Co.Mental Health Svcs
CCMPCB	Chippewa Co Multipurpose Coll Body
CCSS	Case Coordination & Support Standard
CD	Certificate of Deposit
CEO	Chief Executive Officer
CFR	Code of Federal Regulation
CFO	Chief Financial Officer
CHAMPS	Comm.Health Automated Medicaid Payment System
CHF	Congestive Heart Failure
chol.	Cholesterol
CIL	Center for Independent Living
CIO	Chief Information Officer
CIS	Client Information System
ck	Check
clt. (ct.) or cl.	Client
cm	Centimeter
CM	Care management
CM(s)	Care Manager(s)
CMH	Community Mental Health
CMIS	Client Mgt Information System
CMS	Congregate Meal Standard or Ctr for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
CNB	Commercial National Bank
CNS	Central Nervous System or Corporation for National Service
c/o	Complained of
Co.	County or Company
CO	Carbon Monoxide
COA	Common Aging/Council on Aging
Cont.	Continue
COPD	Chronic Obstructive Pulmonary Disease
CP	Care Plan
CP	Cerebral Palsy
CPC	Care Plan Calendars
CPHA	Community Public Health Agency
CPS	Child Protective Svc / Care Plan Sketch
CR	Caregiver Respite (state)
CRC	Council of RICC Chairpersons
CS	Chore Service
C & S	Culture and Sensitivity
CSA	Commission on Svc to the Aging
CSR	Customer Service Record
CSS	Catholic Social Services
CSV	Cash Surrender Value
CTA	Clear to Auscultation
CTS	Client Tracking System
CVA	Cerebrovascular Accident
CX	Canceled

D

DAKC	Disability Advocates of Kent Co.
d.c.	Discontinue
DC	Day Care
D/C; dc; dc'd	Discharge (d)
DCH	Dept of Community Health
DCHD	Dickinson Co. Health Department
DCHS	Dickinson Co. Healthcare System

Appendix XI: Acronyms

DCIS/CIS	Dept of Consumer & Industry Svc
DCW	Direct Care Worker
DD	Developmentally Disabled
DDC	Developmental Disabilities Council
DDI	Developmental Disabilities Institute
DDS	Doctor of Dentistry
DELEG	Dept of Labor & Economic Growth
Dept.	Department
DHHS/HHS	Dept Health & Human Servcies
DHS	Dept of Human Services (formerly FIA)
DHHS AHH	Dept of Human Svc Adult Home Help
Diff.	Different
DIL	Daughter-In-Law
DJV	Degenerative Joint Disease
DM	Diabetes Mellitus
DMB	Deptof Management and Budget
DME	Durable Medical Equipment
DMP	Duraline Medical Products
DNR	Do Not Resuscitate
DOB	Date of Birth
DoE	Department of Education
DoL	Department of Labor
DOJ	Department of Justice
DoT	Department of Transportation
DPH	Department of Public Health
DPOA	Durable Power of Attorney
Dr.	Doctor
DR	Dining Room
DRA	Deficit Reduction Act
drsg. , dsg	Dressing
DSP	Direct Service Provider
DSS	Department of Social Services
D/T	Due To
dtr	Daughter
DV	Domestic Violence
Dx	Diagnosis

E

EASS	Elder Abuse Service Standard
EBT	Electronic Benefits Transfer
ECF	Extended Care Facility
ECG, EKG	Electrocardiogram
ED	Elderly & Disabled
EENT	Eye, Ears, Nose & Throat
EEOC	Equal Employment Opportunity Comm
e.g. , Ex., ex	Example
EHHS	Expanded Home Help Services
EI	Emotionally Impaired
Elec. Med Disp	.Electronic Medication Dispenser
ELM	Elder Law of Michigan
ENP	Emergency Needs Program
EPIC	Elder Prescription Ins. Coverage
ER	Emergency room
ES	Eligibility Specialist
et al.	And Others

F

F (F)	Father or Fahrenheit
FA	Family Assistance
FAP	Food Assistance Program
FAX	Facsimile
FBS	Fasting Blood Sugar
FC	Foster Care
FCC	Federal Communications Comm
FFS	Fee for Service
FGP	Foster Grandparent Program
FHA	Fair Housing Authority
FI	Fiscal Intermediary
FIA	Family Independence Agency
FIL	Father-in-law
fld	Fluid
FMS	Financial Management Standard
FOIA	Freedom of Information Act
FP	Family Planning
FSN	Family Support Network
FSR	Financial Status Report
FTC	Federal Trade Commission
F/U or f/u	Follow-up
FU	Finlandia University
FV	Face Value
FWA	Fraud, Waste, Abuse
FY	Fiscal Year
FX	Fracture

Appendix XI: Acronyms

G

gal	Gallon
GAO	General Accounting Office
g'dtr	Granddaughter
g'son	Grandson
GF/GP	General Fund/General Purpose
GI	Gastrointestinal
Gm	Gram
GLHM, GL	Great Lakes Home Medical
GNHC	Great Northern Home Care
GRASPS	General Req for All Svc Prog Stds
GRIHSPS	General Requirements for IN-Home Svc Programs Standard
gtt(s)	Drop(s)

H

h (hr)	Hour
HAB	Habilitation Waiver
h.a.n.d.s.	HIV/AIDS Network & Direct Service
Hb (Hgb)	Hemoglobin
HB	House Bill
HBH or HBHA	Hiawatha Behavioral Health Authority
HCBS/ED	Home & Community-Based Services for the Elderly and Disabled Waiver - commonly known as MI Choice
HCBW	Home Care Based Waiver
HCBWS	Home Care Based Waiver Svcs
HCFA	Health Care Financing Administration, US Dept. of Health and Human Svc
HCMCF	Houghton Co.Medical Care Facility
HCPCS	Health Care Procedure Codes
Hct.	Hematocrit
HDM	Home Delivered Meals
HFA	Home for the Aged
Hg	Mercury
HH	Human Help or Home Help
HHA	Home Health Aide
HHAS	Home Health Aide Standard
HHS	Handheld Shower
HHS	Home Help Services
HI	Hearing Impaired
HIPAA	Health Ins Portability & Accountability Act
HIV	Human Immunodeficiency Virus
HMA, (H.A.) \ HA, HMK =	Homemaker Aide
HMO	Health Maintenance Organization
HNJH	Helen Newberry Joy Hospital
h/o	History Of
HOH	Hard of Hearing
Hosp.	Hospital
hr.	Hour
HR	House Bill (federal)
HS (h.s.)	Hour of Sleep or Homemaking Std
HAS	Health Systems Agency
HR	Hip Replacement
HSS	Health Screening Standard
ht	Height
HTN	Hypertension
H & P	History and Physical
HUD	Housing and Urban Development
HV, hv	Home Visit
Hx	History

I

IADL	Instrumental Activities of Daily Living
IAW	In Accordance With
I&A	Information and Assistance
I&R	Information and Referral
IADL	Independent Activities of Daily Living
IC	In Compliance
ICF/MR	Intermediary Care Facility/Mental Retardation
ICHD	Iron County Health Department
ICGH	Iron County General Hospital
ICU	Intensive Care Unit
ID	Identification
IDDM	Insulin Dependent Diabetes Mellitus
i.e.	That Is
IL	Independent Living
ILP	Independent Living Plan
I.M.	Intramuscular
IM	Information Memorandum
inct. Suppl.	Incontinence supplies
inj	Injection
Ind.	Independent
I & O	Intake and Output
IoG	Institute of Gerontology
IPS	Individual Plan of Service
I & R	Information and Referral
IRA	Individual Retirement Account
IV	Intravenous
IVP	Intravenous Pyelogram

Appendix XI: Acronyms

J K

JCAH	Joint Comm for Accreditation of Hospitals
JCAHO	Joint Comm on Accreditation of Healthcare Org now JTC
JFA	Justice for All
JTC	The Joint Commission
K	Potassium
KBIC	Keweenaw Bay Indian Comm
Kew.	Keweenaw
Kg	Kilogram
KHN(H)	Keweenaw Home Nursing & Hospice
KHS	Keweenaw Home Services
KMMC	Keweenaw Memorial Med Ctr
KMS	Kline Medical Supply

L

L	Left (Liter)
Lab	Laboratory
LAS	Legal Assistance Standard
lb.	Pound
LBSW	Licensed Bachelor Social Worker
LCIL	Lakeshore CIL (Holland area)
LEP	Limited English Proficiency
LI	Life Insurance
liq	Liquid
LL	Life Line
LMAS	Luce, Mackinaw, Alger, Schoolcraft Health Department
LOC	Level of Care or Loss of Consciousness
LOS	Length of Stay
LPN	Licensed Practical Nurse
LR	Living Room
LSP	Legal Services Program
LSSU	Lake Superior State University
LTC	Long Term Care
LTCC	Long Term Care Connection
LTCOAS	Long Term Care Ombudsman/ Advocacy Standard
LTCOP	Long Term Care Ombudsman Prog
LTML	Long Term Memory Loss
LV	Living Room

M

M	Mother
MA	Medicaid or Masters
MA	Medical Assistance
MACIL	MI Asso. of Centers for Ind Living
MADSA	Michigan Adult Day Svc Assn
MA ID#	Medicaid Recipient Identification #
MA HMO	Medicaid Health Maintenance Org
MAS	Marquette Aging Services
MC	Medicare
MCB	Michigan Comm for the Blind
MCCA, MCCOA	Marquette Comm on Aging
MCO	Managed Care Organization
MCDC	MI Comm on Disability Concerns
MCF	Medical Care Facility
MCQC	MI Campaign for Quality Care
MD	Medical Doctor
MDRC	Michigan Disability Rights Coalition
MDS	Menominee-Delta-Schoolcraft
MDS-HC	Minimum Date Set for home care
meds	Medications
mEq	Milliequivalent
MFC	Michigan Financial Corporation
MFP	Money Follows the Person
mg	Milligram
MGHH(& H)	Mqt Genl Home Health (& Hospice)
MH	Mechanical Help or Mental Health
MHSCC	MI Hispanic Senior CitznCoalition
MI	Myocardial Infarction/Mentally Ill
MIACoA	MI Indian Advisory Council on Aging
MiCassa	Medicaid Community Attendant Serv
MICHOICE	MI Home & Comm Based Waiver
MICIS	MI Choice Information System
MIL	Mother-in-law
min	Minute
MIS	Managed Information System
MIWorks!	Michigan Works
ml	Milliliter
MLSC	Michigan Legal Services Corp
mm	Millimeter
MMAP	Medicare/Medicaid Assistance Prog
MMIS	Medicaid Mgt Information System
MMLTCI	MI Managed Long Term Care Initiative

Appendix XI: Acronyms

MMS	Medication Management System
mo.(s)	Month(s)
MOM	Milk of Magnesia
MOU	Memo of Understanding
MOW	Meals on Wheels
MPAS	Michigan Protection and Advocacy Services
MPHI	MI Public Health Institute
MPRO	Michigan Peer Review Org
MQCCC	MI Quality Comm Care Council
MRSA	Methicillin-Resistant Staphylococcus Aureas
MS	Multiple Sclerosis
msg	Message
MSA	Medical Services Administration
MSAC	MI Senior Advocates Council
MSC	Michigan Senior Coalition (formerly Senior Power Day)
MSG	Michigan Society of Gerontology
MSH	Mackinaw Straights Hospital
MSHDA	MI State Housing Develop. Auth
MSW	Masters of Social Work
mtg.	Meeting
MTU	Michigan Technological Univ
MYP	Multi-Year Plan

N

N4A	Nat'l Assn of Area Agencies on Aging
NA	Narcotics Anonymous
N/A, n\a	Not Applicable
NAPIS	Nat'l Aging Prog InforSystem
NAS	No Added Salt
NASW	National Assn of Social Workers
NASUA	Nat'l Assn of State Units on Aging
NC	Not in Compliance
NCBA	National Center on Black Aged
NCOA	National Council on Aging
NCSC	Natl Council of Senior Citizens
neg	Negative
NEMT	Non-Emergency Med. Transptn
NF	Nursing Facility
NFA	Notification of Financial Assist.
NFCSP	Nat'l Family Caregiver Support Program
NFLOC	Nursing Facility Level of Care
NFTI	Nursing Facility Transition Initiative
NFTS	Nursing Facility Transition Svc
NG	Nasogastric
NH	Nursing Home
NIA	National Institute on Aging
NIDDM	Non-insulin Depdt Diabetes Mellitus
NISC	Natl Institute of Senior Citizens
NKA	No Known Allergies
NM	Never Married
NMAIL	Northern MI Alliance for IL
NMH	Northern Michigan Hospital
NMU	Northern Michigan University
noct. (noc)	Night
NPO	Nothing By Mouth
NSSC	National Senior Service Corps
N & V	Nausea & Vomiting
NWHN	North Woods Home Nursing
NWS	North Woods Service

O

O	Zero/None/No
OAA	Older Americans Act
OAVP	Older American Volunteer Prog
OC	Option Counselor
OCR	Office of Civil Rights
O2	Oxygen
OHDS	Ofc of Human Development Svc
OIG	Office of Inspector General
OLOM	Our Lady of Mercy Nursing Home
O/M CIL	Oakland & Macomb CIL
OMH	Ontonagon Memorial Hospital
OOB	Out Of Bed
OOT	Out Of Town
OP	Out Patient
Ophth	Ophthalmology
O.R.	Operating Room
Ortho	Orthopedics
os	Opening
OS	Outreach Standard
OSA	Office of Services to the Aging
OT	Occupational Therapy
OTC	Over The Counter
OWL	Older Women's League
oz	Ounce

Appendix XI: Acronyms

P

p	After
P	Pulse
PA	Prior Authorization
PA	Public Act
PAM	Program Administrative Manual
PAS	Pre-Admission Screening
PASS	Plan to Achieve Self-Sufficiency
p.c.	After meals
P.C. (PCA), PC	Personal Care (Aide)
PCP	Person Centered Planning
PCS	Personal Care Svc (Standard)
PCN	Penicillin
Pd or pd	Paid
PDN	Private Duty Nursing
PDP	Prescription Drug Plan
PDS	Physical Disability Services
PEM	Program Eligibility Manuel
PERLA	Pupils Equal & Reactive to Light & Accommodation
PERS	Personal Emergency Response System
ph	Phone
PH	Portage Hospital
PHI	Protected Health Information
PHR	Portage Health Resources
PHS	Portage Health Services
Phys.	Physician
PI	Participant Information or Program Instruction
PIHP	Prepaid Inpatient Health Plan
PK	Prime Kare
p.m. (PM) or p	Afternoon
p.o.	By Mouth
POA	Power of Attorney
POC	Plan of Care
pos or +	Positive
postop	Postoperative
PPA	Patient Pay Amount
PPB	Prepaid Burial
PR	Peer Review / Press Release
preop	Preoperative
prep	Preparation
PRM	Program Reference Manual
p.r.n., PRN	As needed
PRR	Program Revision Request
prt.	Participant
PS	Protected Services
PSA	Protected Spousal Amount or Planning and Service Area
PSL	Provider Service Log
PSP	Physician's Sponsored Plan
pt.	Patient
PT	Physical Therapy
PT	Prothrombin Time
PTS	Participant Tracking System
PVD	Peripheral Vascular Disease
PY	Program Year

Q

Q	Every
QA	Quality Assurance or Quality Analyst
QC	Quality Control
qh	Every Hour
q.h.s.	At Bedtime
q.i.d.	Four Times A Day
QMB	Qualified Medicare Beneficiary
q.o.d.	Every Other Day
q.o.m.	Every Other Month
qowk	Every Other Week
qt.	Quart

R

R (Rt.), r	Right
R-19	A screening to determine medical eligibility to receive MA reimbursement for NF care
RAI-HC	Resident Assessment Instrument for Home Care
RAMAST	Reassessment Table in CTS
RBC	Red Blood Cell
RBS	Random Blood Sugar
R/C	Returned Call
RCS	In-Home Respite Care Standard
RCSC	Real Choice Systems Change
Re	Regarding
Rec'd	Received
Rep.	Representative
RFP	Request For Proposal
RN	Registered Nurse

Appendix XI: Acronyms

RO	Regional Office
RT	Respiratory Therapist
R/T (r/t)	Related To
R/O	Rule Out
ROI	Release of Information
ROM	Range Of Motion
RSDI	Retirement, Survivors, Disability Insurance
RSVP	Retired & Senior Volunteer Prog
RSW	Registered Social Worker
RUG	Resource Utilization Group
Rx or trxt	Treatment or Prescription

S

s	Without
S (S)	Son or Sign
SA	St.Assistance / Substance Abuse
SAC	State Advisory Council
SAIL	Superior Alliance of IL (Mqt)
SAM	System Awards Management
SB	Senate Bill (state)
sc (sq) (sub q)	Subcutaneous
SC	Supports Coordinators
SBA	Skilled Bath Aide or Stand by Assistance
SCI	Spinal Cord Injury
SCP	Senior Companion Program
SCSEP	Senior Comm Svc Employment Prog
SCSS	Senior Center Staffing Standard
SD	Self Determination
SDA	State Disability Assistance
SE	Side Effects
SEAQRT	Senior Exploitation and Abuse Quick Response Team
SGA	Statement of Grant Award
SHP	Special Health Plan
SHN	Superior Home Nursing
SIL	Son-in-law
SILC	State Independent Living Council
SFH	St. Francis Hospital
SFHH	St. Francis Home Health
SLMB	Specified Low-Income Medicare Beneficiaries
SLP	Speech Language Pathologist or Speech Therapist
SMHC	Schoolcraft Memorial Home Care
SMP	State Medical Program
SMSA	Std Metropolitan Statistical Area
SNAFU	Situation Normal All Fouled Up
SNB	Superior National Bank
SNF	Skilled Nursing Facility
SNU	Skilled Nursing Unit
SOB	Shortness of Breath
S/P	Status Post
SPE	Single Point of Entry
spec	Specimen
SR	Senate Bill (federal)
SR	Service Request
ss or 1/2	One Half
SSA	Social Security Administration
SSDI	Social Security Disability Ins
SSI	Supplemental Security Income
SSN	Social Security Number
S & S (s/sx)	Signs and Symptoms
ST	Speech Therapy
staph	Staphylococcus
stat	Immediately
STML	Short Term Memory Loss
strep	Streptococcus
SUA	State Unit on Aging
supp; supp.	Suppository
SW	Social Worker

T

24/7	24 hours/7 days per week
T	Temperature
TA	Technical Assistance
TANE	Temp Asst for Needy Families
TANF	Temp Aid to Needy Families
TB	Tuberculosis
TBI	Traumatic Brain Injury
Tbsp. (T)	Tablespoon
T/C (T.C)	Telephone Call
TCHH	Team Care Home Health
TCHS	Team Care Home Services
TCM	Targeted Case Management
TDN	The Disability Network (Flint area)
TIA	Transient Ischemic Attack
t.i.d.	Three Times Per Day

Appendix XI: Acronyms

TIP	Temporarily Ineligible Participant
TLC	Tender Loving Care
t.o.	Telephone Order
TPL	Third Party Liability
TPN	Total Parental Nutrition
TPR	Temperature, Pulse, Respiration
TRC	Targeted Respite Care
TS	Transportation/Escort Standard
TSH	Thyroid Stimulating Hormone
tsp. or t	Teaspoon
TSR	Tobacco Settlement Respite (state)
Tx	Treatment

U

UA	Urinalysis
UCP	United Cerebral Palsy
UMBHS	Upper MI Behavioral Health Svc
UP	Upper Peninsula
UPCAP	Upper Peninsula Commission for Area Progress
UPHN &H	UP Home Nursing & Hospice
UPHP	UP Health Plan
UPPCO	Upper Peninsula Power Co
UPPD	Upper Peninsula Private Duty
URI	Upper Respiratory Infection
USDA	US Department of Agriculture
UTI	Urinary Tract Infection

V

VA	Veterans' Administration
Vag	Vaginal
Val	Value
VAMC	Veterans Admin Medical Center
Vet	Veteran
Vet. A	Veteran's Affairs
VFD	Volunteer Fire Department
VFW	Veterans of Foreign Wars
Vit	Vitamin
VC	Vital Care
v.o.	Verbal Order
VS	Vital Signs

W

w/ or c	With
WA	Waiver
WAP	Weatherization Assistance Prog
WASTAT	Waiver Status Table
W.B.C	White Blood Cells
W/C (WC) w/c	Wheelchair
W & F	Wright & Filippis
WHCoA	White House Conf on Aging
WISP	Waiver Information Svc Portal
wk.	Week
WMH	War Memorial Hospital
WNL	Within Normal Limits
w/o, s	Without
WO, W.O , w.o.	Work Order
WP	Waiver Pending
WPC	Working Care Plan
wt.	Weight
WUPDHD	Western Upper Peninsula District Health Department
Yr. (yr)	Year

Appendix XI: Acronyms

SYMBOLS

≅	Approximate
≻	Changed
✓	Checked
🡻	Decrease
f ℥	Fluid Ounces
🡹	Increase
<	Less Than
>	Greater Than
∧	Negative or None
#	Pound or Number
∴	Therefore
1, I,	One
2, II,	Two
3, III,	Three