MI CHOICE WAIVER

POLICIES & PROCEDURES

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	# Mission, Goals and Objectives		
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Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave		Category: All

Since 1974, the mission and goals of UPCAP Services, Inc.'s Long-Term Care (LTC) Programs have been centered around supporting adults to live independently for as long as possible in the setting of their 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 Services, Inc.'s LTC Programs use trained, professional staff (Supports Coordinators) and a comprehensive Community-Based Service Provider Network to deliver services across the Upper Peninsula.

- Based on standardized health and social needs assessments, Supports Coordinators 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 Supports Coordinator 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 UPCAP Services, Inc.'s Long-Term Care Programs have been established to guide staff and support UPCAP Services, Inc.'s mission to assist Upper Peninsula residents in receiving supports and services in a setting of their choice and maximize independence.

	# MI Choice Waiver Program Description	
Policy Number: 2022-01-01	Effective Date: 10/01/2022	Revision Date(s):
Reviewed by: Ellen Bernier & Terry LaFave	Approved by: Theresa LaFave	Category: SC

MI Choice Waiver Program Description

MI Choice is a waiver program operated by the Michigan Department of Health and Human Services (MDHHS) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan Nursing Facility Level of Care criteria. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under sections 1915(b) and 1915(c) of the Social Security Act.

UPCAP complies with the Michigan Department of Health and Human Services (MDHHS) Contract requirements for MI Choice Operating Criteria to meet program standards for MI Choice Waiver Program. UPCAP aims to improve the quality of life for all its clients and seeks to provide person-centered services that specifically address client goals.

Eligibility Criteria

The MI Choice Waiver Program is for those over the age of 65, or adults age 18 and older, who are blind or disabled, and who meet the MI Medicaid Nursing Facility Level of Care Determination (NFLOCD) for long-term care services in a nursing home. Persons must also meet the special Medicaid financial eligibility criteria, and want their long-term care services provided in their home or other independent community setting. MI Choice Waiver participants must require and receive at least two (2) Waiver services, one of which being Supports Coordination. Participants must meet all eligibility criteria in order to be eligible for enrollment in the Mi Choice Waiver program.

MI Choice Waiver Services

MDHHS and CMS have outlined an array of services available to participants enrolled in the MI Choice Waiver Program. In addition to services covered by State Plan Medicaid, participants enrolled in the MI Choice Waiver program may receive the following services:

- Adult Day Health
- Chore Service
- Community Health Worker
- Community Living Supports
- Community Transportation
- Counseling Services
- Environmental Accessibility Adaptations
- Fiscal Intermediary Services
- Goods and Services
- Home Delivered Meals
- Nursing Services
- Personal Emergency Response System
- Private Duty Nursing/Respiratory Care
- Respite
- Specialized Medical Equipment and Supplies
- Supports Coordination

- Training

The participant must meet the specified criteria for a service in order to be eligible to receive the service. The criteria for each service is outlined in MI Choice Waiver Chapter of the Medicaid Provider Manual.

Evidence and Professional Standards

The MI Choice Waiver Program follows guidelines and standards outlined in the current MI Choice Waiver Contract. The current contract must meet federal CMS approval before implementation. Federal regulatory source documents include the Social Security Act, Code of Federal Regulations (CFR), CMS Audit Guidelines and Decisions, CMS instructions, technical guides, and review criteria, and Medicaid Policy.

MI Choice Waiver program content, materials for participants, staff training curriculum, and linguistic and cultural appropriateness is reviewed against evidence based and professional standards used by the National Association of Social Workers (NASW), American Case Management Association (ACMA), and Case Management Society of America (CMSA) by a team comprised of the Director of Long-Term Care Programs, the SC Quality Coordinator, and at least two other professional employees, preferably (1) Nurse and (1) Social Worker. This review occurs at a minimum every two years.

The Director of Long-Term Care Programs, Regional SC Supervisor, SC Quality Coordinator, and at least two other professional employees annually review the MDHHS contract requirements for the Mi Choice Waiver program and the Mi Choice chapter of the Medicaid Provider Manual upon its release. UPCAP's Policy and Procedures are reviewed and updated to ensure that they meet the contract, State, and Federal requirements. If mid-contract updates occur, these are discussed and implemented into practices as outlined in the update. All program-related contract documents and updates are disseminated to program staff once reviewed.

Program Goals

- At least 90% of UPCAP MI Choice Waiver Program participants surveyed will report satisfaction with their experiences in the Mi Choice Waiver Program. Participant satisfaction will be measured by responding "agree" or "strongly agree" on the survey administered by UPCAP.
- At least 90% of UPCAP Mi Choice Waiver participants surveyed will report an overall improvement in their quality of life since enrollment in the Mi Choice Waiver program. This will be measured by participants responding "agree" or "strongly agree" on the survey administered by UPCAP.
- Less than 10% of actively-enrolled UPCAP MI Choice Waiver participants will transition into long-term care placement each year.
- Less than 3% of actively-enrolled UPCAP MI Choice Waiver participants will report a hospital admission within 30 days of a previous hospital discharge
- At a minimum, 90 % of all progress notes will be entered into the participant's record in COMPASS within 7 days of contact.
- At a minimum, 90% of all assessments will reflect accurate data and responses when compared to the correlating NFLOCD completed by the Supports Coordinator.
- UPCAP MI Choice Waiver Participants will report issues with inadequate meals and/or nutrition during their assessment at a rate equal to or below the Statewide average
- UPCAP Mi Choice Waiver Participants will report a recent fall (within 30 days) or frequent falls (2 or more falls within 90 days) during their assessment at a rate equal to or below the Statewide average.

Case Management and Supports Coordination

Supports Coordination is an approach to case management defined by the MDHHS Mi Choice contract. Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's PCSP. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the participant.

The Mi Choice contract outlines the following functions as integral to provision of Supports Coordination:

- Assure the participant meets the Nursing Facility Level of Care per MDHHS policy.
- Conduct the initial assessment and periodic reassessments.
- Facilitate person-centered planning that is focused on the participant's preferences, includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports.
- Develop a Person-Centered Service Plan (PCSP), including revisions to the PCSP at the participant's initiation, or as changes in the participant's circumstances may warrant.
- Communication with the participant is a requirement and must be incorporated into the person-centered service plan.
- Make referrals to and coordinate with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.
- Monitor MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes providing opportunities for the participant to evaluate the quality of services received and indicate whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
- Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.
- Provide advocacy to support the participant's access to benefits, assure the participant's rights as a program beneficiary, and support the participant's decisions.
- Maintain documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other relevant policies, and meet the performance requirements delineated in the waiver agency's contract with MDHHS.

The functions of Supports Coordination are performed by Supports Coordinators, who are required to be either a Registered Nurse (RN) or Social Worker (SW), licensed in the State of Michigan.

References

Medicaid Provider Manual MI Choice Waiver

	# Program Overview	
Policy Number: 2022-02	Effective Date: 05/01/2022	Revision Date(s): 11/01/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: All

This manual is designed to assist UPCAP Services, Inc.'s Supports Coordinators in carrying out the goals and objectives of the Upper Peninsula's Long-Term Care Programs. The following policies, procedures, appendices, and amendments are based on requirements set forth in contracts with the Bureau of Aging, Community Living and Supports (ACLS) and the Michigan Department of Health & Human Services (MDHHS).

MI Choice Waiver Program

The MI Choice Waiver Program is for those over the age of 65 or adults age 18 and older who are blind or disabled, and who meet the MI Medicaid Nursing Facility Level of Care Determination (NFLOCD) for long-term care services in a nursing home. Persons must also meet special Medicaid financial eligibility criteria, and want their long-term care services provided in their home or other independent community setting.

An initial screening by UPCAP's trained 2-1-1 Call Center staff will help determine if a potential participant would be appropriate for a formal evaluation. If the 2-1-1 Call Center screening indicates that an individual qualifies for a formal evaluation, an in-person meeting with UPCAP Supports Coordinators (Registered Nurse & Social Worker) will be scheduled. The Supports Coordinator will conduct the MI Medicaid Nursing Facility Level of Care Determination (NFLOCD) and discuss the special financial eligibility criteria needed in order to qualify for financial assistance through the Michigan Medicaid program.

Through a person-centered planning process, UPCAP's Supports Coordinators will provide information on the in-home long-term care services that can help maintain or increase independence.

[Refer to ***Policy Number: 2022-02 A - MI Choice Waiver Program Description*** for a more comprehensive description]

Care Management

To be eligible for Care Management, a person must be over the age of sixty (60) and at risk of, but not necessarily in need of, a nursing facility level of care. An initial screening by UPCAP's trained 2-1-1 Call Center staff will help determine if a potential participant would be appropriate for a formal evaluation. If the 2-1-1 Call Center screening indicates that an individual qualifies for a formal evaluation, an in-person meeting with UPCAP Supports Coordinators (Registered Nurse & Social Worker) will be scheduled. The Supports Coordinator will conduct the MI Medicaid Nursing Facility Level of Care Determination (NFLOCD). There are no financial requirements to participate in the Care Management Program.

Nursing Facility Transition

Nursing Homes play a vital role in Michigan's Long-Term Care system, particularly in the area of rehabilitative services following hospitalization. Nursing homes are required to plan for the discharge of all individuals entering their facility.

Sometimes barriers get in the way and a short-term stay turns into something much longer. The longer a person stays in a nursing home, the more barriers arise to returning home. This is where UPCAP's Nursing Facility Transition Program can help.

Nursing Facility Transition to Home Services are specifically designed to address and overcome all barriers in an effort to assist current nursing home residents to return to their home (or other community settings) where they will be able to receive their long-term care services. While nursing homes provide extremely valuable long- term care services, many people currently residing in a nursing home might benefit from receiving their long-term care services at home or in a less restrictive setting.

UPCAP Services, Inc. and the Superior Alliance for Independent Living have trained staff to help nursing home residents and their families determine if returning to home is a realistic and appropriate option for them. If returning home is a possibility, UPCAP Services, Inc.'s Supports Coordinators have resources available to overcome the barriers currently keeping someone in a nursing home and will collaborate with SAIL on the coordination of transitioning from the Nursing Facility.

Outreach and Promotion

Policy Number: 2022-03	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

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 Long-Term Care Programs staff are expected to participate in on-going outreach activities. Supports Coordinators are expected to participate in community collaborative care meetings with other health care entities (hospitals, providers, etc) specific to their local area, as their schedule allows.

The goal of promoting the Care Management and MI Choice Waiver programs is to generate inquiries and referrals for individuals interested in program services. MDHHS, ALCS Bureau, other funding and/or contractual sources, and copyrighted materials will be acknowledged in all printed, social media, web sites, video, and audio promotions.

Supports Coordination

Policy Number: 2022-04	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
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Scope

Supports Coordination is the method that facilitates access to and arrangement of services and other forms of support needed and wanted by MI Choice participants. Supports Coordinators work with participants to determine how and who will meet the participant's long-term services and support needs. Supports Coordinators assist participants in arranging for services and supports and monitor the quality of services received. Supports Coordination includes valuing the cultural backgrounds of participants in the decision-making process.

Policy/Definition

Supports Coordination is a service designed to inform, assist, and coordinate a variety of home and other community-based services needed by elderly and other adults with disabilities aged 18 years and older who meet the NFLOCD. Supports Coordinators utilize all available services and supports before authorizing MI Choice services while assisting the participant in planning interventions. Supports Coordinators work in partnership with participants to determine the interventions that will promote the participant's goals and facilitate the achievement of desired outcomes while addressing the participant's service and support needs.

Supports Coordinators assure a person-focused, self-determination approach to the participants' services and supports. Supports Coordinators arrange formal services based upon participant choice and approval. The participant and their Supports Coordinators explore other funding options and intervention opportunities when personal goals expand beyond meeting basic needs.

Supports Coordination must be provided by a licensed RN and licensed SW.

Supports Coordination Service Functions:

Assessment

The iHC Assessment System, consisting of the iHC and Clinical Assessment Protocols (CAPS), is the basis for the MI Choice Assessment. Supports Coordinators perform a comprehensive evaluation including assessment of the individual's: unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The Supports Coordinator must fully engage the participant in the interview to the extent of the participant's abilities and tolerance.

Specific iHC items identify applicants who could benefit from further evaluation of particular problems and risks for functional decline. These items, called "triggers," link the iHC to a series of problem-oriented CAPs. The CAPs are

procedures that guide the Supports Coordinators through further assessment and individualized service and support planning with participants.

Person Centered Service Plan Development

Supports Coordinators work with participants to plan interventions from both allies and community resources that will meet each participant's identified needs. A written person-centered service plan (PCSP) documents the issues, concerns, conditions, and specific supports and interventions needed. The Supports Coordinator bases the PCSP upon participant preferences and needs identified during a PCP assessment process. The PCSP must be completed and approved by the participant within 90 days.

Service Access

Supports Coordinators arrange and/or purchase in-home health and social services and supports established in the approved PCSP. Supports Coordinators provide education of participant options in receiving services and supports.

Follow-Up and Monitoring

Supports Coordinators contact participants to ensure that responsible parties implement plans of service as written and according to participant preferences.

Reassessment

On a periodic basis, Supports Coordinators conduct a standardized in-person reexamination of the participant's needs, strengths, and preferences, using the iHC.

Social Emotional Support

Supports Coordinators provide support to participants and their allies to facilitate life adjustments and reinforce the participant's circle of support. Supports Coordinators also conduct case conferencing as determined necessary and approved by the participant.

Advocacy

Supports Coordinators provide support to ensure participants and their families receive benefits and services they need and to which they are entitled. Supports Coordinators also provide assistance with accessing Medicare, Medicaid, and other third-party benefits and services.

References

Medicaid Provider Manual - MI Choice Waiver

	# Referrals/Screening	
Policy Number: 2022-05	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC, Case Tech

Scope

The Michigan Department of Health and Human Services (MDHHS) and the Bureau of Aging, Community Living, and Supports (ACLS Bureau) contracts with UPCAP Services, Inc. to screen individuals residing in the Upper Peninsula for services who are referred to any of UPCAP's Long-Term Care Programs. A referral represents any request for participation in either UPCAP's Care Management or Mi Choice Waiver Programs. Referrals are screened utilizing the Michigan Intake Guide (MIG) in Compass.

Policy

It is the policy of UPCAP Services, Inc. to route all Information & Referral/Assistance calls through the U.P. 2-1-1 Call Center (2-1-1) by simply dialing 2-1-1 or 1-800-338-1119. Agencies and individuals must call 2-1-1 to make a referral. Referral-type calls received at any one of UPCAP's field office locations should be directed to contact 2-1-1. All individuals requesting enrollment into UPCAP's Mi Choice Waiver or Care Management Programs are required to have the intake/referral form and Michigan Intake Guide (MIG) completed. All screens should be conducted within two (2) business days of the referral.

For callers who are only calling for information on programs or services in their area, the 2-1-1 Call Specialists are trained on asking probing questions to determine if the caller would benefit from a referral.

The 2-1-1 staff are trained on utilizing and completing the Intake/Referral Form and the MDHHS Intake Guidelines (MIG). Screening should be conducted with the individual wishing to receive services, but may be conducted with a caregiver, referral source or third party if the individual is aware of the referral and is not capable of answering the questions or talking on the phone. If the referral is from someone other than the potential participant, they are asked if the participant is aware the referral is being made. If it is determined the participant is not aware, the caller must make them aware and receive their permission to make the referral before the intake/referral form and the MIG can be completed.

The screening process identifies the individual's abilities and needs in performing activities of daily living, basic financial information, health, social and emotional needs as well as demographic data.

The Intake/Referral form captures the caller/referral demographic information, participant demographic information, nursing facility/hospital information (if applicable), type of insurance, Veteran status, income ranges, services currently in place, living arrangements and the referrals made, if any. There are four types of referrals that come into the U.P. 2-1-1 Call Center:

- Community Referrals
  - Option Counseling for those who do not score eligible on MIG
- Nursing Home Referrals
- MDS Section Q Referrals
- Options Counseling

Community Referrals

Once the intake/referral form and the MIG are completed and a score is determined the caller is notified of the results. For those scoring a C, D or E the referral is given to the U.P. 2-1-1 Call Center Manager to add to the Compass waitlist and the internal excel waitlist, assign priority status and then forward to the appropriate field office for assignment by the Case Tech. For those individuals that score an A or B on the MIG the call specialists offer options counseling by a Supports Coordinator. See Options Counseling Referrals below.

Nursing Home Referrals

Nursing home referrals (non MDS-Section Q) will be put on the waitlist and assigned a priority ranking by the U.P. 2-1-1 Call Center Manager. The referral will then be sent to the appropriate field office for distribution by the Case Tech. Once received by the Case Tech, they should immediately open an episode in Compass and enter a program status of "NFT" with the intake date as the start date.

A member of a team (Nurse or SW) should contact the participant within three (3) business days of referral and set up a time to meet with them in person or telephonically. Supports Coordinators are **not** required to do an assessment or NFLOCD at this time and it is not required that a "team" go out for the first visit.

Scenario 1

If at the time of the visit the Supports Coordinator feels the participant would be eligible for the MI Choice Waiver or Care Management program, the individual has **no barriers** and will be discharging within the next six months, the participant can be opened on the date of the visit, and a status form with the care setting and SC initials completed. The open status and financial status can be left blank until the date of discharge. Once the individual has a planned discharge date, the Supports Coordinator should schedule the assessment & NFLOCD to be completed at the nursing facility or telephonically, if it will be prior to discharge (no sooner than 14 days prior to discharge) or at the participants home if on the day of discharge. A participant's assessment and NFLOCD must be completed prior to or on the day of discharge if they will be classified as WA-P. The NFLOCD should not be entered into CHAMPS until the day of discharge. The participant can be classified appropriately (WA-P, CM, LCM1, etc.) on the day of discharge.

Scenario 2

If at the time of the visit the Supports Coordinator feels the participant would be eligible for the MI Choice Waiver or Care Management program, **has barriers** and will be discharging within the next six months, complete a status form with the care setting status and SC initials. The open status and financial status can be left blank until the date of discharge.

If there are barriers that need to be addressed prior to discharge the Supports Coordinator can make a referral to the Superior Alliance for Independent Living (SAIL). It will be the Supports Coordinators responsibility to provide SAIL with an overview of the participant's case and what barriers need to be addressed. If SAIL is able to accept the referral then both UPCAP and SAIL will be involved in transition activities. The Supports Coordinator will still be responsible for communicating with the participant and SAIL to check on the progress of addressing the barriers. SAIL may request our Supports Coordinator to help complete the Community Transition Assessment for them if they are unable to meet with the client right away and it will cause a delay in discharge.

SAIL will only be addressing barriers (housing, home modifications, misc. purchases, etc.) that need to be addressed prior to discharge that our Supports Coordinators have identified. It is UPCAP's Supports Coordinators responsibility to be sure the participant has appropriate services (Meals, CLS, etc.) in place on the day of discharge.

Once the individual has a planned discharge date, the Supports Coordinators should schedule the assessment & NFLOCD to be completed at the nursing facility if it will be prior to discharge (no sooner than 14 days prior to discharge) or at the participants home if on the day of discharge. A participant's assessment and NFLOCD must be completed prior to or on the day of discharge if they will be classified as WA-P. The NFLOCD should not be entered into CHAMPS until the day of discharge. The participant can be classified appropriately (WA-P, CM, LCM1, etc.) on the day of discharge.

Scenario 3

If at the time of the visit the Supports Coordinator feels the participant would be eligible for the MI Choice Waiver or Care Management, **has barriers** and will be discharging within the next six months, the participant can be opened on the date of the visit, and a status form with the care setting and SC initials completed.

If SAIL is unable to accept the referral to address barriers the Supports Coordinator should contact the Director of Long-term Care or the Regional Supervisor to review the barriers and costs associated with them. Depending on the need and expenditures, approval for purchasing or assisting in costs associated with the transition (housing, home modifications, etc.) will be needed by the Executive Director. Any purchases made for a participant prior to transition will be paid utilizing 221 funds and the appropriate transition service code (T2038). Anything related to transition that is purchased **after** the transition will be paid utilizing the appropriate funds for their classification as long as it is a listed waiver service (non-transition).

Once the individual has a planned discharge date, the Supports Coordinators should schedule the assessment & NFLOCD be completed at the nursing facility if it will be prior to discharge (no sooner than 14 days prior to discharge) or at the participants home if on the day of discharge. A participant's assessment and NFLOCD must be completed prior to or on the day of discharge if they will be classified as WA-P. The NFLOCD should not be entered into CHAMPS until the day of discharge. The participant can be classified appropriately (WA-P, CM, LCM1, etc.) on the day of discharge.

Scenario 4

If at the time of the visit the Supports Coordinator feels the participant would not be eligible for the MI Choice Waiver or Care Management program, or will not be discharging within the next six months, the case may be closed following normal procedures. For those that will not be discharging within the next six months, educate them on making another referral when they have a planned discharge date. For those that will not be eligible for MI Choice Waiver or Care Management program referrals can be made to the appropriate agencies for services.

If the participant is on Medicaid and has barriers a referral can be made to SAIL for transition services. It's important the Supports Coordinator notifies SAIL that the participant is not eligible for MI Choice and that's why the referral is being made.

MDS Section Q Referrals

On October 1, 2010 Michigan Medicaid MI Choice Waiver Agencies were designated as the Local Contact Agency (LCA) for individuals who wish to return to a home setting from a nursing facility, county medical care facility, hospital long-term care units, hospital swing beds, and ventilator dependent care units.

The LCA's role is to contact residents referred to them by nursing facilities through the Section Q process, to provide the resident timely information about choices of services and supports available in the community, and to make an appropriate referral to support transition to community living if the resident so chooses after learning about options. UPCAP Services, Inc. is considered the LCA.

The nursing facility is required to contact the LCA within 10 business days of a resident's "yes" response to Q0500A from Section Q on the MDS 3.0. The LCA must record the referral date, nursing facility name, the nursing facility contact name and phone number, and the resident's name and phone number.

The LCA then has three business days to contact the resident by phone to schedule an initial face-to-face visit. Unless the resident reconsiders interest in learning about community options, the LCA must complete the initial face-to-face visit within 10 business days of the referral date.

MDS Section Q referrals are added to the waitlist by the U.P. 2-1-1 Call Center Manager and then sent to the appropriate field office for distribution by the Case Tech. Once received by the Case Tech, they should immediately open an episode in Compass and enter a program status of "Case Coordination" with the intake date as the start date.

MDS Section Q referrals are not treated the same way as Care Management, MI Choice Waiver, VA or UPHP-C Waivers. MDS Section Q referrals should be distributed on either a rotating basis amongst staff separately from other referrals or taken voluntarily by a Supports Coordinator, whichever works best for the office.

1. The initial phone contact must be made within **three business days** of the referral date. The phone contact is to determine if the individual is interested in moving forward with the referral and to determine if the individual has any barriers that need to be addressed in order to return home.
2. If upon receipt of the referral it is determined the individual is enrolled in the MI Health Link program (UPHP), the Case Tech should make a note on the MDS Section Q referral form of such and submit to Missy and close the episode in Compass (Chose MI Health Link). The referral should then be sent to the Program Director so it can be submitted to UPHP.
3. If the individual is not interested in moving forward with the referral or refuses a visit (face-to-face or telephonically) a status should be completed to close the referral, the MDS-Section Q form completed and submitted to Missy.
4. If a visit (face-to-face or telephonically) is requested, it must be completed within **ten business** days of the referral date. It will be at this visit that the Supports Coordinator will provide the resident with information about choices of services and supports available in the community. You are **not** required to do an assessment or NLOCD at this time and it is not required that a "team" go out for the first visit.
5. If at the time of the visit the Supports Coordinator feels the resident would be eligible for the MI Choice Waiver or Care Management program, the waitlist should be updated to change **MDS** to **NFT**. The status form should also be updated to reflect the NFT status using the face-to-face or telephonic visit date, the care setting status and the SC initials. At this time the referral would be given a priority status and assigned like a regular referral following the Nursing Home referral guidelines. The MDS Section Q referral form should be completed and sent back to the U.P. 2-1-1 Call Center Manager.
6. If the individual doesn't appear they will be eligible for the MI Choice Waiver or Care Management program, a referral can be made to appropriate agencies for services, a closure status completed and submitted to the Case Tech and the MDS Section Q referral form should be completed and sent to the U.P. 2-1-1 Call Center Manager.
7. If the individual has barriers to returning to a home setting a referral should be made to the Superior Alliance of Independent Living (SAIL) for their Nursing Facility Transition program. Once that referral is made and accepted a status can be completed to close the referral in Compass and the MDS Section Q referral form completed and sent to the U.P. 2-1-1 Call Center Manager.
8. Chart all contacts in Compass

Options Counseling

Individuals who request enrollment into the Mi Choice Waiver or Care Management Programs, but do not score eligible on the MIG for an assessment are offered options counseling. This will give individuals the opportunity to discuss their needs via phone with a Supports Coordinator. If an in-home visit is requested after the initial phone contact the Supports Coordinator will meet with the individual. The Supports Coordinator may complete a NFLOCD to determine medical eligibility.

Options Counseling (OC) referrals are for those individuals who did not pass the initial screen in 2-1-1. When an individual does not pass the screen they are offered referrals to resources in their area or a referral to a Supports Coordinator for Options Counseling.

OC referrals are added to the internal excel waitlist by the U.P. 2-1-1 Call Center Manager and then sent to the appropriate field office for distribution by the Case Tech. Once received by the Case Tech, they should immediately open an episode in Compass and enter a program status of "AAA/Options Counseling" with the intake date as the start date. Once an OC referral is assigned, the Case Tech should put the Supports Coordinators name on the internal excel waitlist where the OC referrals are located.

Options Counseling referrals are not treated the same way as MI Choice Waiver, Care Management, VA or UPHP-C Waivers. OC referrals should be distributed on either a rotating basis amongst staff separately from other referrals or taken voluntarily by a Supports Coordinator, whichever way works best for the office.

1. The Supports Coordinator assigned must contact the individual within 5 business days of receiving the referral.
2. If a Supports Coordinator is unable to contact the individual, then contact the alternate contact (if listed) or the referral source.
3. Review prescreen questions/answers and ask if there is any other information to share regarding the individuals ADL's/IADL's.
4. If after the review of the screen and obtaining more information about their needs, if the individual sounds like they could potentially qualify for Care Management or MI Choice Waiver you can do a mock NFLOCD. If you feel the individual would score eligible on a NFLOCD you can ask the Case Tech to have the individual added to the Compass waitlist with the appropriate priority ranking. Explain to the individual, alternate contact or referral source that they will be added to the waitlist and someone will contact them within the next week to set up an assessment.
5. If after the review of the screen you feel the individual **would not** score eligible on a NFLOCD you can review their needs and provide them with resources to meet those needs (grant, meals on wheels, etc.). There are times 211 has already provided the individual with additional resources, if so they will be listed on the referral form. You can review those with the individual as well.
6. If no further assistance is needed you will need to notify the Case Tech utilizing a status form, that the case can be closed. The Case Tech will update the internal excel waitlist. Once notified of the outcome, the U.P. 2-1-1 Call Center Manager will send the individual an adequate action notice.
7. Chart all contacts Compass.

Not Eligible

For those individuals that a referral was received, but were found not eligible for Mi Choice Waiver and with an income at or below the current years guidelines , an Adequate Action Notice is mailed by the U.P. 2-1-1 Call Center Manager reporting the results of the MIG (Screen) and the individual's right to request a fair hearing.

Follow Up

Any referrals for which a NFLOCD is completed, that were made by someone other than the potential participant, Supports Coordinators are required to follow-up and provide the referral source with the outcome of the referral by utilizing the post assessment referral letter.

For any referrals that a NFLOCD was **not** completed (refused, canceled, unable to reach, etc.) the Supports Coordinator must complete a compass status form, submitting it to the appropriate Case Tech. Once the Case Tech receives and enters the compass status form in Compass it will be their responsibility to notify the referral source (phone call or letter) on the outcome of the referral.

Any actions taken by either the Supports Coordinator or Case Tech (phone or letters) are required to be documented in Compass.

References

Medicaid Provider Manual - MI Choice Waiver
MDHHS Intake Guidelines (MIG)

Scheduling Assessments

Policy Number: 2022-05-1	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC, Case Tech

Policy

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

Assessments are to be scheduled by priority ranking and the order in which they were received as indicated on the wait list. All field offices are required to meet weekly to review current referrals and Supports Coordinator schedules. Depending on the individual procedures for each field office, the Case Tech or the Supports Coordinator will schedule the assessments with participants.

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

The Regional Supervisor or Program Director shall be notified in the event a Participant or responsible party requires that an assessment be scheduled outside of normal business hours. Staff will be permitted to alter their normal work schedules to compensate for meeting Participant/Responsible Party considerations. Changes in work schedules must be noted as approved by the Regional Supervisor or Program Director on the Supports Coordinator timesheet.

If a scheduled assessment is canceled or rescheduled, the Supports Coordinator is responsible for either scheduling another assessment in its place or informing the Case Tech for their office to schedule another assessment.

Once scheduling has been completed, the Case Tech or the Supports Coordinator (depending on individual field office procedures) shall send a confirmation letter to the Participant or responsible party, which includes the following:

- The agreed upon date and time for the assessment
- A list of all items which will be needed by the Supports Coordinator during the assessment process
- Information about the Self-Determination Program option and Person-Centered Planning

	# Waiting Lists	
Policy Number: 2022-06	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC

Scope

The ACLS Bureau and MDHHS require the maintenance of waiting lists. This policy applies to all participants in the fifteen (15) counties of the Upper Peninsula who have been determined as presumptively eligible for the Mi Choice Waiver Program or the Care Management Program.

Policy

Participants, who are determined presumptively eligible for the Mi Choice Waiver Program or the Care Management Program, through use of the Mi Choice Intake Guideline (MIG) or the Nursing Facility Level of Care Determination are placed on the waiting list. Individuals are placed on the waiting list in the order in which they apply, according to the waiting list priority categories as long as the waiver agency has an available slot for an enrollment. The waitlist list portal in Compass provides UPCAP Services, Inc. and MDHHS with real time access to information regarding persons waiting for a Mi Choice enrollment.

Procedures

All individuals screened, who qualify for an assessment, and are requesting enrollment into the Mi Choice Waiver Program, regardless of whether or not an assessment will be conducted, must be placed on the Compass Wait List.

All referrals are processed through the U.P. 2-1-1 Call Center. The U.P. 2-1-1 Call Center staff conduct the MIG and forward results to the U.P. 2-1-1 Call Center Manager. The U.P. 2-1-1 Call Center Manager reviews all referrals, assigns the priority ranking for each referral, adds the information to the Compass Wait List and forwards the referral to the appropriate field office. All referrals will be “assumed” to be financially eligible for the Mi Choice Waiver until determined otherwise through a formal assessment.

Supports Coordinators are responsible for notifying the Case Tech assigned to their field office on the status of individuals on the waitlist as changes occur or at weekly staff meetings. The Case Tech is responsible for sending updates to the U.P. 2-1-1 Call Center Manager, who will then update the Compass Wait List.

Priority Rankings

- Priority 1 – Individuals transitioning from a Medicaid (MA) children’s program who have on-going need for Private Duty Nursing.
- Priority 2 – Individuals currently in a nursing facility.
- Priority 3 – Referrals from Adult Protective Services or an imminent risk of nursing facility placement.
- Priority 4 – Other community-based referrals that do not fit into any of the previous priority groups.

Follow-Up

All individuals on the waiting list 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. The Case Tech or the Supports Coordinator (depending on individual field office procedures) shall be responsible for these contacts and for documenting the results of the contacts in COMPASS.

Removal from the Waitlist

Individuals can be removed from the Compass Wait List for the following reasons:

- Death
- Priority Change – still waiting
- NH Placement – no longer waiting
- Enrolled in Waiver
- Enrolled in AASA/CM program
- Enrolled in DHHS Home Help Program
- Enrolled in LCM program
- Chose MI Health Link
- Enrolled in another program
- Appropriate housing not available
- Moved, not transferred to another agent
- Moved, transferred to another agent
- Does not require Waiver service
- Not financially eligible
- Not medically eligible
- Unable to locate/contact
- Applicant choice
- Other
- Not financially or medically eligible.

Supports Coordinators are required to do a Compass status change form notifying the appropriate Case Tech of effective date for removal and removal reason.

Program Slot Capacity

If at any time UPCAP Services, Inc. has reached Mi Choice Program slot capacity, any individual on the waiting list must be sent a Capacity Action Notice informing them of UPCAP's inability to assess them at this time. Supports Coordinators must also contact the referral source to inform them of the slot capacity and offer them resources to meet the immediate needs of the individual they made the referral for (Adult Home Help, Home Health, MI Health Link, information for agencies that offer private pay or have ACLS Bureau grant funding, etc.). Both the referral source and the potential participant must be provided with an approximate date program enrollment will be open. Individuals who are already Medicaid eligible must be informed of, and assisted with, the right to appeal the Capacity Action Notice.

The Program Director shall be responsible for notifying both the Bureau of Aging, Community Living, and Supports (ACLS Bureau) and the Michigan Department of Health and Human Services (MDHHS) that the agency has met its capacity to serve new individuals.

Internal Excel Waitlist

The U.P. 2-1-1 Call Center Manager also maintains UPCAP's internal wait list. This waitlist is maintained for all individuals, regardless of potential program classification. The internal waitlist is designed for each field office to keep track of referrals, their priority, scheduled assessments, last contact date and those referrals waiting to be scheduled.

Case Techs are responsible for keeping the internal waiting list up-to-date and sending updates to the U.P. 2-1-1 Call Center Manager on a weekly basis.

References

Medicaid Provider Manual - MI Choice Waiver

Unable to Contact

Policy Number: 2022-06-01	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Policy

UPCAP Long-Term Care Program Staff are required to make multiple attempts to contact prospective and/or current participants before taking any action that could affect the participant's access to services. All contact attempts must be made on different days and at different times. The caller should provide appropriate contact information, including work days and hours, in a voicemail message, if available. All attempts must be documented in the Participant's case record.

Procedures

Referral

When a referral is received, the designated staff person for each office attempts initial contact with the potential participant and/or designated representative. When the participant and/or designated representative does not answer:

1. First Contact:
    a. Leave a voicemail message explaining the reason for the call and request for a return phone call.

2. Second Contact:
    a. Leave a voicemail message explaining the reason for the call and request a return phone call.
    b. Referral should be reviewed and if an alternate contact is listed, a phone call should also be made to the alternate contact. If alternate contact cannot be reached, the caller should leave a voicemail message explaining the reason for the call and request a return phone call.

3. Third Contact:
    a. Leave a voicemail message explaining the reason for the call and request a return phone call.
    b. At this time a phone call should be made to the referral source to see if the referral source could be of assistance in contacting the potential participant.

4. Fourth Contact:
    a. An "Unable to Contact" letter should be mailed to the participant at the address listed on the referral, instructing the potential participant to contact UPCAP if they are interested in participating in the program. This letter should provide the participant with a date by which they will need to contact UPCAP or their referral will be closed. This date should be ten (10) calendar days out from the mailing date.
    b. If a potential participant or designated representative does not call back by the deadline date, the referral will be closed and the waitlist updated.

Existing Participant

For existing participants, Supports Coordinators should make every effort to contact the participant.

1. First Contact:
    a. Leave a voicemail message explaining the reason for the call and request participant return call.

2. Second Contact:
    a. Leave a voicemail message explaining the reason for the call and request participant return call.

3. Third Contact:
    a. Leave a voicemail message explaining the reason for the call and request participant return call.
    b. The Supports Coordinator should also contact any service providers that are currently providing in-home services to the participant. Inquire if the provider has had recent visits with participant and if the provider has alternative contact information for participant.
    c. The Supports Coordinator should also attempt to contact any informal supports listed in the PCSP who are providing regular assistance to the participant.

4. Fourth Contact:
    a. If the in-home service provider has not had contact or has not been able to provide services, AND/OR informal supports are not able to assist with contacting the participant, the Supports Coordinator should complete an in-person well check visit at the participant's home residence.

5. Fifth Contact:
    a. If the well-check is unsuccessful, a phone call should be placed to the emergency contact on file, if applicable.

6. Sixth Contact (at least 30 days from the first contact):
    a. An "Unable to Contact' letter should be mailed to the participant, instructing the participant to contact their Supports Coordinator. The letter should provide the participant with a date by which they will need to contact UPCAP or their Waiver case will be closed. This date should be 10 days out from the mail date.
7. Seventh Contact
    a. If the participant does not contact the Supports Coordinator by the date outlined on the "Unable to Contact" letter, the Supports Coordinator will mail an Adverse Benefit Determination letter and close the participant's Waiver case.

Documents and Forms for Initial Assessment

Policy Number: 2022-07	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Per MDHHS requirements, all participants must receive an informational packet which includes the participant handbook.

Policy

It is the policy of UPCAP Services that Supports Coordinators supply potential participants with the required materials found within the participant informational folder and assessment packet at the beginning of each initial assessment.

Participant Informational Folder

- MI Choice Waiver Participant Handbook (MDHHS) with handbook acknowledgement signature form
- Estate recovery pamphlet
- Fraud, waste and abuse pamphlet
- Elder Abuse pamphlet
- What to do in case of severe weather handout
- List of contracted service providers for service area
- Person-Centered planning information
- Medicaid appeal information
- Review of HIPAA and privacy notice of protected health information
- Advance directives/end of life planning materials
- Acknowledgment of risk form

Click here to view all contents of the client informational folder

Additional Assessment Materials/Documents

- Nursing Facility Level of Care Determination tool
- Freedom of Choice form
- UPCAP consent and authorization form
- Email consent and authorization forms
- Text consent and authorization form
- Plan of care signature sheet
- Medical Consent and Release Form
- Cost share Determination (Optional)

	# Initial Assessment	
Policy Number: 2022-08	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The initial in-home visit and assessment are vital to ensuring all potential participants are thoroughly assessed and made aware of all options available to them through UPCAPs Long-Term Care programs. A multidisciplinary Care Management team, composed of a Registered Nurse Supports Coordinator and a Social Work Supports Coordinator, both with valid Michigan licenses to practice their profession, is responsible for conducting the initial visit and assessment.

Policy

It is the policy of UPCAP Services, Inc. to follow initial assessment processes as required by the Michigan Department of Health and Human Services. The assessment process is designed to review and confirm eligibility for participation in the Care Management Program or MI Choice Waiver program; identify comprehensive information regarding the participant's strengths, needs, preferences, current supports, health, and functional status; confirm the applicant's need for supports coordination and at least one additional MI Choice service on a regular basis (Mi Choice Waiver only); assist in planning for the participant's needed services, supports, and interventions; inform the participant of their program options, services, and community resources; review the participant's rights and responsibilities; and obtain the participant's formal consent for participation in the Care Management or MI Choice Waiver Program.

Assessment Process

The assessment process is comprised of the following elements:

1. Assessment Preparation
2. Introduction and Program Explanation
    - Review of UPCAP Participant Informational Folder and Program Options
        - [Folder Contents & Required Documents]
3. Review of Eligibility Criteria
    - Financial Eligibility and Medicaid
    - Functional Eligibility: NFLOCD & Freedom of Choice
    - Service Need
4. COMPASS Assessment (InterRAI-HC)
5. Person Centered Service Plan (COMPASS)
    - Plan of Care Signature Sheet
6. Optional Forms
    - Cost Sharing Determination
    - Medical Release of Confidential Information

Assessment Preparation

Supports Coordinators will receive the Intake/Referral Form with all of the information received during the 2-1-1- phone referral process prior to the assessment. If the potential participant has a current Medicaid case, the Supports Coordinator will need to review the information on the CHAMPS eligibility report, including any Program Enrollment Types (PET) codes that may affect the potential participant's enrollment into MI Choice. If the potential participant does not have a current Medicaid case, there will not be any information available on the CHAMPS Eligibility Report.

On the day of the scheduled assessment, Supports Coordinators call the prospective participant before traveling to their home to verify that the person is still interested in participating in an assessment and available at the date and time scheduled. During this conversation, the Supports Coordinator will confirm that the prospective participant is aware that they have the right to have any other informal supports, caregivers, or individuals of their choosing present at the visit.

If the prospective participant is not available and would like to reschedule, the Supports Coordinator or Case Tech will coordinate to reschedule on a day and time most convenient for the participant. If the prospective participant is no longer interested in the in-home visit or assessment, the Supports Coordinator will close the referral, notify the appropriate Case Tech, and submit a MICIS status report denoting closure due to "refusal to participate".

The Participant Informational Folder [Folder Contents & Required Documents] can be assembled in advance to the assessment, however, the assigned Supports Coordinators are responsible for ensuring that the Participant receives all of the required documents and forms at the initial visit.

Introduction and Program Explanation

In order to ensure the potential participant is able to make an informed decision to participate in the Care Management or MI Choice Waiver program, Supports Coordinators must provide an explanation of the available programs, the eligibility criteria, and the services and/or supports available through each program.

After general greetings and introduction, Supports Coordinators will provide the participant with a copy of the Participant Informational Folder. Supports Coordinators will explain program options and processes, and briefly go through the Participant Handbook, paying particular attention to the participant's Rights and Responsibilities. Documents included in the informational folder will be introduced and reviewed. The participant will be instructed to keep the Participant Informational folder in a designated location and retain the copies of all forms provided.

During the first reassessment cycle and annually thereafter, one or both Supports Coordinator team members are expected to conduct a thorough review of all aspects of the Participant Handbook with the participant. Supports Coordinators are to confirm that the participant has retained the Participant Informational Folder and its contents. If the participant is missing any element of the folder, the Supports Coordinator will provide a new copy. The purpose of this ongoing review is to ensure that the Participant (or responsible party) has the most current copy of the Participant Handbook, is fully aware of all rights and responsibilities, and remind them that they have the opportunity to have a voice in improving the quality of the care management and service delivery process.

Review of Eligibility Criteria

Supports Coordinators will review eligibility criteria for participation in the MI Choice Waiver Program as well as the Care Management Program.

MI Choice Waiver Program

The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities age 18 or older and meet the following eligibility criteria:

1. An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility section.
2. Must be categorically eligible for Medicaid as aged or disabled.
3. The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD).
4. It must be established that the applicant requires at least two waiver services, one of which must be Supports Coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

Care Management Program

The Care Management Program is available to persons who are elderly (age 60 or older) and meet the following eligibility criteria:

1. The applicant is medically complex with functional and/or cognitive limitations.
2. The applicant is at risk of, but not necessarily in need of, a nursing facility level of care. An applicant at risk demonstrates one or more of the following characteristics:
    a) determined medically eligible for nursing facility placement.
    b) functionally unable to provide self-care without assistance due to illness or declining health and without sufficient support for meeting care needs.
    c) multiple, complex and diverse service needs.
    d) a weak or brittle informal support system.
    e) currently resides in a nursing home, but because of insufficient resources and lack of other supports, is unable to obtain needed community services to return home.
3. The applicant is in need of a nursing facility level of care, but not eligible for Medicaid-supported long-term care services.

The Care Management program is an appropriate option for potential participants who do not meet the financial eligibility criteria for the MI Choice Waiver program but are still in need of supports coordination services and assistance with arranging available services and/or resources.

Establishing Eligibility for the MI Choice Waiver Program

Financial Eligibility

Financial eligibility for Medicaid LTSS services is determined by the State through the MDHHS Field Office. As a provision of the waiver, MI Choice participants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is available to participants in the special home and community-based group under 42 CFR §435.217 with a special income level up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice. Special Initial Asset Assessment Rules are applied for Mi Choice Participants with a community spouse as laid forth in the MDHHS Bridges Eligibility Manual.

If the potential participant already receives Medicaid assistance through MDHHS, a CHAMPS report will be run to confirm the participant's program eligibility. See *Excluded from Eligibility.* If the potential participant is eligible for the Mi Choice Waiver program based on eligibility in CHAMPS, the Supports Coordinator is still required to confirm financial

eligibility through completing the FS section of the InterRAI-HC Assessment and collect proof of current income and assets. Verifications of financial eligibility will be documented and kept in the participant file.

Supports Coordinators are responsible for assisting participants determined medically eligible who need to apply for Medicaid. The Supports Coordinators will collect financial information during the assessment to substantiate an applicant's potential financial eligibility. Information is assembled for verification review and a Medicaid application is completed for submission to the MDHHS Field Office with all required financial documentation. Supports Coordinators are able to determine the participant's "Presumptive Financial Eligibility" through this process.

[Refer to ***Policy Number: 2022-11 - Waiver Financial Requirements and Policy Number: 2022-12 - MI Choice Waiver Medicaid Guide*** for more information]

Functional Eligibility

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 (NFLOCD) criteria as set forth in Policy Bulletin MSA 04-15, dated November 1, 2004. Supports Coordinators will complete the NFLOCD Determination Tool to determine the potential participant's functional eligibility.

[Refer to ***Policy Number 2022-09 - Nursing Facility Level of Care Determination***]

If the participant is found functionally eligible, the Supports Coordinator will complete the corresponding Freedom of Choice (FOC), ensuring that the participant understands all options for Long-Term Care Services available to them through their eligibility on the NFLOCD.

[Refer to ***Policy Number 2022-10 - Freedom of Choice***]

Service Need

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of two covered services, one of which must be Supports Coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to receive MI Choice services on a regular basis, at least every 30 days.

An applicant cannot be enrolled in MI Choice if their service and support needs can be fully met through the intervention of State Plan or other available Medicaid services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications.

Excluded from Eligibility

The MI Choice population specifically excludes the following groups:

- Medicaid-eligible persons who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or a state psychiatric hospital,
- Medicaid-eligible persons enrolled in a qualified health plan (e.g., health maintenance organization) or managed care organization,
- Persons enrolled in PACE,
- Persons enrolled in the Habilitation Supports Waiver program,
- Persons enrolled in the MI Health Link program,
- Persons enrolled in the Home Help Services program whose service and support needs are fully met by that program,
- Persons enrolled in the Healthy Michigan Plan,

- Nursing facility residents, and
- Medicaid-eligible persons admitted to a hospice or palliative care facility.

Establishing Eligibility for the Care Management Program

Financial Eligibility

Eligibility to participate is not based on a person's level of income, and participation may not be denied because individuals do not meet low income criteria.

Functional Eligibility

Supports Coordinators will utilize the Nursing Facility Level of Care Determination tool in addition to a formal assessment to determine the participant's functional eligibility for the Care Management program. Although participants are not required to score eligible on the NFLOCD, the NFLOCD along with information gathered during the assessment related to the participant's health status, physical and social/emotional functioning, medications, physical environment, and informal support potential will assist the Supports Coordinators in making a determination of functional eligibility.

Service Need

A formal requirement for service need is not an eligibility requirement of participation in the Care Management program.

Verifying Participant Information

As part of the assessment process, Supports Coordinators are responsible for confirming the participant's identifying information. Supports Coordinators will need to confirm the participant's date of birth, address, county, social security number, Medicare/Insurance information, and Medicaid number, if applicable. Supports Coordinators will need to notify the appropriate Case Tech and complete an Administrative Database Change Form if the Social Security Number needs to be updated in the COMPASS system. All other identifying information can be updated within the Participant Case File in COMPASS by the Supports Coordinator.

Assessment

For participants who meet the eligibility criteria set forth above, a formal, comprehensive assessment will be conducted. The MI Choice program and Care Management program have established the Resident Assessment Instrument – Home Care (InterRAI-HC) as the approved assessment instrument for assessing the functional status of participants. Qualified staff perform the initial assessment function as a team. Qualified staff includes a RN and SW, both with valid Michigan licenses to practice their profession.

The InterRAI-HC Assessment System, consisting of the InterRAI-HC Assessment and Clinical Assessment Protocols (CAPs), is the basis for the MI Choice/Care Management assessment. Supports Coordinator's perform a comprehensive evaluation including assessment of the individual's unique preferences; physical, social, and emotional functioning; medications; physical environment; natural supports; and financial status. The Supports Coordinator must fully engage the participant in the interview to the extent of the participant's abilities and tolerance. Whenever possible, the participant is the primary source of information.

Specific InterRAI-HC items identify applicants who could benefit from further evaluation of particular problems and risks for functional decline. These items, called "triggers," link the InterRAI-HC to a series of problem-oriented CAPs. The CAPs are procedures that guide the SCs through further assessment and individualized service and support planning with participants.

Supports Coordinators must complete all mandatory items within the InterRAI-HC Assessment or clearly document the reason for an incomplete item in the file. For the initial assessment, it is required that the RN Supports Coordinator completes the medical sections of the assessment while the Social Work Supports Coordinator completes the social sections of the assessment. The SW Supports Coordinator is also responsible for completing the Financial Section of the InterRAI-HC and the financial information must be updated no less than annually.

MDHHS requires electronic data collection for all assessments completed for MI Choice applicants. SCs must input all assessment data into COMPASS. The data system must record the date of and person responsible for any additional information put in the record or changes made to the original assessment data collected. Supports Coordinators may utilize the COMPASS GO option on their laptops or a hard copy printed version of the COMPASS Assessment and Person-Centered Service Plan at the in-person assessment, as long as all of the recorded information is entered into the COMPASS system in a timely manner. All information should be recorded and the InterRAI-HC assessment completed in COMPASS within two (2) business days of the in-person visit with the participant.

When the Supports Coordinators assess potential participants in nursing facilities, hospitals or outside of their usual living environment, the Supports Coordinators must also see the participant in their home environment to update assessment information and to assess the home environment. This update should occur within seven (7) calendar days after the return to the home environment. [Insert InterRAI-HC Assessment Questions and Field Guide]

Person-Centered Service Planning

The Supports Coordinator will begin the care planning process at the initial visit. The Supports Coordinator will make recommendations of specific supports, services, and interventions to meet the expressed issues and needs of the participant based on the assessment. The Supports Coordinator will also assist the participant in outlining strengths and setting specific goals that will be used and documented in the person-centered service plan.

The Supports Coordinator will also offer the participant the option to schedule a formal Person-Centered Care Planning meeting and document the participant's preference in the participant file. If the participant would like to schedule another meeting, the Supports Coordinator will coordinate a day and time that works best for the participant and ensure that the participant is aware that they can invite anyone else from their current support network to attend the meeting.

The process of service planning will continue as the Supports Coordinator works to arrange service providers and coordinate with supports, both formal and informal. However, the initial Person-Centered Service Plan (PCSP) in COMPASS must be completed and finalized within five (5) days of completing the InterRAI-HC Assessment in COMPASS. The COMPASS PCSP can be updated and amended as requested by the participant at any point or as interventions or services are added or removed from the plan of care.

[Refer to ***Policy Number: 2022-17 - Person-Centered Care Planning, Monitoring and PCSP*** for a more detailed process]

Documents

After confirming eligibility, Supports Coordinators must obtain the participant's signature, or the signature of their legal representative, on multiple documents.

Consent and Authorization

The UPCAP Consent and Authorization form is required to be reviewed and signed at the initial assessment and annually thereafter. As outlined in the document, the authorization expires after 1 calendar year from the date on the form. This document must be completed in its entirety, listing any additional entities for which consent is being granted. Supports Coordinators retain a copy of the completed consent and authorization for the participant's file as well as a copy left for the participant. Supports Coordinators should place the participant copy in the participant's Informational Folder.

Consent and Authorization Form

Email Consent and Authorization

If the participant or any authorized representatives would like to communicate with their Supports Coordinators via email, it is important to gather an additional level of consent to ensure the participant is informed and aware of any potential issues with privacy and their protected health information. Supports Coordinators document authorization and retain a copy for the participant file. Each email address for which consent is being granted will need to be listed on the form or a separate consent form will need to be completed for each email address.

Email Consent and Authorization

Text Consent and Authorization

If the participant or any authorized representatives would like to communicate with their Supports Coordinators via text message, it is important to gather an additional level of consent to ensure the participant is informed and aware of any potential issues with privacy and their protected health information. Supports Coordinators document authorization and retain a copy for the participant file. Each phone number for which consent is being granted will need to be listed on the form or a separate consent form will need to be completed for each phone number.

Text Consent and Authorization

Handbook Acknowledgement

Signed acknowledgment of receipt of the MDHHS Participant Handbook is required at the initial assessment or with any authorized revision of the document. A copy must be retained for the participant's file as well as a copy provided to the participant, if requested. Supports Coordinators should place participant's copy in the participant's Informational Folder.

Plan of Care Signature Sheet

After completing the initial care planning process, the plan of care signature sheet will need to be completed to establish an initial authorization of the plan of care. It will also provide the participant with the opportunity to designate entities whom they would like to receive the formal service plan once completed. A more formal authorization will be received after the development of the formal Person-Centered Service Plan (PCSP) in COMPASS. The participant, their informal support if available, and both disciplines of Supports Coordinators will be required to sign and date the form at the initial assessment.

Plan of Care Signature Sheet

Referral Outcome Letter

Supports Coordinators are responsible for notifying the participant's original referral source (except for self-referrals) in writing of the assessment outcome. The referral letter, on UPCAP letterhead, will be mailed to the referral source listed on the referral form. A copy of the Post Assessment Referral Letter will be placed in the participant file.

If the referral source was a subcontracted agency that receives AAA (Title III) funds [Link to AAA Grant Providers] from UPCAP, the agency must be notified immediately (via phone call) of the outcome of the MI Choice COMPASS Prescreen and the date/status of the initial assessment. These agencies need not conduct their own assessment if a formal assessment is going to take place within ten (10) business 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 participant is not being opened to the MI Choice Waiver or Care Management program, the Supports Coordinator should provide the referral agency with any pertinent information gathered at the in-person visit.

Medical Release Form

Supports Coordinators use the Medical Release Form to send to physicians and/or medical providers requesting specific information regarding treatments, current medication lists, and other medical records. Although the UPCAP Consent and Authorization includes authorization for obtaining the participant's medical records, Supports Coordinators will also use the Medical Release form as it is more specific to the participant's current health issues and elicits physician insight and information pertinent to assessing the current needs of the participant as it relates to potential MI Choice Waiver services. The consent and authorization expires after one (1) calendar year from the date on the form. Supports Coordinators document and retain a copy for the participant file.

Medical Release Form

Cost-Share Form (Care Management Only)

Supports Coordinators will complete the Cost-Share Form (See Cost Share policy) for all participants of the Care Management Program who are not financially eligible for the MI Choice Waiver, as required by ACLS Bureau. Supports Coordinators are to explain to the participant that the determined amount represents a quarterly "fee" for their participation in the Care Management program. The participant will be sent a statement following their first three months of participation and then every three months thereafter. The Supports Coordinator shall complete the form using the participant's financial information provided at the assessment. Once completed, the form must be signed and dated by the Supports Coordinator and kept in the participant's file. A copy of the form is mailed to the Waiver Director and to the participant.

Cost Share Form

References

ACLS Bureau Operating Standards for Service Programs
iHC Assessment Guide – COMPASS
Mi Choice Contract - Attachment C
Medicaid Provider Manual MI Choice Waiver
BEM 106

Nursing Facility Level of Care Determination

Policy Number: 2022-09	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

An individual's need for nursing facility level of care is determined through the completion of the Michigan Nursing Facility Level of Care Determination (NFLOCD) assessment tool. The NFLOCD must be administered by a qualified and licensed health professional – licensed Registered Nurse Supports Coordinators and licensed Social Worker Supports Coordinators are considered qualified to administer the NFLOCD assessment tool.

The NFLOCD is a scientifically-validated and reliability-tested tool utilized during initial application and program eligibility redeterminations. Other assessment tools or variations of the NFLOCD cannot take the place of the formal NFLOCD assessment tool. Use of the NFLOCD assures a consistent and reliable process for determining that individuals meet the functional eligibility requirements.

The NFLOCD is a "point in time" assessment; that is, it determines the individual's functional eligibility at the time of the assessment. MDHHS assumes that beneficiaries will maintain functional eligibility until they are determined otherwise through a reassessment or the NFLOCD's End Date. The NFLOCD must be conducted or adopted prior to or on the day of a participant's enrollment in MI Choice Waiver Program.

Participants have the right to refuse services and a NFLOCD determination. When a participant refuses to participate in the NFLOCD determination and does not have an active NFLOCD in CHAMPS, the individual or authorized representative must be informed that he or she will not be eligible for MI Choice services until the waiver agency conducts the NFLOCD and determines medical eligibility.

Policy

It is the policy of UPCAP Services, Inc. that Supports Coordinators conduct the Nursing Facility Level of Care Determination (NFLOCD) on every individual interested in enrolling in the MI Choice Waiver program, yearly thereafter and if there has been a significant change of condition.

Procedures

The NFLOCD should be an accurate reflection of an individual's current functional status. This information is gathered in a face-to-face meeting by speaking to the individual and those who know the individual well, observing the individual's activities, and reviewing an individual's medical documentation.

Nursing Facility Level of Care Determination criteria includes seven domains of need, called Doors. The Doors include: (1) Activities of Daily Living; (2) Cognitive Performance; (3) Physician Involvement; (4) Treatments and Conditions; (5) Skilled Rehabilitation Therapies; (6) Behaviors; and (7) Service Dependency.

Guidance on administering the NFLOCD, including definitions and methods, is provided in the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines.

Depending upon the participant's qualifying criteria on the NFLOCD, the Supports Coordinators may need to gather supporting evidence of functional eligibility. It is the Supports Coordinator's responsibility to contact the participant's physicians or medical providers to gather the supporting documentation to support the NFLOCD findings prior to submission.

[Refer to examples of supporting documentation provided by MDHHS]

Eligible

If the potential participant **does** score functionally eligible on the NFLOCD and the Supports Coordinator confirms this finding through their assessment and observations, the potential participant is considered medically eligible for the MI Choice Waiver. The Supports Coordinator will need to ensure that the participant's assessment record also reflects the information on the NFLOCD including the specific Door through which the participant is eligible.

Not Eligible

If the potential participant **does not** score functionally eligible on the NFLOCD and the Supports Coordinator confirms this finding through their assessment and observations, the potential participant is not eligible for the MI Choice Waiver. This is considered a Door 0 designation. The potential participant has the opportunity to appeal this determination and the Supports Coordinator will provide them with the appropriate information and directions related to the appeal process. For those participants with Medicaid, or presumed financially eligible, the Supports Coordinator must still submit the NFLOCD for entry into CHAMPS along with a separate document summarizing the findings and supporting the designation of a Door 0 or functional ineligibility. [see Door 0 Write Up Example] MDHHS will complete a secondary review of these findings, if requested by the potential participant, and make a final determination of functional eligibility. NFLOCD's do not need to be submitted for entry into CHAMPS for participants that do not have Medicaid.

Not Eligible – Frailty Exception

If the potential participant **does not** score functionally eligible on the NFLOCD, but the Supports Coordinator confirms through their assessment and observations that the potential participant meets exception criteria set forth to qualify individuals who are medically or physically fragile, the Supports Coordinator can request a Frailty Exception [See Exception Criteria]. Frailty exceptions are only available to those participants who are current Medicaid beneficiaries or whose Medicaid applications are currently being processed. The Supports Coordinator must still submit the NFLOCD for entry into CHAMPS along with a separate document summarizing the findings and supporting the request for a Frailty Exception. Supports Coordinators will be responsible for contacting MDHHS or its designee (MPRO) of the NFLOCD and supporting documentation. Supports Coordinators must request this review on the SAME business day as the NFLOCD was completed. MDHHS will make a final determination of functional eligibility.

Eligibility & Submitting the NFLOCD

Only the NFLOCD application in CHAMPS can determine functional eligibility. The NFLOCD must be verified in CHAMPS in order to be considered valid for establishing functional eligibility for the Mi Choice Waiver program. The NFLOCD used for enrollment into the MI Choice program can be verified in one of two ways:

- The Supports Coordinator completes the NFLOCD in person and the submits the assessment tool to the assigned Case Tech for entry into the online NFLOCD application system (CHAMPS). The information submitted is put through an algorithm within the application to determine whether the applicant meets NFLOCD criteria.
- The Supports Coordinator adopts an existing NFLOCD. Per MDHHS policy, the NFLOCD is associated with the beneficiary, rather than the provider serving the beneficiary. Therefore, if a potential Mi Choice Waiver participant has a current NFLOCD in CHAMPS, the Supports Coordinator may choose to adopt that NFLOCD to

confirm functional eligibility. The Supports Coordinator will notify their assigned Case Tech of their intention to adopt the NFLOCD. The Supports Coordinator must confirm that the existing NFLOCD being adopted is still an accurate representation of the participant's functional status. If it is not, the Supports Coordinator will complete a new NFLOCD for entry.

All NFLOCDs must be entered in CHAMPS within 14 calendar days from the date the face-to-face NFLOCD was conducted. If an NFLOCD is older than 14 days before enrollment into the MI Choice program, a new NFLOCD must be completed prior to establishment of the Waiver enrollment date and the enrollment date must correspond to the subsequent NFLOCD.

NFLOCD Verification Review

MDHHS has developed a verification review process (NFLOCD-VR) to determine if the NFLOCD was conducted properly according to policy and resulted in the correct determination of eligibility. A randomly selected sample of NFLOCDs will be reviewed by MDHHS or its designee (MPRO). CHAMPS will randomly select a statistically significant sample of NFLOCDs entered in the system.

Upon submission of the NFLOCD in the system, CHAMPS will immediately notify the provider if the NFLOCD provider is required to submit all relevant documentation used to support the NFLOCD; including, but not limited to, observation notes, assessment reports, physician orders or notes, caregiver reports, cognitive test results, time studies, nursing or case management notes, intervention reports, or evidence of other medical or community services provided. The related CHAMPS NFLOCD Application ID must be indicated on all documents for tracking purposes. Documents must be uploaded electronically in CHAMPS within one business day of the NFLOCD being selected for verification review in CHAMPS.

NFLOCD Dates

The NFLOCD Start Date will be the date the NFLOCD was conducted if the NFLOCD is entered in CHAMPS within 14 days of the conducted date. The participant's functional eligibility is valid for 365 days from the NFLOCD start date. The application ID and end date will be entered into the participant record in COMPASS by the Case Tech after the NFLOCD is entered into CHAMPS.

The end date will not change unless a new NFLOCD is conducted and entered into CHAMPS. Supports Coordinators are responsible for monitoring the participant's NFLOCD end date and ensuring another NFLOCD is completed with the participant and entered into CHAMPS prior to the end date in the system or when there is a significant change in the participant's functional status. If a subsequent NFLOCD is conducted prior to the NFLOCD end date and confirms the individual meets NFLOCD criteria, the new NFLOCD will have a 365-day end-date.

Passive NFLOCD Redeterminations

The Minimum Data Set (MDS) for nursing facility residents and interRAI Home Care Assessment System (iHC) for MI Choice Waiver Program participants contain items that correspond to the items in the NFLOCD. Under certain conditions, MDHHS will use a passive redetermination process based upon information from the participant's most recent assessment. When this assessment data is available, MDHHS will apply an algorithm that uses the common assessment items to allow CHAMPS to generate a new NFLOCD for the beneficiary.

When this process confirms continued functional eligibility, the Start Date of the CHAMPS-generated NFLOCD will be the date of the MDS or iHC assessment. CHAMPS will set the End Date at 365 days from the newly established Start Date. This process will repeat with each new MDS or iHC when the passive redetermination process confirms the beneficiary meets NFLOCD criteria and allows CHAMPS to generate a new NFLOCD. When a beneficiary is currently eligible through a door that the passive redetermination process cannot confirm, the NFLOCD will be bypassed from the passive redetermination process and the current end date will remain in effect.

MDHHS notifies UPCAP of any participants whose eligibility dates were extended through the passive determination process. These dates will be reviewed by the Waiver Director or designee and the end dates updated in the participant's case record in COMPASS.

Supports Coordinators are not to rely on a potential passive redetermination and must complete a NFLOCD by it's due date, unless otherwise notified by the Director or designee.

Ongoing Functional Eligibility

Regardless of NFLOCD end dates, Supports Coordinators are responsible for ensuring the participant's ongoing functional eligibility at all times. For participants found functionally eligible through a temporary door (Doors 3, 4, & 5), Supports Coordinators are still expected to verify the participant's continued eligibility every 90 days. This can be completed through a home visit or through a monthly contact and ongoing eligibility must be documented in the participant's file. When a Supports Coordinator possesses information that a beneficiary may no longer meet eligibility, they must conduct a face-to-face reassessment and NFLOCD. Such information may come in the form of progress notes, routine assessments, staff observations, or any other documentation that might call into question the continued functional eligibility of the beneficiary.

References

Medicaid Provider Manual - MI Choice Waiver
MDHHS NFLOCD

Freedom of Choice

Policy Number:2022-10	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The Michigan Department of Health and Human Services (MDHS) and the Health and Aging Services Administration (HASA) requires a signed Freedom of Choice (FOC) form for any Nursing Facility Level of Care Determination (NFLOCD) conducted or adopted.

Policy

It is the policy of UPCAP Services, Inc. to ensure a FOC form is completed and signed for all individuals a NFLOCD was completed on.

Procedures

When an individual meets NFLOCD criteria, they automatically meet the functional eligibility requirement for nursing facility care, MI Choice Waiver Program, PACE, and MI Health Link HCBS Waiver Program. It is vital that all potential participants and their legal representatives are informed of all of the Medicaid long-term services and supports options available to them.

Supports Coordinators must explain all Medicaid Long-Term Services and Supports (LTSS) options as well as other available LTSS to the individual in a language the individual understands, as well as culturally and linguistically appropriate. It is important that potential participants understand their options and that they have ongoing access to information about all settings and programs. As the functional ability of the participant may change over time and program options may change, it is important to continue to update their options and discharge plan.

Qualified participants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE (not available in Upper Peninsula), MI Choice and MI Health Link cannot be chosen in combination with each other. The Freedom of Choice form (FOC) confirms that these options and referral processes have been explained to the individual.

Participants must indicate their choice and document via their signature and date that they have been informed of their options through the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any NFLOCD process. Participants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. Participants currently receiving Home Help State Plan services will need to be informed that they cannot continue to receive their Home Help services while in the MI Choice Waiver.

Before a potential participant can enroll in the MI Choice Waiver, they must have a completed FOC form, signifying the selection of the MI Choice Waiver Program. The FOC form must be completed in its entirety, signed and dated by the Supports Coordinator and the participant (or their legal representative) seeking services, and is to be maintained in the applicant's case record and a copy provided to the participant. A FOC must be completed EACH time a NFLOCD is conducted or adopted.

When adopting a current NFLOCD in CHAMPS, the Supports Coordinator will notify the assigned Case Tech of their intention to adopt the NFLOCD in CHAMPS. The Case Tech will print out the computer-generated FOC from that NFLOCD record. The Supports Coordinator will complete the form with proper signatures and date. The Supports Coordinator must sign and date the CHAMPS-generated FOC from the adopted NFLOCD record. The FOC must also be signed by the participant or their legal representative within seven (7) calendar days.

The completed FOC form must be kept in the participant's file as well as a copy left for the participant. The FOC form must be completed with each conducted NFLOCD and any time an NFLOCD is adopted.

References

Mi Choice Contract - Attachment C
Medicaid Provider Manual - MI Choice Waiver
MDHHS NFLOCD

Waiver Financial Requirements

Policy Number: 2022-11	Effective Date: 05/01/2022	Revision Date(s): 01/12/2023 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The Mi Choice Waiver Program's special income level for Medicaid participants is up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. This changes annually and is adjusted in accordance with the SSI Federal Benefit Rate and Consumer Price Index.

Policy

Supports Coordinators are to keep up-to-date on yearly financial requirements for the M-Choice Waiver Program.

Current income and assets for 2023 are as follows:

- Gross Income: $ 2,742.00
- Single Assets: $ 2,000.00
- Married / Community Spouse Protected Resources
    - Minimum Resource Standard: $29,724.00
    - Maximum Resource Standard: $148,620.00

Scope

Financial eligibility for Medicaid LTSS services is determined by the State through the MDHHS Field Office. The MDHHS Field Office will complete the financial eligibility determination process within the defined standard of promptness and notify the applicant and the waiver agency of the outcome.

Policy

It is the policy of UPCAP Services, Inc. for all Supports Coordinators to offer their assistance to persons determined medically eligible who need to apply for Medicaid assistance. If the participant accepts the assistance, the Supports Coordinator assists with completing the Medicaid Assistance Application, collecting relevant financial information, submitting the application online or delivering the application to the appropriate MDHHS office. The following procedures provide an overview of the different types of Medicaid eligibility depending on circumstances.

Procedures

Financial eligibility for the Mi Choice Waiver consists of limits established for both gross income AND total assets. MDHHS is ultimately responsible for determining Medicaid eligibility for MI Choice Waiver participants but Supports Coordinators should understand the financial eligibility requirements established by MDHHS in order to provide support and assistance to participants applying for Medicaid and the MI Choice Waiver.

Ensuring participant financial eligibility is an ongoing responsibility of Supports Coordinators. Supports Coordinators are responsible for confirming and documenting the participant's financial eligibility at the participant's initial assessment and enrollment into the MI Choice Waiver as well as at each subsequent reassessment, no less than annually.

Supports Coordinators are also responsible for communicating to the participant the importance of reporting any changes to income or assets to the participant's Supports Coordinator and MDHHS. If at any time during the participant's enrollment in the MI Choice Waiver, a change in income or assets makes them financially ineligible, the Supports Coordinator will notify MDHHS.

Bridges Eligibility Manual

The Bridges Eligibility Manual is utilized by MDHHS and contains the policies and procedures related to determining Medicaid program eligibility and the level of program benefits, such as non-financial eligibility factors, financial eligibility factors and budgeting policy. This manual should be used as a resource for Supports Coordinators to assist the Mi Choice Waiver participant with the application process and to address any issues with the participant's financial eligibility. Supports Coordinators are not MDHHS staff but can offer the participant clarification on how to approach asset eligibility – i.e. excess assets, divestment concerns, etc. by referring to MDHHS Medicaid policy set forth in the BEM. In addition to the BEM, establishing relationships with local MDHHS eligibility specialists is encouraged as they can often offer assistance and clarification with questions of financial eligibility.

Mi Choice Waiver-Specific Bridges Eligibility Manual (BEM) Sections:

- BEM 106: MA Waiver for Elderly and Disabled
- BEM 400: Assets
- BEM 402: Special Asset Rules
- BEM 405: MA Divestment
- Full BEM

Medicaid Application

Supports Coordinators are responsible for assisting the participant in applying for Medicaid with the intention of qualifying for enrollment in the MI Choice Waiver. Applications can be filed online using Mi Bridges, an online portal where applicants can apply and manage their Medicaid benefits, OR using the paper application, which can be completed and turned into any local MDHHS office. Regardless of application process, Supports Coordinators should keep a hard copy record of the application and verifications submitted in the participant file. Supports Coordinators will also provide a cover letter on UPCAP letterhead with the initial application submission notifying MDHHS of the participant's assessment of functional eligibility and request for participation in the MI Choice Waiver program. MDHHS Cover Letter

Waiver Medicaid for Single Person

A single participant's gross income must be at or below 300 percent of the SSI Federal Benefit Rate. An individual cannot spend down income to waiver eligibility. If a potential participant's income is above the gross income limit, the participant is not eligible for the Mi Choice Waiver.

A single participant's assets must be at or below the appropriate asset limit for the extended care category of Medicaid. Assets are defined in the BEM as cash, personal property and real property. More specific details on assets are included in the BEM 400. One home and one vehicle are exempt from the total asset amount used to process eligibility.

Waiver Medicaid for Married Couple

A married participant's gross income is treated the same as a single participant's income. A married participant cannot spend down income to meet Waiver eligibility. If a potential participant's income is above the gross income limit, the participant is not eligible for the Mi Choice Waiver.

A waiver participant is a group of one even when he lives with his spouse, however, special asset rules apply when determining initial asset eligibility. In order to establish the participant's asset eligibility, an Initial Asset Assessment must be completed and processed prior to the Medicaid application to establish the first day of continuous care for Medicaid eligibility. The IAA is also used to establish the amount of the couple's assets protected for use by the community spouse.

The first period of continuous care is a period of at least 30 consecutive days where the participant has been or is expected to be in a hospital and/or LTC facility or receiving appropriate home and community-based services specified under the approved state waiver. The first period of continuous care may have occurred in the past; however, the applicant must be currently receiving services in order to be eligible for the IAA. Supports Coordinators will assist with preparing and submitting the Initial Asset Assessment (IAA) and must submit the following to the MDHHS Long Term Care Eligibility Specialist per BEM 106:

- Verification Waiver Agent conducted assessment utilizing the MI Choice MDHHS Letter submitted with the IAA
- Verification from Waiver Agent indicating there is an available waiver slot for the participant utilizing the Waiver Slot Letter
- Copy of the participant's signed Person-Centered Service Plan
- Copy of the participant's Service Summary which shows services in place, including Supports Coordination

MDHHS is responsible for processing the IAA and verifications and notifying the participant of their eligibility and/or the couples protected assets and the total amount of assets required to be spent in order to approve the participant for

Waiver eligibility. The maximum protected spousal amounts are listed in the BEM 402 and are adjusted annually at the Federal level.

If the marital assets are under the minimum resource standard amount, the participant and spouse enter a presumed eligibility period of one year. During this year, the participant is found eligible by MDHHS and will be enrolled in the MI Choice Waiver with the full extent of services available to them as deemed appropriate and necessary in the plan of care. The participant and spouse have the presumed eligibility period to transfer any assets between themselves, without penalty. At the end of this year-long period, the participant can have no more than $2000.00 in total assets in their name. All other marital assets that exceed $2000.00 should be in the community spouse's name. After this initial period, the married participant's ongoing financial eligibility will be processed as a single person.

In the event that total marital assets exceed the minimum resource standard amount, the married couple will need to spend down the excess assets on the cost of their care and/or MDHHS-approved purchases. MDHHS is responsible for notifying the participant of the protected spousal amount determined by the IAA. During this time period, any Waiver services currently being provided, including the cost of Supports Coordination/Care Management, will need to be billed directly to the participant. Medicaid-funded waiver services cannot be provided until the participant is deemed financially eligible by MDHHS. Supports Coordinators will provide the participant and spouse with information regarding appropriate handling of excess assets so as not to be in violation of MDHHS rules, namely divestment.

All expenditures by the married participant and spouse will need to be closely monitored and record of all payments/receipts should be kept and provided to MDHHS as verification of asset eligibility. Supports Coordinators should be assisting the participant and spouse and checking in regularly during monthly contacts to note progress in the participant's record.

For participants with significant assets, the married participant and spouse may choose to utilize an Elder Law or Estate Attorney to assist with organizing their assets and filing the IAA and Medicaid application. In the event that an attorney is involved in establishing financial eligibility for the MI Choice Waiver, Supports Coordinators are responsible for contacting the attorney and coordinating financial eligibility. Supports Coordinators should request a copy of the application being filed with MDHHS for the participant's records. Supports Coordinators will also assist in providing any verifications to the attorney or MDHHS needed to establish eligibility.

Once the participant and spouse have spent down the excess assets to the determined amount specified by MDHHS, documentation will need to be submitted to MDHHS to determine asset eligibility. Once MDHHS confirms the eligibility date for the participant, the Supports Coordinator will submit the appropriate document for enrollment in the MI Choice Waiver.

Divestment

Divestment penalty periods may apply to participants of the MI Choice Waiver if MDHHS determines that assets were handled inappropriately while processing the Medicaid application. Divestment is defined by MDHHS as the transferring of assets or property for less than its market value over a defined look-back period. BEM 405 provides specific information on divestment and how it applies to eligibility.

Divestment results in a penalty period in MA, not ineligibility. The penalty period is computed based on the difference between the value of the asset and the amount received for that asset divided by the average monthly private long-term care cost in Michigan. The long-term care cost amounts used in the calculation are listed in the BEM.

During the divestment penalty period, Medicaid will not pay for any long-term care costs for the participant. A person should be enrolled into the MI Choice Waiver during the divestment penalty period but they will be expected to use their own resources to privately pay for their MI Choice Waiver services.

- Participants may elect to pay their providers privately for their Waiver services during their divestment period. In the instance, UPCAP would bill the participant only for their support's coordination/care management costs.
- Participants may elect to reimburse UPCAP for the total monthly cost of their care plan. In this instance, UPCAP would bill the participant for the cost of supports coordination/care management and all other contracted Waiver services.

Supports Coordinators should notify the Waiver Director immediately if a Participant is deemed to be in a divestment penalty period to determine a course of action and payment options.

In order to resolve the divestment penalty period, the participant will need to provide verification to MDHHS that they paid privately for at least one MI Choice Waiver service in addition to Supports Coordination/Care Management, for the entirety of the penalty period. Medicaid-funded MI Choice services will resume once divestment penalty has been resolved.

Redeterminations

MDHHS requires a redetermination of financial eligibility on an annual basis. MDHHS will notify clients of their redetermination date and the documents participants are required to complete and return to MDHHS. Supports Coordinators will assist participants with completing the redetermination paperwork and gathering any required verifications. Once completed, the Supports Coordinator will forward the redetermination paperwork to MDHHS and keep a copy for the participant file.

Supports Coordination/Care Management

When calculating care plan costs for participants with excessive assets or participants with divestment penalties, Supports Coordinators will use $490.00/month as the cost for Supports Coordination/Care Management. The cost of other services will be determined using the prices listed for each contracted provider in the UPCAP Code Manual.

References

Medicaid Provider Manual - MI Choice Waiver
Bridges Eligibility Manual (BEM)

	# Medicaid Codes (PET, Benefit, etc.)	
Policy Number: 2022-13	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC

Program Enrollment Type (PET) Codes and Benefit Plans

Benefit Plans and Program Enrollment Type (PET) codes are found on every Medicaid Beneficiary's CHAMPS Eligibility Report. The CHAMPS Eligibility Report should be reviewed prior to MI Choice Enrollment to ensure that the potential participant is eligible for enrollment.

Benefit Plans identify the specific program in which the beneficiary is enrolled. PET codes identify a Medicaid beneficiary's type of admission or managed care enrollment along with their living arrangement. Both the PET code and Benefit Plan ID are found in the Benefit Plans section of a participant's CHAMPS Eligibility Report, along with the applicable Benefit Plan data.

All PET codes, Benefit Plan IDs, Names, Descriptions, Type, Funding Source and Covered Services can be found in the Michigan Department of Health and Human Services Benefit Plan table.

Many benefit plans allow for seamless enrollment into the MI Choice Waiver program by entering the participant/beneficiary's information directly into CHAMPS. However, there are a number of Benefit Plans that conflict with MI Choice Waiver enrollment and would require the potential participant to disenroll from their current benefit plan before enrolling in the Mi Choice Waiver. Disenrollment from existing benefit plans requires coordination between the Supports Coordinator, the Participant and MDHHS. Once disenrollment is confirmed, the participant would be eligible for MI Choice Enrollment.

PROGRAM CODES

Program codes can be found on a beneficiary's CHAMPS Eligibility Report as they coincide with the MAGI program for categorizing individuals based on their adjusted gross income. Supports Coordinators will also want to make sure that a potential participant's program code does not conflict with MI Choice Waiver Enrollment. Checking the program code for a potential participant can aid with determining whether or not their Medicaid Benefit Plan conflicts with Mi Choice Waiver enrollment.

The program codes are only reported on a CHAMPS Eligibility Report when the inquiry start date and the inquiry end date are the same day. The program code will not be available on a CHAMPS Eligibility Report that is populated over a designated timespan.

Mi Choice Waiver Allowable Program Codes are: A, B, E, M, O, P

If a potential participant has a different program code, then they would not be eligible for enrollment into the Mi Choice Waiver.

If a potential participant has an allowable program code, but no benefit plan listed, they would not be eligible for enrollment into the MI Choice Waiver until the Supports Coordinator verifies an application was submitted.

TYPES OF BENEFIT PLANS & PET CODES

Listed below are some common Benefit Plans IDs and PET codes that may show up on a potential participant's CHAMPS Eligibility Report. This is not a complete list – please refer to the MDHHS Benefit Plan table for a full list of Benefit Plans. If you are unsure of whether or not a Benefit Plan conflicts with the MI Choice Waiver, check the Program Code on the CHAMPS report to confirm eligibility for enrollment.

MI Health Link

If there is a MI Health Link enrollment in CHAMPS and the MI Choice waiver agency is trying to enroll the beneficiary for that same month, the MI Choice Waiver enrollment must be postponed until the following month. Beneficiaries enrolled in MI Health Link can not disenroll until the end of the month.

If a potential participant is interested in disenrolling from MI Health Link and enrolling in the MI Choice Waiver, the Supports Coordinator must assist the potential participant with contacting MI Enrolls to disenroll or "opt-out" of MI Health Link, and continue to monitor their CHAMPS Eligibility Report to coordinate a MI Choice Waiver enrollment date. MI Choice Waiver enrollment cannot be entered into CHAMPS until the MI Health Link PET code/Benefit Plan is removed from the CHAMPS Eligibility Report.

Benefit Plan ID - **ICO-MC: Integrated Care Organization Managed Care**

Medicaid Health Plans (MHP):

Medicaid Health Plans are not Healthy Michigan Plans. Beneficiaries can disenroll from any community-based Medicaid Health Plan any day in a month. If a potential participant is interested in enrolling in the Mi Choice Waiver, the Supports Coordinator will need to note in the participant's understanding that enrollment in the MI Choice Waiver means that they will be disenrolled from their current Medicaid Health Plan. When a MI Choice enrollment is entered in CHAMPS, it will automatically set the end date of the Medicaid Health Plan.

Healthy Michigan Plan (HMP)

There is no asset verification or disability determination requirement for the Healthy Michigan Plan (HMP) enrollment. Healthy Michigan Plan beneficiaries can be not "presumed" financially eligibility based on their Medicaid status in CHAMPS. They must also meet the age and disability status requirement for the Mi Choice Waiver.

An asset verification must be conducted by the Supports Coordinator in order to assure that the potential participant meets Mi Choice financial eligibility requirements before MI Choice Waiver enrollment can be considered. Each Mi Choice Enrollment for someone enrolled in an HMP must be handled by MDHHS on a case by case basis. A potential participant **CAN NOT** be enrolled in MI Choice until the HMP has been removed in CHAMPS. This may take some time to do given the Medicaid eligibility approvals and adjustments that need to occur at the MDHHS level.

Supports Coordinators must contact their local MDHHS office to start the process of disenrolling the beneficiary from the HMP. Supports Coordinators may need to gather additional verifications for MDHHS to complete the disenrollment process – i.e. proof of disability determination; bank statements and financial records; etc.

Benefit Plan ID's - **MA-HMP: Healthy Michigan Plan or MA-HMP-MC: Healthy Michigan Plan Managed Care**

Long Term Care

The long-term care distinction in CHAMPS denotes a conflicting residential setting, not necessarily a program conflict. If a potential participant is interested in enrolling or re-enrolling in the MI Choice Waiver, the Supports Coordinator will need to confirm that the participant has been discharged from the facility, is living in a community-based setting, and meets all eligibility requirements for the Mi Choice Waiver. Mi Choice Enrollment cannot be entered until the potential participant has been discharged. When a MI Choice enrollment is entered in CHAMPS, it will automatically set the end date of the long-term care designation.

Benefit Plan ID - **NH: Nursing Home**

PET CODES:

- LTC-CMCF: Nursing Facility Residing at County Medical Care Facility
- LTC-NFAC: Nursing Facility, not CMCF
- LTC-NFAC: Hospital LTC Unit
- LTC-NFAC: Hospital Swing Bed
- LTC-NFAC: Ventilator Dependent Care Unit

Hospice

Participants, both potential and existing, can be dually enrolled in the Mi Choice Waiver as long as the participant is receiving hospice services in their home, not in a facility. A MI Choice Waiver enrollment may be entered directly into CHAMPS.

Benefit Plan ID - **HOSPICE: Hospice**

PET CODES:

- MHP-HOSH: Medicaid Health Plan and receiving Hospice at home
- HOS-COMM: Hospice in the Community

If a beneficiary is receiving Hospice in another setting, they would not be eligible for dual enrollment.

PET CODES:

- HOS-NFAC: Hospice in Nursing Facility
- HOS-RESD: Hospice in Residence Facility (ex: Hospice House)
- MHP-HOSN: Medicaid Health Plan and receiving Hospice in a Nursing Facility
- MHP-HOSR: Medicaid Health Plan and receiving Hospice in a Hospice Residence Facility

Program All-Inclusive Care for Elderly (PACE)

Currently there are no PACE programs in the Upper Peninsula of Michigan. However, it should be noted that a participant in the PACE program is not eligible for MI Choice Waiver re enrollment until they are disenrolled from the PACE program. PACE disenrollment is handled internally at MDHHS and disenrollment only occurs at the end of the month.

Benefit Plan ID - **PACE: Program All Inclusive Care for Elderly**

Children's Special Health Care Services (CSHCS)

A beneficiary enrolled in CSHCS-MC, a managed care Medicaid Health Plan, cannot be enrolled in the MI Choice Waiver at the same time. If the potential participant has CSHCS-MC on their CHAMPS Eligibility Report, they must be disenrolled and their current benefit plan and switched to CSHCS Fee for Service in CHAMPS before a Mi Choice Waiver enrollment can be entered. A potential participant receiving CSHCS must still meet all eligibility criteria for the Mi Choice Waiver, including age, in order to be eligible to be enrolled.

If it is determined that a potential participant would like to enroll in the MI Choice Waiver, Supports Coordinators must notify the Waiver Director. The Waiver Director will send a request to MDHHS to change the code in CHAMPS. Once CSHCS Fee for Service shows up in CHAMPS, the MI Choice Enrollment can be entered. MI Choice Enrollment must occur on the 1st of the month following the CSHCS-MC disenrollment and change to CHSHCS fee for service.

Benefit Plan ID:

- **CSHCS-MC: Children's Special Health Care Services Managed Care**
- **CSHCS-MH: Children's Special Health Care Services Medical Home**

Habilitation Supports Waiver (HSW)

A beneficiary may not be enrolled in the Habilitation Supports Waiver and the Mi Choice Waiver program at the same time. If it is discovered that a new referral is currently enrolled in the HSW, Supports Coordinators may want to discuss the potential participants service needs and appropriateness for the Mi Choice Waiver prior to scheduling a Mi Choice Assessment. The MDHHS MI Choice Manager must also be contacted to confirm that it would be "an appropriate transfer from HSW to MI Choice".

If determined appropriate, the Mi Choice assessment and participant care planning must be handled carefully as to ensure no break in coverage. Disenrollment from the HSW would end the last day of a month with MI Choice starting the 1st day of the following month.

Benefit Plan ID - **HSW-MC: Habilitation Supports Waiver Program Managed Care**

Other Residential Settings

Medicaid beneficiaries who are not residing in the community or an authorized residential setting (HFA/AFC) are not eligible for the Mi Choice Waiver program.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C
Benefit Plan table
LOC to PET Crosswalk
MDHHS BEM 101 – MA Desk Aids

Third-Party Liability

Policy Number: 2022-14	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Policy

UPCAP Services, Inc. shall pursue and secure all available third-party funding, including Medicare benefits, Medicaid State Plan benefits, Veteran's benefits, insurance benefits, and other available sources. Third-party Liability (TPL) funding, when available, shall be utilized prior to any Mi Choice Waiver funding. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access Mi Choice Waiver services.

Neither UPCAP Services, Inc. or any contracted service provider will require monetary donations from participants of the Mi Choice Waiver Program as a condition of participation. No paid or volunteer staff person may solicit contributions from Mi Choice Program Participants, offer for sale any type of merchandise or services, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

Procedure

During the initial assessment of a potential participant, the Primary Supports Coordinator shall obtain copies or verify all insurance policy information and determine if the potential participant is financially able to contribute toward their service needs. The Supports Coordinator compares the insurance information provided during the initial assessment to CHAMPS data to ensure consistency. If a Supports Coordinator does not have access to CHAMPS, the Case Tech can run the TPL/Insurance

Discrepancies shall be reported to MDHHS within ten (10) business days of the initial assessment. All collaboration between Third-Party Liability payors, MDHHS and the Supports Coordinator must be documented in progress notes.

References

Medicaid Provider Manual - MI Choice Waiver

Participant Enrollment

Policy Number: 2022-15	Effective Date: 05/01/2022	Revision Date(s): 11/01/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Policy

MI Choice waiver agencies determine the participant's enrollment start dates upon verification of eligibility. No participant can be enrolled and assigned a Waiver start date until they meet ALL of the eligibility requirements. Supports Coordinators are responsible for assigning the participant's enrollment start date and submitting the appropriate forms for entry into CHAMPS.

Procedures

Enrollment Start Dates

The MI Choice enrollment start date is on or following the assessment date. The enrollment date usually coincides with the date of assessment. However, the following situations may delay enrollment for a MI Choice participant:

1. The participant is assessed in a nursing facility or hospital, or the participant has another Medicaid PET code assigned at the time of the assessment.
    a. On a date following assessment, the participant returns home, to the community, or terminates participation in the other Medicaid program. MI Choice enrollment may begin only after the individual returns home or terminates participation in the other program.
    b. Waiver agencies coordinate with the MDHHS Field Office or the other program to ensure termination from the other program before enrolling the participant in MI Choice. As a reminder, individuals transferring from MI Health Link, PACE, or the Habilitation Supports Waiver may only do so on the first of the month. Waiver agencies submit enrollment information in CHAMPS.
    c. The participant's enrollment date follows discharge from the nursing facility, hospital, or other program. MI Choice enrollments can occur on the day of discharge from the nursing facility or hospital. The enrollment date must not be the assessment date when the individual was assessed while in the nursing facility or hospital unless the assessment date was the day of discharge from the nursing facility or hospital.
2. The participant is hospitalized after the waiver agency conducts an assessment and prior to the enrollment date being established. Enrollment must be delayed until after the participant is discharged from the hospital.
3. The participant currently participates in the Home Help Services program. It must be verified and documented that the Home Help Services program no longer meets the service and support needs of the participant through an in-home assessment. Participants CAN NOT be required to request and have additional Home Help Services benefits denied before making this determination.

a. Supports Coordinators will need to coordinate with the Adult Services worker to confirm termination of the Home Help Services program before MI Choice enrollment. The participant will also need to notify the MDHHS Field Office of this decision to terminate the Home Help Services program enrollment.
b. Participants are entitled to receive State Plan services while in MI Choice; however, MI Choice will meet all personal care needs so that the individual does not require Home Help Services when enrolled in MI Choice. The Supports Coordinators (SCs) should fully explain this choice to participants requesting to switch from the Home Help Services program to MI Choice.

4. The participant is assessed at the end of a month. With participant's approval, MI Choice enrollment may be postponed until the first day of the following month.
5. During the assessment, it is determined that the participant meets NFLOCD criteria but has excess assets. The waiver agency shall delay enrollment into MI Choice until the MDHHS Field Office determines the participant to be financially eligible.
6. The participant is enrolled in another managed long-term services and supports (LTSS) program, including MI Health Link, PACE and Habilitation Supports Waiver, at the time of assessment. These are managed care programs where disenrollment is effective at the end of the month. Coordination is required to ensure that the first day of enrollment into MI Choice is the first day of the month after the effective date of the MI Health Link, PACE or Habilitation Supports Waiver disenrollment.
7. The participant does not have Medicaid at the time of assessment. Before the participant can be presumed financially eligible for MI Choice, the participant must submit a Medicaid application to the MDHHS Field Office.

Determining Start Dates with Pending Medicaid

There are multiple options when determining the start date for a participant whose Medicaid application has just been filed and is currently being processed by MDHHS for financial eligibility. Special enrollment circumstances apply to married participants. For more information regarding establishing enrollment dates for married participants, please refer to the Mi Choice Waiver Medicaid Guide.

[Refer to ***Policy Number: 2022-12 - MI Choice Waiver Medicaid Guide*** for a more detailed process]

Do Not Enroll Until Eligibility is Confirmed

The Supports Coordinator, based on the information gathered during the Medicaid application process and review of financial eligibility, may wait to enroll the participant in MI Choice until MDHHS has made a final determination of financial eligibility. In most cases, this applies to married participants whose total and protected spousal assets need to be determined by MDHHS before financial eligibility can be confirmed.

The Supports Coordinator will notify the MDHHS Field Office that it has assessed the participant and determined that they meet all MI Choice Waiver eligibility criteria, except Medicaid eligibility. This means the participant has been approved for the MI Choice Waiver, but the participant will not be enrolled until MDHHS has determined the participant's Medicaid eligibility. Supports Coordinators will not submit the Enrollment Notification form for entry into CHAMPS until the financial eligibility date is verified by MDHHS. The participant will be enrolled into the Care Management program (60+ years old) or the Local Care Management Program (59 years old and under) and assigned the appropriate program status (OSA/CM) or (LCM-1) while Medicaid eligibility is being determined by MDHHS.

MI Choice enrollment occurs when all eligibility criteria has been confirmed and cannot be sooner than the date that the MDHHS Field Office confirms Medicaid eligibility, regardless of any retroactive Medicaid eligibility dates. Depending on the length of time between the initial assessment of functional eligibility and the determination of financial eligibility by MDHHS, it may be necessary to complete an additional NFLOCD or iHC assessment before enrolling the participant in MI Choice, especially if there has been a change in the participant's functional status or condition.

Presume Eligible until MDHHS confirms Eligibility

The Supports Coordinator, based on the information gathered during the Medicaid application process and review of financial eligibility, may presume that the MDHHS Field Office will approve the participant's Medicaid application. This participant will be considered to have a "presumed eligibility" and will be enrolled as though they are financially eligible.

The Supports Coordinator will notify the MDHHS Field Office that it has assessed the participant and determined that they meet all eligibility criteria, except Medicaid eligibility and determined that the participant is "approved" for the Waiver. The Supports Coordinator will submit the Enrollment Notification to the Medicaid Specialist for entry into CHAMPS. The participant will be assigned a status of Waiver-Pending. During this time, the participant will be eligible to receive the full array of services identified in their person-centered service plan (PCSP) and the Supports Coordinator will proceed as if the participant has met all eligibility criteria.

For married participants whose assets are at or below the minimum resource standard and the enrollment date is being determined to establish the first day of continuous care for Medicaid eligibility, the Supports Coordinator will follow the same steps as listed above for a single participant. The Supports Coordinator will need to notify the MDHHS Field Office that the participant meets all eligibility criteria, except Medicaid eligibility and has determined that the participant is "approved" for the Waiver. The participant will be assigned the status of Waiver-Pending and the Enrollment Notification will be submitted to the Medicaid Specialist for entry into CHAMPS. During this time, the participant will be eligible to receive the full array of services identified in their person-centered service plan (PCSP) and the Supports Coordinator will proceed as if the participant has met all eligibility criteria.

Program Status

Once the enrollment start date has been determined, the Supports Coordinator will update the participant's Status Report and assign program status of Waiver-Pending to the participant. The start date for Waiver-Pending must match the start date listed on the Enrollment Notification form. Supports Coordinators will submit the updated status report to the appropriate Case Tech for entry.

The Waiver-Yes program designation is only applied once enrollment has been confirmed in CHAMPS and is entered by the Medicaid Specialist.

Mi Choice Waiver Enrollment Notification

The Supports Coordinator will complete and submit the MI Choice Waiver Enrollment Notification to the Medicaid Specialist for entry into CHAMPS. The notification must be submitted within five (5) business days of establishing the participant's eligibility and enrollment start date. This form must also be documented in the participant file.

Entering Enrollment into CHAMPS

The Medicaid Specialist will enter the participant's Waiver Enrollment date and required information into CHAMPS. To ensure the accuracy of the information provided on the enrollment notification form, the Medicaid Specialist will confirm the participant's name, address, date of birth, social security number, and Waiver start date by reviewing the participant's status report and COMPASS file before entering the enrollment in CHAMPS.

Once the enrollment is entered into CHAMPS, the Medicaid Specialist will then notify the MDHHS Field Office of the new Waiver Enrollment. The Medicaid Specialist will document in the participant's file and continue to monitor the enrollment for completion in the CHAMPS system.

If there are any PET code or Benefit Plan conflicts or issues with enrollment, the Supports Coordinator will be notified of the issue and be responsible for following up with the participant and/or the appropriate entity to resolve the issue.

Confirming Mi Choice Waiver Enrollment

The Mi Choice PET code and Benefit ID will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. CHAMPS will be checked daily and continued monitoring will be noted in the participant file. As soon as the MI Choice code is updated and the MDHHS Field Office confirms Medicaid eligibility, the Medicaid Specialist will update the participant's Status Report and change the program status from Waiver-Pending to Waiver-Yes as of the initial enrollment date. The Supports Coordinator will be notified of the status change and will add the updated report to the participant file. Only the Medicaid Specialist, Waiver Director, or other designated staff are able to update the participant's program status to Waiver-Yes.

If the participant was presumed eligible but MDHHS denies eligibility, the participant's status must be changed from Waiver-Pending to Waiver-Financially Ineligible during the period of time from the initial assessment to the date of denial. All Waiver services rendered during that time frame cannot be reimbursed using Medicaid funds as Medicaid eligibility has been denied. The Supports Coordinator and/or the Medicaid Specialist will be responsible for notifying the Waiver Director of the determination of ineligibility. All services will need to be re-coded during the Waiver-Financially Ineligible period. The Waiver Director will notify the MDHHS Home and Community-Based Services Staff and formally request the removal of the MI Choice enrollment date in CHAMPS. If the participant would like to continue to receive Supports Coordination/Care Management services after the denial, the participant can be opened to the Care Management or Local Care Management program at that time.

Enrollment – Care Management

Participants who are not financially eligible for enrollment into the MI Choice Waiver but still require Supports Coordination/Care Management services, or are going to actively spend down their excess assets to obtain future financial eligibility into the MI Choice Waiver, will be enrolled into the Care Management program. Supports Coordinators will assign the program status of AASA/CM (60+) or LCM-1 (Under 60) on the participant's status report therefore enrolling them in the Care Management or Local Care Management program as of the initial assessment date.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C

Case Classifications

Policy Number: 2022-16	Effective Date: 05/01/2022	Revision Date(s): 10/06/22
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Every participant enrolling into one of UPCAP's Long-Term Care Programs must be assigned a case classification. Case classifications are used to identify the program the participant is enrolled in.

Policy

Supports Coordinators or Case Techs are required to designate a case classification for each Participant either at the time a referral is received or after an initial assessment, depending on the type of referral and/or program enrollment. All case classifications, including changing from one classification to another, must be supported by appropriate documentation in the Participant's progress notes. Case classifications are made by utilizing the COMPASS Status Form

Procedures

Waiver

The Waiver classification (WA-Y) classification is only to be used for participants who are medically eligible, financially eligible and require two services provided by Mi Choice on a monthly basis.

Waiver Pending

The Waiver Pending (WA-P) classification is only to be used if a participant meets medical eligibility, requires two services provided by Mi Choice on a monthly basis and appears financially eligible as a result of the "Presumptive Eligibility" determination and the Supports Coordinator is awaiting formal MDHHS approval of a submitted application, and the Supports Coordinator has determined a need to begin purchasing services prior to formal MDHHS notification. If the participant does not want services during this period time, the Participant is to be classified as Care Management-AASA CM (age 60 and over) or Local Care Management-LCM1 (under 60).

Waiver Divestment

The Waiver Divestment (WA-D) classification is only to be used if a participant meets medical eligibility, requires two services provided by Mi Choice on a monthly basis, is financially eligible, but is serving a penalty period (divestment) as determined by MDHHS.

Waiver Financially Ineligible

The Waiver Financially Ineligible (WA Fin-I) classification is only to be used for individuals who were presumed financially eligible for Mi Choice and previously classified as Waiver Pending, but Medicaid was denied by MDHHS.

Waiver Ineligible

The Waiver Ineligible (WA-I) classification is to be used for individuals previously classified as Waiver, but are temporarily in a nursing facility. For those participants that close due to nursing home placement, the day of placement should be classified as Waiver Ineligible.

Care Management

The Care Management (AASA-CM) classification is only to be used for participants who are medically eligible, but not financially eligible and meet age requirements (over 60). This classification includes individuals who have excess assets above the allowable MDHHS level even if the asset level will be reduced to the MDHHS limit within thirty (30) days.

Targeted Care Management

The Targeted Care Management (AASA-TCM) classification is to be used for participants age 60 and over who are medically eligible, 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 the segment of the population who have opted to maintain their MDHHS Home Help worker as the primary caregiver.

Targeted Care Management classification can also be used for individuals who may benefit from Mi Choice Waiver, but the Waiver agency has a waiting list for available waiver slots.

Options Counseling

The Options Counseling (AASA/Options Counseling) classification is to be used for participants that do not score eligible on the Michigan Intake Guide (MIG), but wish to speak to a Supports Coordinator on other available options in their community.

Case Coordination

The Case Coordination (Case Coord) classification is to be used temporarily for referrals from Nursing Facilities for individuals that answered “yes” to Section Q of the MDS Assessment.

Nursing Facility Transition

The Nursing Facility Transition (NFT) classification is to be used temporarily for referrals from Nursing Facilities for participants wishing to return to the community.

Veterans

The Veterans classification is to be used for individuals referred to UPCAP Services, Inc. through the Veterans Self-Directed Care Contract.

Upper Peninsula Health Plan

There are four different classifications for Upper Peninsula Health Plan participants.

- UPHP-AHH – Individuals enrolled in Mi Health Link only needing personal care services
- UPHP-C Waiver – Individuals enrolled in Mi Health Link’s C-Waiver program
- UPHP-Pending – To be used for referrals received from UPHP for a C-Waiver assessment, but approval not received yet or for nursing facility transitions on an individual enrolled in Mi Health Link
- UPHP-I – To be used for Mi Health Link participants for the time between a UPHP referral date and a C-Waiver enrollment date, if different.

Significant Support System

The Significant Support System (SSP) is a special designation for participants who meet certain criteria as defined by MDHHS. The Director of Long-Term Care Programs will notify the Supports Coordinator when a participant qualifies for the SSP designation. This designation is tracked by utilizing the SMOU classification in the COMPASS status report.

Person Centered Care Planning, Monitoring and PCSP

Policy Number: 2022-17	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The Person-Centered Planning process is a contract requirement for MI Choice waiver agencies, which provide community-based long-term care services to people who are aging and/or have disabilities.

Policy

It is the policy of UPCAP Services, Inc. to utilize a person-centered planning process to establish a written Person-Centered Service Plan (PSCP) for all participants in the MI Choice Waiver program. The PCSP will be based upon the iHC assessment and choices and preferences expressed by the Participant. It will build upon the individual's capacity to engage in activities that promote community life, maximize independence, and that reflects the needs, goals, and preferences that are important to the participant. The participant's cultural background shall be recognized and valued in the planning process, and the Supports Coordinator will provide information in an understandable way.

Procedures

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 plan is not static, and will change as new opportunities and challenges arise. 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. This may include guardians, family, friends, professionals, caregiving staff and other formal supports and allies that the individual desires or requires. The Supports Coordinator will assist the participant in identifying specific, measurable, achievable and relevant objectives to meet their goals.

The Supports Coordinator must utilize a person-centered care planning process. This starts with information provided by the Participant during the initial screening and continues on with the completion of the iHC assessment by a Supports Coordinator. During the assessment process the participant is encouraged to describe what problems or issues they feel need to be addressed in order for them to remain in the community. The Supports Coordinator explains the full array of services, supports, and options that may be available to the Participant depending on their financial circumstance, availability of a Waiver slot, and the limitations of the Waiver, ensuring that the individual is provided with information regarding all choices. The Supports Coordinator is responsible for supporting the Participant and authorizing the person-centered service plan (PCSP), which is based on the expressed preferences, desires and choices of the Participant. All services and interventions must be approved by the participant prior to implementation.

The PCP Process

- Includes people chosen by the individual.
- Provides necessary information and support to ensure the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the participant.
- Reflects cultural considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
- Offers choices to the participant regarding the services and supports the participant receives and from whom.
- Includes a method for the participant to request updates to the plan, as needed.
- Records the alternative home and community-based settings that were considered by the participant.

PCP meetings are conducted when the participant is not in crisis and at a time of the participant's choice. The participant has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process. An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the participant is not ready to fully participate in PCP. Interim care plans are authorized for no more than 30 days without a follow-up visit (or planning meeting) to determine the participant's status.

COMPASS Person Centered Service Plan

The Person-Centered Service Plan (PCSP) will be developed, updated and revised as the participant's needs change. The PCSP will maximize the participant's strengths, cultural and ethnic needs, stated preference, available resources, personal control and independent living, taking into consideration the whole person. There will be active involvement of the participant, guardians, family members, caregivers, and others as deemed appropriate by the participant.

Supports Coordinators are required to utilize a person-centered planning process to establish a written PCSP for all participants in the MI Choice Waiver program. The PCSP will be based upon the iHC assessment utilizing the choices and preferences expressed by the Participant. It will build upon the individual's capacity to engage in activities that promote community life, maximize independence, and that reflects the needs, goals, priorities, and preferences that are important to the participant.

The Michigan Department of Health and Human Services (MDHHS) and the Bureau of Aging, Community Living, and Supports (ACLS Bureau) require that UPCAP utilize a standardized care plan that identifies and addresses the Participant's strengths, weaknesses, needs, goals, expected outcomes and planned interventions.

UPCAP Supports Coordinators work with each participant and their allies to develop a written PCSP. The PCSP must reflect the services and supports important for the individual to meet the needs identified through the iHC assessment, and what is important to the individual regarding preferences for the delivery of services and supports. Supports Coordinators inform the participant or his or her representative of all options to address identified issues and needs. The Supports Coordinator and the participant concur upon the services and supports arranged, as well as the frequency and duration of those services.

The Supports Coordinator will utilize the **COMPASS Person Centered Service Plan** that coincides with the COMPASS iHC assessment. Through this assessment a CAPs and Triggers report is populated identifying any problems and potential areas of need. Supports Coordinators will discuss the results of this report with the Participant, along with the information obtained through the person-centered planning process to develop a comprehensive PCSP. While the PCSP may include CAPs for each protocol triggered, not all CAPs triggered are applicable to each Participant. A participant may

state that they do not wish to include specific CAPs on their PCSP. The PCSP should also never be restricted to those CAPs triggered by the Participant's assessment.

All problems and needs identified from the assessment must be addressed on the PSCP, regardless of payment source or informal service provision. Participant preferences for requested or declined services including service delivery and communication must be documented. All formal and informal services planned are to be listed, including community services to be arranged and purchased, and those that are funded from sources other than MI Choice. This includes services obtained through allies, Medicare, the State Medicaid plan, other public programs, and/or paid and unpaid supports that meet identified participant needs. It must also include those interventions provided directly by Supports Coordinators including interventions such as advocacy and/or limited counseling.

The PCSP must contain, at a minimum:

- An indication that the participant chose the setting in which the participant resides.
- The participant's preferred method of communication.
- The services and supports that are important to the individual to meet the needs identified during the individual's assessment.
- The individual's strength and preferences.
- The clinical and support needs identified by a functional assessment.
- The services and supports (paid and unpaid) that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural and informal supports.
- Risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Language that is understandable to the participant, and the individuals important in supporting him or her. It must be written in plain language, with no acronyms, and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- The individual or entity responsible for monitoring the plan.
- Participant-focused goals and outcomes, ranked and prioritized based on the Participant's preferences
- The informed consent of the individual in writing, and signed and dated by all individuals and providers responsible for its implementation.
    - Participants may provide verbal approval of the PCSP so that service delivery can begin. Supports Coordinators must document the verbal approval, including date on the PCSP, and secure the participant's signature at a subsequent in person encounter.
- Distribution to the individual and other people involved in the plan as designated by the participant.
- All service directed services.
- Only necessary or appropriate services and supports.

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

The initial PCSP must be developed within five (5) business days of completing the iHC. Formal service delivery must begin with seven (7) business days of the initial assessment or indicate a plan to address Participant needs until such time as approved formal service delivery can begin. The participant must approve the PCSP and a signature obtained. If a signature cannot be obtained, verbal approval may be obtained from the participant/representative for initiating services. Verbal approval and date of approval must be documented.

A copy of the Participant's PCSP and COMPASS Service Summary must be provided to the participant and/or their designated representative each time a permanent change is made to the service plan - i.e. a service is added, decreased, stopped, etc.

The PCSP must be reviewed and updated with the Participant as frequently as necessary or preferred, but at least 90 days after the initial assessment, then every 180 days thereafter. Supports Coordinators will review the Participant's current services to ensure that they are appropriate and meeting the Participant's needs and expectations. The Participant's goals and outcomes will also be reviewed and updated with their progress, allowing for revisions or adjustments to the PCSP if the Participant is not able to attain desired outcomes.

REFERENCES

Medicaid Provider Manual - MI Choice Waiver
Compass User Guide Assessment/PCSP

Participant Management of Risk

Policy Number: 2022-18	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Participant management of risk embraces all the decisions one makes and activities one undertakes with the intent of improving one's health and safety in their environment and living arrangements. Each risk involves the possibility of detrimental consequences and their likelihoods. The management component of risk management involves decisions about these risks. In MI Choice, effective risk management builds upon the service planning and monitoring processes.

Policy

Waiver agencies are required to assist MI Choice participants in managing the risks associated with choosing home and community-based service programs over institutionalization. Critical risks should be addressed during the PCSP development process by incorporating strategies into the plan to mitigate whatever risks may be present. The Supports Coordinators will identify potential risks to the participant during all assessments and fully discuss these risks with the participant and their allies upon identification. Supports Coordinators will provide information regarding potential interventions and/or modifications available to address the risks identified. Supports Coordinators will educate the participant to ensure that the participant makes informed choices concerning their risks. The participant will ultimately determine what risks to include in their PCSP and the preferred methods of monitoring their potential impact.

The Supports Coordinators are responsible for informing service providers of a participant's risk status when ordering services in the traditional MI Choice program. The participant or, if preferred, the Supports Coordinators inform service providers of the participant's risk status when the participant chooses the Self-Determination option.

Procedures

Clinical Assessment Protocols (CAPs) and Triggers

The iHC is designed to "trigger" items, called Clinical Assessment Protocols (CAPs), based on answers provided by the participant during the assessment process. These CAPs identify areas of concern or "risk" that may apply to the participant. CAPs cover problems in four broad areas of concern: Functional Performance, Clinical Issues, Cognition and Mental Health, and Social Life. Within these four categories, there are 27 total CAPs. These specific CAPS are designed to identify issues or areas that could benefit from further evaluation of specific problems and risks for functional decline. Some of the CAPs form the core of the PCSP when relevant to the participant's existing problems and risks, others will not.

Supports Coordinators may choose to use the computerized report called the CAPs and Triggers Report (C&T report) that generates following each assessment of a participant. Supports Coordinators can use the information on the C&T report to

identify problems, evaluate causes and associated conditions for the problems, and to assist in the development of necessary goals and related approaches to services and referrals for services and supports.

The review of the C&T report requires Supports Coordinators to evaluate a wide variety of triggered problems. The focus is not just on simple maintenance services or planning a response to an immediate problem. While these are included, the system also helps Supports Coordinators to assess for opportunities to rehabilitate function, prevent decline, and maintain participant strengths. In responding to urgent needs, the participant and their Supports Coordinators can identify service and support priorities. In looking at chronic problems, the participant and their Supports Coordinators can maintain comprehensive well-being. All risk planning and management is contingent on the participant and families agreeing with the assessment and SC recommendations in care planning.

It is important to note that not all conditions triggered apply to every participant. The Supports Coordinator or participant may have already planned for, ameliorated, or determined a specific condition is not a problem to the participant. Conversely, the CAPs do not include every problem that the participant needs to have addressed in care planning and risk management. However, the CAPs are sound starting points covering most frequent problem situations that Supports Coordinators need to address in care planning and risk management. Supports Coordinators fully discuss strategies to mitigate risk with the participant and their allies, family, and relevant others during PCP. The Supports Coordinators inform the participant of risks and educate the participant about consequences of chosen risks, as necessary. Supports Coordinators document the participant's informed choice in the case record. Only participant-approved risk strategies are added to the PCSP.

Service Need Levels Based on Identified Risks

Supports Coordinators must categorize each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports. Supports Coordinators must make direct service providers aware of the service need levels and the classification of each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

1. Immediacy of need for the provision of services
    - Immediate – the participant cannot be left alone
    - Urgent – the participant can be left alone for a short time (less than 12 hours)
    - Routine – the participant can be left alone for a day or two

2. Availability of Informal Supports
    - No informal supports are available for the participant
    - Informal supports are available for the participant
    - The participant resides in a supervised residential setting

Grid of Service Need Levels

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means you cannot be left alone. If your services are not delivered as planned, your backup plan needs to start immediately.
Immediate	Available	1B	This means you cannot be left alone. If your services are not delivered as planned, your family or friends need to be contacted immediately.
Immediate	SRS	1C	This means you cannot be left alone. Staff at your place of residence must be available to you as planned or follow established emergency procedures.
Urgent	None	2A	This means you can be left alone for a short time. If your services are not delivered as planned, your backup plan needs to start within 12 hours.
Urgent	Available	2B	This means you can be left alone for a short time. If your services are not delivered as planned, your family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means you can be left alone for a short time. Staff at your place of residence must check on you periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means you can be left alone for a day or two. If your services are not delivered as planned, your backup plan needs to start within a couple of days.
Routine	Available	3B	This means you can be left alone for a day or two. If your services are not delivered as planned, your family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

Contingency Planning

The development of contingency plans is one way to address some of the risks encountered by MI Choice participants. MDHHS identifies both emergency plans and backup plans as contingency plans for MI Choice participants. The Back-up Plan populated in COMPASS incorporates both an emergency plan and back-up plan into one document, pulling from information within the participant file and assessment, as well as work orders entered.

Back Up Plans

Once the participant's iHC assessment is finalized in COMPASS and work orders authorizing all services are entered, the back-up plan must be printed and provided to the participant, service providers, and any others as preferred and authorized by the participant. Contracted providers that utilize Vendor View will have access to the participant's back-up plan within the Vendor View system.

The back-up plan must be updated at least annually and reviewed whenever there is a change. The Supports Coordinator will be responsible for sending a copy of the updated back-up plan to the participant and any others as requested by the participant. A copy of the most up-to-date back-up plan must also be located in the participant file.

Backup Plans must include the following information:

- Participant name, address, and contact information
- Direction for contacting emergency services - 911
- Name and contact information for participant's primary care physician
- Name and contact information of primary Supports Coordinator, including back-up contact information if primary Supports Coordinator cannot be reached
- Service need level of participant
- Emergency contacts and their contact information
- Contact information for Participant's Guardian or responsible party, if applicable
- Existence of Advance Directives and location of document
- Type of assistance needed in case of an emergency, including evacuation plans and designation of emergency exits
- Whether or not the participant has medical equipment requiring power
- Location of the participant's medication list
- Alternative caregivers and contact information
- Contingency plan for service provision, including participant's preference to not have a back-up provider if applicable
- Informal Supports and contact information
- Name and phone number of all formal service providers, both purchased and arranged

It is the Supports Coordinators responsibility to ensure that all the information within the participant's COMPASS file and assessment is fully completed and accurate so that the backup plan reflects the participant's current needs and information.

In situations where services are limited or not available due to a participant residing in a remote area and/or limited provider agency 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 Supports Coordinator should note the unaddressed need(s) in the Participant's COMPASS Assessment under Section Q: Service Utilization - Formal Care. A brief summary should be added to the section entitled *My Back-Up Plan for Care is:* stating specifically which services will not be provided and that the participant is aware of risks.

Supports Coordinators are responsible for addressing issues that may arise with service provision. If informal supports are delayed in relieving agency staff, the informal supports will be instructed to contact the Supports Coordinator. If the Supports Coordinator is unavailable, the informal support will contact the service provider. If the Supports Coordinator determines that increased services are necessary based on the participant's service level need, they may authorize extra time on a one-time-only basis. If informal supports are consistently unreliable, the Supports Coordinator will want to address the issues and concerns with the participant and informal supports, focusing on the agreed-upon responsibilities of the informal support system. The Supports Coordinator may adjust the person-centered care plan if necessary and approved by the participant.

If there are consistent missed or no-show visits on behalf of the provider, the Supports Coordinator will be responsible for communicating these concerns to the provider. These concerns may be voiced at monthly case conferences or on individual phone calls with the provider as they occur. The Supports Coordinator may also want to alert their Team Leader and/or Waiver Director. Information regarding the reliability of a provider can also be relayed to the Quality Assurance Team and addressed during their provider monitoring.

Sample back-up plan

Advanced Directives

Advanced directives are legal documents that allow the participant to document their decisions about end-of-life care ahead of time. At the initial home visit and assessment, the Supports Coordinator will review the importance of completing an Advanced Directive.

If the participant has already completed an Advanced Directive, the Supports Coordinator will ask permission to make a copy for the participant's file, making note of the participant's end of life wishes. If unavailable, the Supports Coordinator will take note of the location of the completed form and note participant's wishes in the file.

If the participant does not currently have an Advanced Directive in place, the Supports Coordinator will provide the participant and/or approved representative with the Advance Directives document to complete. The Supports Coordinator can assist the participant with reading through the Advance Directive document and answer any questions. However, it is a conflict of interest and not appropriate for the Supports Coordinator to act as a witness or accept the responsibility of becoming the participant's decision maker.

If the participant is not interested in completing an Advance Directive form or the Supports Coordinator deems that it is not appropriate, the Supports Coordinator must document this in the participant's record.

Durable Power of Attorney for Health Care

Participants also have the opportunity to assign someone the responsibility of making health care decisions for them if and when they are unable to do so safely. The Durable Power of Attorney for Health Care document allows for the participant to formally name a trusted individual as their Durable Power of Attorney (DPOA) to make decisions in the event that they have become incapacitated. The DPOA must be a willing party and must sign the document assuming the responsibility. Many Advance Directives documents provide a DPOA form that can be completed at the same time.

The designation of the DPOA provides evidence of the participant's wishes, not formal delegation of decision-making authority. The participant remains in charge of all decision-making until they voluntarily delegate responsibility, two health care officials activate the DPOA, or the court grants that responsibility to another individual.

Guardianship

The Support Coordinator's goal is to promote the general welfare of all 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” is 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. If a Guardian is already in place for a participant, it is the Supports Coordinators responsibility to make a copy of guardianship paperwork for the file. The guardian will ultimately be responsible for providing authorization and signing all legal documents with respect to enrollment in the MI Choice Waiver.

When a participant makes decisions that are self-injurious or jeopardize the safety of others, Supports Coordinators determine if an appropriate substitute decision-maker can act informally or if they should seek a guardian to protect the participant.

When a Supports Coordinator determines 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 unsafe 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, Supports Coordinators 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. Supports Coordinators 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 explored as a last resort for the most severely impaired. Supports Coordinators are required to inform the Regional Supervisor and/or Waiver Director anytime they feel the pursuit of guardianship is necessary. The participant’s case may need to be evaluated by the Waiver Director and/or Regional Supervisor, to ensure that all other options have been explored. It shall not be the responsibility of UPCAP or its employees to initiate any guardianship activities. If, after consultation with the Regional Supervisor and/or Waiver Director it is determined that guardianship is appropriate, Supports Coordinators will be directed to contact the local MDHHS office to request Guardianship procedures be initiated. MDHHS will not pursue Guardianship if they do not agree with the Supports Coordinator’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.

Use of Physical Restraints or Seclusion

Under no circumstances shall a Supports Coordinator 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.

An exception to restraints or restrictive intervention is bed rails or bed canes. If bed rails or bed canes are used, this must be based upon assessed need for the participant and documented in the person-centered service plan. If the participant resides in a provider-controlled setting, there must be an order from a licensed medical professional, and this must be kept on file in the participant's case record at the waiver agency. As per requirements in federal law and the Home and Community-Based Services Chapter in the Medicaid Provider Manual, the use of bed rails or bed canes must be reviewed on an annual basis to ensure they are still required. If no longer required, the bed rail or bed cane must be removed.

Supports Coordinators shall assess the utilization of any restraints, seclusion or restrictive interventions by family or caregivers as necessary and no less than annually at the in-person assessment. Supports Coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions. If the Supports Coordinator determines that the use of such restraints or restrictive measures are inappropriate, unsafe, not in the best interest of the participant, or has caused participant injury, the Supports Coordinator should notify the Regional Supervisor or Waiver Director to discuss their concerns. If appropriate, the Supports Coordinator may also need to make an Adult Protective Services referral and complete a Critical Incident Report.

[Refer to ***Policy Number: 2022-28 - Critical Incidents***]

Informed Risk

Supports Coordinators are responsible for assessing potential safety risks given the Participant's choices and providing the Participant with education on how to mitigate the risks their choices pose to their safety or the safety of others. In some circumstances, more comprehensive documentation of the participant's understanding of the potential negative outcomes from their choices may be necessary. For this reason, UPCAP has developed an Informed Risk Agreement form.

The Informed Risk Agreement Form is a tool designed to assist in educating a participant regarding decisions they are making and the risks associated with the decisions. The tool is designed to confirm participant understanding of the identified risks, outline a plan for addressing those risks, and establish a timeline for follow up.

The following are examples of situations in which the tool is utilized:

- Participant is transitioning from SNF and the situation may be unsafe.
- Participant is choosing to live in a situation with an unsafe back up plan for supports, services or emergent situations
- Participant is making choices that may be harmful or detrimental to themselves or others
- Participant behaviors or actions are putting them at risk of losing their supports and services
- Participant is exhibiting risky behavior

The Supports Coordinator determines if the situation warrants the completion of the tool. If it is determined that an Informed Risk Agreement is appropriate, the Supports Coordinator:

- Contacts their Team Leader and/or Director of Long-Term Care Services, if needed.
- Informs the participant their behavior or decisions warrant the completion of the Informed Risk Agreement
- Completes the form with the participant.
- Documents the completion of the tool and participant understanding of the identified risks in COMPASS.

Once the form is completed, the Supports Coordinator must mail a copy to the participant, requesting a signature with a return envelope. The completed, signed copy is then placed in the Participant's file and a copy uploaded and attached to the Participant's record in COMPASS. The participant is also provided a copy of the signed form. If the participant refuses to sign the tool, the Supports Coordinator documents the participant's refusal in COMPASS.

[Informed Risk Agreement Form SAMPLE]

References

Medicaid Provider Manual - MI Choice Waiver

Participant Medications

Policy Number: 2022-19	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Purpose

To identify participants who are at risk for unsafe medication management and ensuring appropriate interventions are in place to facilitate proper medication management and education.

Policy

In compliance with MDHHS standards, all MI Choice participants are assessed for risk in managing their medications. Effective risk management is built upon the assessment, service planning, and monitoring process. At-risk planning is contingent on the participant's agreement with the Supports Coordinator's assessment and recommendations for care. UPCAP respects the participant's right to make choices as long as the participant appears capable of understanding the consequences and risks associated with those choices.

Supports Coordinators are required to create a complete list of medications for each participant in COMPASS, and perform a medication reconciliation upon participant enrollment and whenever warranted by the Supports Coordinator's professional judgment. Reasons to complete reconciliation include, but are not limited to: multiple or recent changes to medications; hospital or nursing facility discharge; the participant is unsure of what medications they are taking; discrepancies are noted when collaborating with other health care systems; the participant is taking high risk medications such as opioids and psychotropic medications; the participant is experiencing an adverse drug event or is at risk for one.

Medication lists should be compared against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the participant at all care transition points within the hospital, nursing home and amongst Primary Care Physicians and Specialists. Adherence to the medication regimen should be documented accurately in the participant's case record during monthly contacts and reassessments.

Supports Coordinators are not authorized to handle or administer a participant's medication. Supports Coordinators are only authorized to handle the containers the medications are stored in. This is to gather the information to create or update the medication list in COMPASS.

Procedures

1. The Supports Coordinator will utilize the COMPASS iHC assessment to obtain a complete list of the medications the participant is currently taking, including all prescriptions, herbal supplements, vitamins, homeopathic, and over the counter medications. The Supports Coordinator must complete all COMPASS fields for each medication including, strength, frequency, route, purpose, and prescribing physician. All herbal, homeopathic, and over the counter medications should be listed and noted as such. Supports Coordinators must note all important medication information, including the dosage, how the medication is taken (route/administration), number of puffs for inhalers, number of drops, where a medicated cream is used on the body, etc. This list is reviewed and updated at each Participant reassessment, post-hospital or nursing home visit, and as warranted.
2. Supports Coordinators must ask participants to see all of the medication bottles or containers to confirm all information, as well as any medications kept in other areas of the home, such as a bedroom or bathroom, kitchen fridge, or in a bag/purse.
3. Once the initial assessment is completed, and the medication list is as accurate as possible, the Supports Coordinator should run the Medication/Allergy Report from COMPASS and submit to the participant's primary care physician with the Medical Release Form and request a review. The physician can sign the COMPASS report as accurate, make notes on the report and return, or send the SC their own list. Supports Coordinators will review the physician's records and update the medication list in COMPASS if needed.
4. When a participant is discharged from the hospital or nursing home, Supports Coordinators must review the discharge instructions and medications, noting if there are changes and updating the medication list in Compass.
5. When obtaining skilled care or hospice plans of care and medication lists, Supports Coordinators must review the information, noting if there are changes and updating the medication list in Compass.
6. All documentation of reconciliation received from the participant's physician or any other provider should be saved in the participant's case record.
7. The Supports Coordinator is responsible for a thorough assessment of the participants health literacy regarding their current medications and their uses. The Supports Coordinator should assess the participant's understanding of their medical diagnoses and reason for taking each medication. Education should be provided when needed and documented in the participant's case record.
8. Supports Coordinators are also responsible for assessing any risks related to medication management. The participant's process for managing their medications should be thoroughly documented in the assessment. If the participant's compliance rate for taking medication is less than 100%, Supports Coordinators should be looking to see what interventions are needed to improve compliance. The Supports Coordinator should assist with mitigation of risks by offering interventions and education when warranted. All interventions related to medication management must be added to the participant's Person-Centered Service Plan, and any education provided should be documented in the participant case record.
9. If the Participant does not agree or authorize medication management interventions recommended by the Supports Coordinator and expresses an understanding of the risks associated with the mismanagement of prescribed medications, the Supports Coordinator will document this in the participant record.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C

Residential Services

Policy Number: 2022-20	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The Residential Services option within the Community Living Supports (CLS) Service Standards allows for the provision of CLS and a number of other MI Choice Waiver services to be provided within a licensed Adult Foster Care (AFC) or a licensed Home for the Aged (HFA). Residential services enhance the continuum of care for persons in need of long-term care who choose not to receive services in a nursing facility. This option provides services beyond the usual and customary services provided by AFCs and HFAs and allows participants to age in place.

Policy

Mi Choice Waiver services provided through the residential services option includes only those services and supports that are in addition to, and must not replace, usual and customary supports and services furnished to residents in the licensed setting. Community Living Supports do not include any of the costs associated with room and board. The Participant and/or the participant's informal supports will be expected to pay the home's traditional room and board costs. Room and board costs would be reflected in a monthly lease agreement between the participant and the AFC/HFA. Supports Coordinators will request a copy of the signed agreement, denoting the participant's monthly costs, and place in the participant file.

Only 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, Supports Coordinators will coordinate with the Waiver Director and Quality Assurance Department to establish a formal agreement. Residential services can not be provided until a formal agreement is in place.

UPCAP requires all contracted AFC/HFAs to meet all requirements as outlined in the Home and Community-Based Services Final Rule for all provider-controlled settings. Therefore, modifications to the HCBS Final Rule will not be authorized.

Each participating AFC or HFA will be required, as part of their contractual agreement with UPCAP, to provide documentation indicating the daily assistance provided to residents through its "Usual and Customary Services" provision of licensure. The documented amount of usual and customary care is to serve as the baseline for all service planning activities as part of establishing the participant's PCSP.

When a participant, who is a SSI recipient, is receiving Mi Choice Waiver services in an AFC/HFA home, the home will no longer be eligible to receive the personal care supplement from MDHHS as they will now be receiving payment for authorized services from MI Choice.

Referrals, Assessment, and Eligibility

The referral and assessment process remain the same for potential participants utilizing community-based Mi Choice Waiver services or the Residential Services option. To utilize Residential Services, a potential participant must meet all eligibility criteria for the MI Choice Waiver program: medical/functional eligibility; financial eligibility; service need.

Supports Coordinators complete the initial assessment process as usual and establish a level of service intervention required by the Participant. The total hours of service needed on a daily basis, as determined by the Supports Coordinator through the assessment process, is then compared to the "usual and customary" care provided by 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. This amount qualifies the participant as having a "service need" in relation to the eligibility requirements for MI Choice Waiver enrollment. If it is determined that the facility meets the participant's daily needs through the usual and customary care provided, the participant is not eligible for the MI Choice Waiver as the participant does not meet all of the eligibility requirements for enrollment – i.e. service need.

To determine the amount of care being provided by the home, the Supports Coordinator is to review progress notes, current care plans, 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 provide

Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The participant PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with Activities of Daily Living may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure.

Example: Supports Coordinator 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.

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.

Enrollment and Service Arranging

The enrollment process remains the same for participants utilizing community-based Mi Choice Waiver services or the Residential Services option. After determining eligibility, the Supports Coordinator must submit the appropriate paperwork for Mi Choice Waiver enrollment.

Each participating facility establishes an hourly rate for services as well as the baseline of usual and customary services. This information will be maintained by UPCAP's Waiver Director and made available to each Care Management office. Residential Services are reimbursed on a monthly per diem rate. The per diem rate will likely be different for each participant based on the facility and the participant's overall care needs.

When arranging residential services, the Supports Coordinator must complete a traditional Work Order as well as a Summary of Residential Services and Per Diem Rate. The Summary of Residential Services and Per Diem Rate establishes what UPCAP will reimburse the home on a monthly basis for services provided to the participant. [Summary of Residential Services & Per Diem Rate]

To complete the "Summary of Resident Services and Per Diem Rate" document, Supports Coordinators 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.

The monthly per diem rate is adjusted in the following three situations:

1. If the Participant enters the AFC/HFA or is enrolled in the MI Choice Waiver after the 10th day of the month, the Supports Coordinators are to multiply the daily care total 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 Supports Coordinators of any hospitalization, leave of absence or death of the Participant. Supports Coordinators 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.

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. Supports Coordinators are responsible for establishing their person-centered 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.

The Supports Coordinator will be responsible for negotiating an agreement between the AFC/HFA home and the in-home service provider. The agreement should include a statement that holds 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. This agreement must be in place before UPCAP can purchase services on behalf of the Participant and a copy must be placed in the participant's file.

References

Medicaid Provider Manual - MI Choice Waiver

	# Self-Determination Program	
Policy Number: 2022-21	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

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 the Bureau of Aging, Community Living, and Supports (ACLS Bureau). It allows Participants in the Waiver and Care Management to direct and manage their services. The Participant and their supports work with the Supports Coordinator to determine the appropriate level of services (based on the PCSP/Care Plan) utilizing the person-centered planning process.

Policy

It is the policy of UPCAP Services, Inc. to provide all participants with information on the Self Determination Program. The Supports Coordinator should explain the details of the program and assist the participant with enrollment if desired. 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 managed by the Participant may include multiple SD approved services, or just one.

Procedures

All Waiver Participants are eligible to participate in the SD Program. Participants may choose to involve someone to assist them with the process – informal supports, spouse, DPOA or Guardian. The Participant may also choose to elect a Representative to manage their self-determined services on their behalf. This Representative, however, cannot be a paid caregiver.

If a Participant needs assistance with managing aspects of the self-determination program, including assistance with managing or supervising employees, services and/or supports, the Supports Coordinator will provide additional training or resources to the participant.

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) or Guardian in place. The DPOA or Guardian must be willing to act as the Representative for the Self Determination option or assign another representative and, therefore, cannot be a paid caregiver.

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 does the following:

- 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 or their designated Representative 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 work with their Supports Coordinator 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.

If a Supports Coordinator feels a Participant is not able to direct or manage their services, and lacks the informal supports or ability to elect a Representative, the SC must address these concerns with the Program Supervisor or Program Director. If it is determined that the SD option is not appropriate, the Supports Coordinator must issue a formal Adverse Benefit Determination and provide the Participant with the right to appeal. 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 Supports Coordinator option.)

After the Supports Coordinator 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 Supports Coordinator and the Supports Coordinator Supervisor. The Supports Coordinator 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 Supports Coordinator and Participant of the budget start date. This date must be written on the Enrollment Agreement, signed by the Supports Coordinator and Participant, and a copy sent to the Supports Coordinator Team Leader, Regional Supervisor or Program Director.

The Supports Coordinator Team Leader, Regional Supervisor or Program Director will sign the Budget template giving final approval and mail a copy to the FI, Supports Coordinator, and UPCAP's Accounting Department. The FI will send UPCAP an invoice for 1/12 of the annual budget amount so they can begin paying the SD Participant's employees.

Employee Requirements

Supports Coordinator 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 house cleaning and chore services. Supports Coordinators 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

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.

- Supports Coordinators 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.
- Supports Coordinators complete the annual budget (DSP Budget form) and send to Supports Coordinator Supervisor for approval.
- Supports Coordinator Supervisor signs budget and mails to Participant for their signature.
- Supports Coordinators have Participant sign SD Enrollment Agreement with start date of budget and send to Supports Coordinator Supervisor.

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 Supports Coordinator, 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.

When developing the hourly rate or wage, Supports Coordinators must use the average agency rates of existing UPCAP contracted providers, by service, to determine the total amount budgeted.

If a Participant is currently receiving traditional Waiver services and those services are meeting their needs but has elected to switch to self-determination, 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 Supports Coordinator along with the Participant will determine the appropriate number of service hours.

All budgets must be approved by the Team Leader, Regional Supervisor or Waiver Director before implementation. Participants must sign a copy of their Plan of Care acknowledging their approval of the budget.

Wage Increases

If a Participant requests a wage increase for their employee, the Supports Coordinator must discuss the potential impact it may have on their ongoing budget. A revised Work Order must be completed noting the wage increase and submitted to Data Entry.

Services

The Self-Determination option can be utilized for the following services:

- Chore services
- Community Health Worker
- Community Living Supports
- Community Transportation
- Environmental Accessibility Adaptations
- Fiscal Intermediary Services
- Goods and Services (gaps services under traditional Waiver, not available for Care Management Participants)
- Nursing Services
- Private Duty Nursing/Respiratory Care
- Respite – At home or home of another

The **fund code** for self-directed services is 108 (202 for 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. Supports Coordinators are to use the HCPCS code for the service being provided by the employee as with a traditional agency, utilizing fund code 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

The FI shall bill UPCAP on a bi-weekly basis utilizing Vendor View. They must also complete a monthly expenditure report/budget for each participant. A copy of the monthly expenditure report/budget is sent to the participant and the Supports Coordinator.

The Supports Coordinator 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 Supports Coordinator or FI unless there is a pattern of over spending, or if an item or service appears on the report that the Supports Coordinator did not approve. The Supports Coordinator should then contact the Participant and FI immediately.

All AWCs shall bill on a monthly basis utilizing Vendor View. The AWC will contact the Supports Coordinator 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 Supports Coordinator must contact the FI and tell them what is being purchased, the cost and the name of Vendor. The Vendor must have a signed contract with UPCAP in order to be reimbursed by the FI.

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

Required Forms

Fiscal Intermediary Option

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

Agency with Choice Option

- Self Determination Enrollment Agreement - signed by Participant, Supports Coordinator, and Representative if applicable. Copy to Participant and AWC
- Employment Agreement - signed by AWC, Participant, and Employee. AWC will supply copy to Participant, Employee, and Supports Coordinator
- Annual Budget (DSP form)
- Person Centered Service 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 Care Management Participants

The ACLS Bureau 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 Regional 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 ACLS Bureau.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C

	# Services - Service Arranging		
Policy Number: 2022-22	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022	
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC	

Policy

MI Choice Waiver agencies are required to authorize and purchase all approved waiver services that a participant needs to live successfully in the community that are:

- indicated by the current assessment;
- detailed in the person-centered service plan (PCSP); and
- authorized in accordance with the provisions of the MI Choice Waiver.

Procedures

Services

Waiver agencies are not able to use MI Choice Waiver Medicaid funds to pay for services not specifically authorized in advance and included in the participant's PCSP. Supports Coordinators must also ensure that the service requested and authorized is medically necessary to ensure the ongoing wellbeing and safety of the participant. Services cannot be authorized for the financial benefit of the participant.

Supports Coordinators may only purchase services as authorized in the Medicaid Provider Manual - MI Choice Waiver with MI Choice Funds. Supports Coordinators must pay specific attention to each service definition, corresponding HCPCS codes, minimum standard and limitations and ensure, through documentation in the participant's file, that the participant meets the requirements of each service before authorizing and arranging.

The participant must be informed of all authorized and contracted service providers and have access to any willing and qualified provider within UPCAP's provider network. The participant has the option to select any participating provider in the network, thereby ensuring freedom of choice. The participant must also be informed that any existing services provided through grant-funded sources (ACLS Bureau) will now be provided by the MI Choice Waiver. This may result in a change in service provider if the grant-funded provider is not a contracted Waiver provider.

Waiver participants cannot be asked to contribute to the cost of their MI Choice Waiver services. However, services paid for using MI Choice funds must not duplicate or replace services available through the State Plan Medicaid or Medicare, if applicable. Supports Coordinators must explore other options for available payers first - i.e. Medicaid State Plan, Medicare, Tribal, Veterans Administration, etc. – prior to authorizing Mi Choice payment and must document these attempts in the participant's file. MI Choice is the payor of last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Waiver Service Definitions

The following services are authorized for purchase through the MI Choice Waiver:

- **Adult Day Health:** Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the PCSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.
- **Chore Services:** Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third-party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
- **Community Health Worker:** The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists the participant with obtaining assistance in the community. Not applicable to UPCAP's MI Choice Waiver at this time.
- **Community Living Supports:** Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate waiver service for the beneficiary.
- **Community Transportation**: The Community Transportation (CT) service combines non-emergency medical transportation and non-medical transportation into one transportation service. CT services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual plan of services. The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants.
- **Counseling:** Professional level counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems and/or change in an individual's social situation. Counseling may only be provided through the MI Choice Waiver if no other resources are available.
- **Environmental Accessibility Adaptations:** Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization. Assessments and specialized training needed in conjunction with the use of such EAAs are included as a part of the cost of the service.
- **Fiscal Intermediary Services:** Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's PCSP, controlling a participant's budget, and choosing staff authorized by the waiver agency. The fiscal intermediary helps a participant manage and distribute funds

contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's PCSP. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant directed budget expenditures and identifying potential over- and under-expenditures, and assuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history review checks, and assisting the participant to understand billing and documentation requirements.

- **Goods and Services:** Goods and services are services, equipment, or supplies not otherwise available through the MI Choice waiver or the Medicaid State Plan that address an identified need in the individual PCSP, including improving and maintaining the participant's opportunities for full membership in the community.
- **Home Delivered Meals:** Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or a selected congregate meal site that provides a minimum of one-third of the current recommended dietary intake (RDI) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets as indicated in the participant's PCSP. HDMs cannot constitute a full nutritional regimen.
- **Nursing Services:** MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services shall not duplicate services available through the Medicaid State Plan or third payer resources.
- **Personal Emergency Response System (PERS):** A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided.
- **Private Duty Nursing (PDN)/Respiratory Care:** Private Duty Nursing (PDN)/Respiratory Care services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of nursing/respiratory care assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act or respiratory therapists, consistent with physician's orders and in accordance with the participant's PCSP. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance. PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.
- **Respite:** Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. Services may be provided in the participant's home, in the home of another, a Medicaid-certified hospital, a licensed Adult Foster Care facility, or a Nursing Facility. Respite does not include the cost of

room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence.

- **Specialized Medical Equipment and Supplies:** Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items shall meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.
- **Supports Coordination:** Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's PCSP. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.
- **Training:** Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's PCSP. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, Training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring, training, and supervision, or other areas related to self-direction.

[Refer to Medicaid Provider Manual - MI Choice Waiver]

Provider Selection

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

- The Supports Coordinator will provide the participant with a list of contracted providers available within the service area.
- If a participant indicates a specific choice of provider, the Supports Coordinator will contact the selected provider to arrange services.
- If the participant 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 Supports Coordinator 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. [Link to Self Determination Policy]
- If a participant wishes to utilize a provider that is not enrolled as a contracted provider for UPCAP, Supports Coordinators will assist in coordinating the provider's potential enrollment. Supports Coordinators will contact the potential provider to assess provider interest. If interested, Supports Coordinators will notify the UPCAP's Quality Assurance Manager to start the process.

Service Arranging

Supports Coordinators must establish both frequency and duration of service delivery as part of the care planning process. Supports Coordinators are responsible for contacting the requested provider, confirm the provider's capacity to meet the participant's needs, and determine a formal start date for each service. This is applicable for services being purchased through the MI Choice Waiver or being arranged through a different payor source.

If the service requested requires a physician's order, the Supports Coordinator is responsible for contacting the participant's physician and coordinating the receipt of the corresponding order. Orders must be documented in the participant's file. The requirements for orders are outlined in the Minimum Operating Standards. Supports Coordinators must keep track of the due dates and renewal periods for each required order.

The COMPASS iHC Assessment and corresponding PCSP must be completed and finalized before services can be arranged. The Supports Coordinator must also have a signed and authorized care plan costs review documented in the participant's file before services can begin. Supports Coordinators must attempt to have service delivery begin within seven (7) days of the finalized assessment or develop an alternative plan with informal supports to address the participant's needs until formal service delivery can begin. This must be documented in the participant record.

If a requested provider is unable to meet the participant's needs, the Supports Coordinator will coordinate other potential service delivery options with the participant and other providers. If there is no availability of requested services available, the Supports Coordinator will need to clearly document the lack of provider availability in the Participant's file. The Supports Coordinator will also need to document communication with providers to discuss potential availability on an ongoing, monthly basis until services are arranged.

Care Plan Costs Review

All initial participant care plan costs must be approved by a Field Office Team Leader or the Regional Supervisor before a start date for services can be determined. Supports Coordinators must complete a Care Plan Costs Review for each participant and submit to the appropriate staff person for review and signature. The Care Plan Costs Review must list out the services requested or needed by the participant during the care planning process, the hours/units per week, the monthly costs for each individual service, the overall care plan costs for the first month, and the ongoing monthly costs of the care plan. Once submitted for approval, the Team Leader or Regional Supervisor will review the completed form as well as the participant's corresponding PCSP to ensure that the cost review is appropriate and accurate. Once approved, the signed Care Plan Costs Review will be returned to the Supports Coordinator. The Supports Coordinator will document care plan approval in the Participant record and place the copy of the signed document in the Participant's file. Care Plan Cost Review Form

Work Orders

Work Orders must be used to formally authorize the type of service to be provided, total units, time of day, day of week, start and stop dates, and any changes in services. Work orders are also used to authorize services that are not ongoing and only need to be authorized on a one-time only basis.

- Work orders need to be completed and submitted to the appropriate Case Tech for entry prior the service start date.
- Work Orders must also include information about risks related to health and welfare decisions made by the participant and any instructions the provider should follow in order to minimize risk to agency staff and/or the participant.
- Work orders must contain information regarding participant allergies (pharmaceutical, environmental, or food-related) and any dietary restrictions.
- Work Orders must contain the participant's priority status/service need level
- Work Orders must include appropriate HCPCS codes for each service being ordered and the priority status of the participant.
- Work Orders must include the appropriate fund code for each service being ordered.
- 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 be put on HOLD or STOP unless a specific stop date is indicated on the original Work Order. Supports Coordinators may utilize the participant service summary in COMPASS to HOLD and RESUME services if appropriate.

For some services, such as chores (snow plowing & lawn mowing), days per week can be defined as "when needed." If the authorization states, "when needed," the Supports Coordinator must define when the participant needs such services, i.e. two or more inches of snow, grass is four inches or higher, etc.

Healthcare Common Procedure Coding System (HCPCS) codes for each available MI Choice service and applicable fund codes can be found in UPCAP's HCPCS Code Manual.

[Work Order Forms]

Vendor View

Once the Case Tech enters the work order into MICIS, it will generate a notice to the selected provider in Vendor View. The notice will include the approved service type, frequency, and duration of the service along with any additional notes for the provider as listed on the work order. A Vendor View notification alone is not sufficient to the process of arranging services. The Supports Coordinator is required to call the provider and confirm availability prior to submitting the work order. The provider must receive the service authorization in the form of a formal work order/Vendor View notification before services can begin. The service provider will be required to view the service authorization, accept, and then archive the notice within the system to be considered complete. The date, time, and user identification will be attached to each service authorization once archived. This will act as the service providers "written" confirmation that they assume the responsibility for service implementation.

The majority of UPCAP's contracted providers are registered in Vendor View. However, for contracted or non-recurrent providers not enrolled in Vendor View, work orders should be faxed or mailed 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. Vendor View Providers

Service Summary

Once all work orders have been entered for a participant's care plan, the current authorized services, service provider, frequency, cost per unit, days/times, and total monthly care plan costs can be found on the participant's service summary populated in COMPASS. It is the responsibility of the Supports Coordinator to review the participant's service summary on a regular basis and ensure that the services currently authorized in the system reflect the plan of care and work orders submitted. Supports Coordinators are responsible to send a copy of the service summary with a copy of the person-centered service plan (PCSP) to participants and/or their designated representatives with each permanent change to the current service plan - i.e. when a service is added, changed, or stopped.

Home Modifications

Any Environmental Accessibility Adaptation or Home Repair requested by the Participant, totaling over $600.00, requires a bidding process and Director Approval before a start date can be determined. Per Waiver service Standards, all alternative funding sources must be exhausted prior to the authorization of a service utilizing MI Choice Waiver funding. Supports Coordinators are responsible for documenting evidence, within the Participant's case record, that the adaptations or repairs being requested are the most cost-effective and reasonable alternative to meet the participant's needs. There must also be documentation that such adaptations or repairs are necessary to ensure the health and welfare of the participant or enable the participant to function with greater independence in the home, and without which the participant would require institutionalization.

[Refer to ***Policy Number: 2022-24 - Environmental Accessibility Adaptations/Home Modifications*** for more information on procedures]

Durable Medical Equipment & Medical Supplies

Before Waiver funds can be used to purchase any type of equipment, supplies, or items, Supports Coordinators are to seek payment from other potential sources: Medicare, State Plan Medicaid, Veterans Administration, or private insurance. 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 Supports Coordinator 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 state plan items. If a DME Company is unwilling to provide this required denial, then Waiver funds cannot be used to purchase the state plan service/item on behalf of the Participant unless a Waiver is granted by MDHHS. Supports Coordinators must thoroughly document all conversations with DME companies related to requests for DME or other Medicare/Medicaid reimbursable services.

Supports Coordinators 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. DME Work Order

Lift Chairs

When purchasing a lift chair from a DME company, UPCAP requires the company to 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. Supports Coordinators must use the lift chair Work Order giving instruction to the DME Company to bill Medicare and Medicaid first. The DME Company must send the denial to UPCAP along with the bill before UPCAP will pay for the chair.

In the event that a contracted DME provider is not available, Supports Coordinators may purchase a lift chair through a furniture company with Waiver Director approval. Lift Chair Work Order

Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is a benefit of the MI Choice Waiver program for participants who need assistance getting to and from their medical appointments, pharmacy, urgent care, or hospital.

[Refer to ***Policy Number: 2022-23 - Non-Emergency Medical Transportation***]

Goods and Services

Goods and services are intended to be used by participants enrolled and utilizing Self-Determined services. 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 participant 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 participant's care plan and authorized prior to purchase.

Special approval can be requested for goods and services needed by participant's not enrolled or utilizing self-determined services. However, MI Choice Medicaid funds cannot be used to purchase the items. UPCAP will have to utilize alternative funding sources (221 Fund Code) and will require Waiver Director or Regional Supervisor approval.

Direct Interventions

Supports Coordinators 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 the care plan. 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 or as a substitute for therapeutic treatment for a licensed therapist. 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 Supports Coordinators must continually strive to increase their knowledge regarding regulations of various service programs, and are to seek advice or assistance as needed.

Unauthorized Services

When a Provider furnishes a service in excess of the authorization level, the Provider is essentially rendering a free service to the participant and payment utilizing Waiver funds CAN NOT be made. CMS regulations require that all services must be authorized on participant care plans, and corresponding work orders. For this reason, Supports Coordinators 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 but has not been authorized on the initial care plan or subsequent updates. Usually such events will take place when a Supports Coordinator is not available to discuss the situation with the Provider Agency (evenings or weekends). In such situations, the provider should notify the Supports Coordinator of service provision within 24 hours and provide justification for the extra hours. If appropriate, the Supports Coordinator should approve the additional time provided. In such situations, the Supports Coordinator shall be responsible for completing a one-time only Work Order and submit to the appropriate Case Tech for entry into the system.

Participant Not Utilizing Approved Services

For participants who have multiple instances where they fail to notify their Supports Coordinator or the service provider when they are not home, or who regularly send provider staff home without service provision, Supports Coordinators are to re-evaluate the need for the service and if appropriate, adjust the service plan with the participant's approval.

Provider Missed Visits

Service providers are responsible for immediately notifying UPCAP Services staff if, for any reason, the Provider is unable to provide services to the Participant, as negotiated, (i.e., unavailability of staff, inclement weather) or if a service is not provided as agreed to (i.e., Participant is not at home, an on-going request to change hours or days). The provider must submit documentation of any missed visit through the messaging option in Vendor View or submit the approved Provider Service Log (PSL) on a daily basis.

Case Techs from each Care Management office will check these notifications in Vendor View regularly. Once a notification is received, the Case Tech will print the notification, update the care plan in MICIS to reflect the decrease, and provide a copy of the printed notification to the Supports Coordinator for review. No work order is required as the Vendor View notification acts as the decrease/missed authorization.

If a Provider does not utilize Vendor View, they are required to submit a PSL to notify UPCAP of any missed visits. When a PSL is received, the Case Tech will update the care plan in MICIS to reflect the decrease/missed visit and provide a copy to the Supports Coordinator for review. Daily emails from providers that include notice of missed visits, including detailed reason, can be qualified as a PSL as long as they are printed, the appropriate Case Tech is notified, and a copy of the email is added to the participant file. No work order is required as the PSL acts as the decrease authorization.

If a Supports Coordinator receives notice of missed visit from a source other than a PSL or Vendor View notification, the Supports Coordinator will contact the service provider and request that they complete a formal PSL or notification in Vendor View.

If a Supports Coordinator is notified of a canceled visit or decrease in advance, they will be responsible for following up with the participant to ensure that the participant is aware and to implement the back-up plan for service provision if necessary. The Supports Coordinator will also need to complete a one-time only Work Order for the decrease and submit it to the appropriate Case Tech for entry.

References

Medicaid Provider Manual - MI Choice Waiver

Non-Emergency Medical Transportation (NEMT)

Policy Number: 2022-23	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC

Policy

Non-Emergency Medical Transportation (NEMT) is a benefit of the MI Choice Waiver program for participants who need assistance getting to and from their medical appointments, the pharmacy, urgent care, or the hospital. Supports Coordinators are required to notify participants of the availability of this benefit. This benefit is only for non-emergency medical appointments and Supports Coordinators are not required to honor requests if the participant did not give advance notice of at least one day (24 hours).

As with any service, the Supports Coordinator must utilize family, neighbors, friends, or community agencies that can provide this service without charge. MI Choice Waiver funds can be utilized when all other options are exhausted or no other options are available.

In order for a participant to access NEMT they must contact their Supports Coordinator prior to the scheduled appointment to approve the transportation and determine if the medical appointment is for a Medicaid-covered service. If the appointment is not for a Medicaid covered service, we are not allowed to reimburse for transportation. Participants should not be contacting the family, friend, volunteer, public transporter, etc., for transportation services without prior authorization from the Supports Coordinator if it is going to be billed to UPCAP.

For out of town transportation, Supports Coordinators must determine if the same appointment could be made locally before authorizing the use of NEMT services. Example: Participant from Escanaba calls and needs transportation to an Orthopedist in Iron Mountain, but Escanaba has multiple Orthopedists to choose from. In this case we would not provide NEMT and the Supports Coordinator would have to send an Adverse Benefit Determination for denial of services.

The NEMT service does not cover out of state travel unless the participant cannot receive the same treatment in Michigan. Any out of state travel must be documented thoroughly with rationale as to why out of state travel is required.

If a Supports Coordinator determines the participants qualifies for NEMT, they must arrange the transportation through one of the following methods:

- Volunteer transporters (needs agreement)
- Home Health agency currently providing services to the participants (needs agreement)
- Public transportation (needs agreement)
- Reimburse family or friends (no agreement needed)
- Self-Determination worker, if no transportation was previously included in the plan of care

Prior to authorizing NEMT, the Supports Coordinator must determine what type of hands on assistance the participant will need for transportation. This should be discussed with the transporter so they know in advance what is expected and if they will be able and willing to provide the service.

Volunteer Drivers

All volunteer transporters must sign an agreement with UPCAP, complete a background check, supply a copy of a valid driver's license and submit proof of insurance for the vehicle they will be utilizing to transport the participant. Volunteers must be able to assist the participant from their home into the vehicle and into the building of appointment. Anything more than that needs to be confirmed with the driver before the appointment.

NEMT Reimbursement Form

For volunteer drivers, family, or friends, one reimbursement form per transporter needs to be completed. NEMT Reimbursement Form

The Supports Coordinator must fully complete Section 1: *Participant Information & Approved Expenses* and Section 2: *Medical Provider Information*. The Supports Coordinator is responsible for reviewing the appointment time and estimated travel time to authorize approved meals. The Supports Coordinator must then sign and date the form. The Supports Coordinator will then provide the driver with the form.

The individual driver being reimbursed must fully complete Section 3: *Medical Transportation Information* and Section 4: *Reimbursement*. All sections of the form, including departure and return times, must be completed in order to obtain reimbursement. The form will be returned to the driver if not completed correctly and payment will be postponed. The driver must also obtain a signature from the MD or their representative to confirm the appointment and need for NEMT. **Request for reimbursement will be denied without the MD signature.**

If the participant is requesting reimbursement for meals, a separate form must be completed by the Supports Coordinator authorizing the approved meals. Any individual being reimbursed by UPCAP will need a separate form, unless they agree that one person will be paid by UPCAP and then they will reimburse the others.

For ongoing appointments (weekly dialysis, monthly labs, etc.), the Supports Coordinator may use one reimbursement form authorizing NEMT as an ongoing service. The Supports Coordinator will complete their required sections and check "Ongoing Appointments" in Section 2, making note of the frequency of the scheduled appointments (i.e. weekly, bi-weekly, 3x/wk, monthly, etc). After the Supports Coordinator signs and dates the form, they may make several copies and send them to the driver scheduled to provide the NEMT, eliminating the need for a new form with each appointment.

Attendant Fee

The attendant fee is provided for volunteers or friends who need to assist the participant inside the physician's office and wait inside the appointment for them. The attendant fee is not reimbursable to family members and is not reimbursable for someone just walking the participant to the door.

Meal Reimbursement

Meal reimbursement is available to the driver and the participant as long as all criteria is met. Meals are only reimbursable when traveling out of the local area. Meals are unable to be reimbursed for participants when purchased within a 30-mile radius of their home. Volunteer driver meals are not able to be reimbursed for meals purchased in the town in which they live. Agency staff or SD workers are not eligible for meal reimbursement. **All meals must be supported by a detailed receipt (not credit card receipt). Receipts must show date, time, place of purchase, detail of what was purchased and cost.**

- Breakfast: The vehicle with the beneficiary must depart at, or before, 6:00 AM and must return at, or after, 8:30 AM/$8.50
- Lunch: The vehicle with the beneficiary must depart at, or before, 11:30 AM and must return at, or after, 2:00 PM/$8.50
- Dinner: The vehicle with the beneficiary must depart at, or before, 6:30 PM and must return at, or after, 8:00 PM/$19.00

Mileage Reimbursement

Only Volunteer Drivers can be reimbursed for mileage from their home to the client's home, to the appointment, and back. Family or friends only get reimbursed from client home, to the appointment, and back.

Documentation

All NEMT must be documented in progress notes and added to the PCSP if it will be an ongoing service.

Public/Private Transportation Providers

For public or private transportation providers (vendors) or Self-Determination (SD) workers, a work order is completed and submitted for data entry and a copy sent to the provider. These providers are not required to complete an NEMT form, nor are they required to obtain a physician's signature. They would bill like they normally do. A reimbursement form would only be needed for the **participant** if they want reimbursement for a meal.

The SD worker will be paid through Northern Home Care or GT Independence at the rate in their agreement with UPCAP and not subject to meal reimbursement. Out of State travel provided by a SD worker will be handled on a case-by-case basis. Requests and rationale must be submitted to the Director of Long-Term Care Programs, Terry LaFave.

Submission of NEMT Form

Completed NEMT forms must be submitted to the Director of Long-Term Care Programs to be processed, along with any receipts (if applicable).

References

Medicaid Provider Manual - MI Choice Waiver

Environmental Accessibility Adaptations/Home Modifications

Policy Number:2022-24	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC

Policy

Environmental Accessibility Adaptations (Home Modifications) are physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participants would require institutionalization.

It is the policy of UPCAP Services, Inc. that all Supports Coordinator follow procedures as defined below and in the Medicaid Provider Manual - MI Choice Waiver.

Procedures

Due to the nature of home modifications and repairs under Environmental Accessibility Adaptations and/or Chore Services, review and authorization of the proposed service must be completed prior to the start date of the service. The following procedures apply when considering authorization of a Mi Choice Waiver service under any of the following HCPS and Standard Remark codes:

S5165 Home Modifications, per service	**S5165 Home Modifications, per service**	**S5120 Chore Services, per 15 min**	**S5120 Chore Services, per diem**
5001 Bathroom Modification	5011 Ramp Installation	6002 Install Safety Equipment	6002 Install Safety Equipment
5002 Kitchen Modification	5012 Ramp Repair	6004 Window Installation	6004 Window Installation
5003 Specialized Door Locks	5013 Portable Ramp	6005 Window Repair	6005 Window Repair
5004 Doorway Modification	5014 Safety Railings	6008 Replace/Repair Electrical	6008 Replace/Repair Electrical
5005 Equipment Installation Charge	5015 Wireless Door Alarm	6009 Replace/Repair Plumbing	6009 Replace/Repair Plumbing
5008 Outside Railings	5016 Specialized Electrical System Installation	6011 Install Storm Door	6011 Install Storm Door
5010 Stair Lift	5017 Specialized Plumbing System Installation		
	5018 Other Repair		
	5019 Weatherization		
	5020 Injury Prevention		

Per Waiver service Standards, all alternative funding sources must be exhausted prior to the authorization of a service utilizing MI Choice Waiver funding. Supports Coordinators are responsible for documenting evidence, within the Participant's case record, that the adaptations or repairs being requested are the most cost-effective and reasonable alternative to meet the participant's needs. There must also be documentation that such adaptations or repairs are

necessary to ensure the health and welfare of the participant or enable the participant to function with greater independence in the home, and without which the participant would require institutionalization.

The Participant's home must be intended to be the permanent residence of the Participant and cannot be a condemned structure. If the home is rented by the Participant, the Supports Coordinator must verify, through examination of the rental agreement, that the landlord/landowner is not responsible to furnish repairs or modifications. Adaptations may be made to rental properties when the lease or rental agreement does not indicate the landlord/landowner is responsible for such adaptations, and the landlord/landowner agrees to the adaptation in writing.

Supports Coordinators will attempt to secure two estimates for all home repair/modification services exceeding $600 prior to authorizing the work. Supports Coordinators will contact potential providers, as requested by the Participant, and provide them with the **Provider Bid/Estimate Form** to complete and return. After securing all of the bids/estimates for the proposed adaptations or repairs, the Supports Coordinator must complete and submit the **Home Repair/Modification Request Form.**

If the Supports Coordinator is not able to secure two estimates, there must be documentation within the Participant case record that multiple attempts were made to secure multiple estimates. The Supports Coordinator must also note on the Home Repair/Modification Request Form if two estimates are not available.

All services must be provided in accordance with applicable state or local building codes. For more specific standards and minimum requirements, please refer to the Mi Choice Contract – Attachment H.

Process

1. Supports Coordinators must complete all fields on the Home Repair/Modification Request Form.
    . **Supports Coordinator Information** – *Full Name, Direct Phone Number, Direct Fax Number*
    a. **Participant Information** – *Full Name, Address of proposed repair/modification, Participant phone number, and Alternative Contact information, if applicable*
    b. **Checkbox regarding participant residence –** *Participant states intended to be permanent residence*
    c. **Property Owner Status** – *If the Participant owns the property, check box 'Participant'. If someone other than participant owns property, check 'Other' and complete the Name and Phone Number fields for the property owner.*
    d. **Brief Description of Work to be Completed w/ Rationale:** *Enter a brief description of the repair/modification being requested with a rationale.*
    e. **Owner Signature:** *If the participant owns the home, they would sign and date. If it is a rental, then the landlord/landowner must sign and date.*
    f. **Provider Bids:** *Fill out the information for each bid/estimate received and attach the completed bid/estimate form.*
2. Supports Coordinators are to submit, via email, the completed Home Repair/Modification Request Form, including all corresponding Provider Bids/Estimates received to the Waiver Director (Terry LaFave) and Executive Director (Jonathan Mead).
3. Once a bid/estimate has been approved, the Waiver Director or Executive Director will provide a signature on the Home Repair/Modification Form, formally selecting and authorizing the repair or adaptation. The completed form will be sent back to the Supports Coordinator.
4. The Supports Coordinator will be responsible for notifying the approved Provider and sending them UPCAP's Purchase of Service Agreement for Non-Recurrent Providers and the Direct Purchase Application. Supports Coordinators will explain that the Provider must complete and return the forms with any supporting documentation before the repair or adaptation can begin.
5. The Supports Coordinator will be responsible for coordinating any down-payment or advanced payment required by submitting a Work Order to the appropriate Case Tech for entry.
6. Once the Provider notifies the Supports Coordinator that the work is complete, the Supports Coordinator will request an invoice and a copy of the final inspection report (if available). This must be received within thirty (30) days of project/service completion.
7. The Supports Coordinator is to verify the work is complete, correct, and acceptable to the participant and property owner within fourteen (14) calendar days or ten (10) working days of the notice of completion. This must be documented in the Participant's record.

8. Supports Coordinator must visually review the completed project and photograph the work completed. Photos should be uploaded to the Compass Participant record.
9. Supports Coordinators will submit a work order authorizing the remaining balance, the Provider's final invoice, and a copy of the approved bid to the appropriate Case Tech.

References:

Medicaid Provider Manual - MI Choice Waiver

	# Monitoring & Follow-up		
Policy Number: 2022-25	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022	
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC	

Scope

Monitoring and follow-up includes contact between Supports Coordinators, the participant or service providers to ensure providers deliver services as planned and to the satisfaction of the participant. Supports Coordinators use monitoring and follow-up to evaluate the timeliness, appropriateness, and quality of services implemented under the PCSP. Supports Coordinators monitor all services implemented on behalf of participants as a function of care planning and participant reassessment activities. All contacts are to be documented in the participant case record.

Policy

It is the policy of UPCAP Services, Inc. to complete ongoing monitoring and follow-up with participants according to MDHHS requirements and the procedures below.

Procedures

Participant Progress Notes

Supports Coordinators are responsible for documenting all contacts and correspondence related to a participant's case in the participant's COMPASS case file under Progress Notes. The Supports Coordinator must attempt to enter a record of all contacts within twenty-four (24) hours of when the contact occurred. Supports Coordinators may make late entries in the case record as long as the Supports Coordinator notes that they made the entry sometime after the contact occurred. Late entries must be designated in the note and entered within seven (7) days of the contact.

If it is determined through a peer or supervisory review that previously omitted information should be documented in the case record, the Supports Coordinator may add an entry to amend the record. This entry must be identified as a record amendment and describe why the entry is being made.

No recorded contacts are to be deleted or permanently removed from the participant record for any reason. If previously entered information is incorrect, Supports Coordinators may add entries to the record to correct earlier entries.

Two Week Follow Up

Supports Coordinators contact newly enrolled participants within fourteen (14) days of the agreed- upon service start date to verify the providers deliver services in the manner arranged and to the satisfaction of the participant. This contact must be documented in the participant case record as a "Two-Week Follow Up".

Supports Coordinators may need to contact the service provider in addition to contacting the participant to verify the provision of services and any issues identified by the provider. This requirement does not apply to changed services or participants who are re-enrolling in the MI Choice program after a brief disenrollment period.

Monthly Contacts

Supports Coordinators contact participants on a regular basis to monitor the participant's health and welfare, the provision of services, and the participant's satisfaction with the current PCSP. The standard time frame for contact is every thirty (30) days, but participants can elect to extend the time frame, if needed, to serve the participant's needs. Supports Coordinators must contact the participant no less frequently than every ninety (90) days. Supports Coordinators are not to offer or encourage the extension of the contact time frame unless the participant discloses a need or preference for the extension. The participant's preference for contact is to be documented in the PCSP and progress notes.

It is vital that the participant know that they have a continuous opportunity to provide feedback about services, supports, interventions, and treatments. Participants must be informed that they can contact their Supports Coordinator to discuss their needs at any time during normal business hours.

All follow up and monitoring contacts must be recorded in the participant case record. Any changes in services negotiated during follow up and monitoring on behalf of the participant must also be recorded in the participant's PCSP.

Change in Home Environment

Supports Coordinators are required to complete an in-person meeting (home visit) within seven (7) calendar days of a participant moving or transferring from one residence to another (not nursing facility or hospital) to ensure that participant's needs are being met and to update any assessments as necessary. Supports Coordinators should conduct an assessment of the new living environment and note any accessibility issues or needs. Supports Coordinators will document the in-person visit in the participant record.

Provider Follow Up

Supports Coordinators are required to provide oral or written feedback to providers regarding services furnished according to the PCSP when the Supports Coordinator receives complaints from participants. Supports Coordinators are to maintain lines of open communication with service providers to assist in resolving any issues or concerns with service delivery.

Case Conferencing - Service Providers

Each UPCAP Long-Term Care Programs 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 in-home 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 Supports Coordinator
- 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's case record. Documentation pertaining to general issues may be maintained in the form of meeting notes by the office Case Tech, Office Team Leader, or by the Supports Coordinators. Such notes must be maintained for review by MDHHS and/or for the purpose of Quality Assurance reviews.

Provider Agency Staffing/Participant Preference

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 caseloads by luring employees away from another agency.

Supports Coordinators 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, Supports Coordinators may offer additional choices in service providers.

Supports Coordinators 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. Supports Coordinators 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, Supports Coordinators shall attempt to resolve the problem with the provider initially selected. If the problem(s) cannot be resolved to the participant's satisfaction, Supports Coordinators can access a new service provider.

References

Medicaid Provider Manual - MI Choice Waiver

Participant Non-Compliance

Policy Number: 2022-25-01	Effective Date: 11/01/2022	Revision Date(s): 10/10/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC & Case Tech

Policy

At the initial assessment and annually thereafter, Supports Coordinators review the Participant Handbook with the participant, which contains the Participant's Rights and Responsibilities. The participant must acknowledge understanding of these rights and responsibilities and the requirement that these must be followed in order to safely participate in the Mi Choice Waiver program.

In the event that the participant is non-compliant with these requirements, Supports Coordinators are responsible for addressing any issue or allegation of non-compliance. The Supports Coordinator will investigate the allegation in question and follow up with the participant. After looking into the allegation, if the participant is found non-compliant, the Supports Coordinator will issue the participant a Non-Compliance letter, along with a copy of the participant's Rights and Responsibilities, highlighting the areas of non-compliance. The letter will include a summary of the allegation and will remain in the participant's file.

The below process outlines the steps taken to address alleged participant non-compliance.

If the complaint comes from a contracted provider:

- Supports Coordinator requests written documentation of the allegation(s), including any steps or interventions the provider has taken or is planning to take to address the issue.
- Supports Coordinator reviews the allegation documentation.
- Supports Coordinator contacts the participant and informs them of the allegation from the provider, obtains participant feedback on the alleged "incident", and reviews the program rights and responsibilities

If the Supports Coordinator determines that the participant **did** violate program rights and responsibilities:

- Supports Coordinator prints the Rights and Responsibilities, as outlined in the Participant Handbook, and highlights the areas of participant non-compliance.
- Supports Coordinator completes the Non-Compliance Letter, summarizing the violation and issue as it pertains to the Rights and Responsibilities. [Sample Non-Compliance letter]
- Supports Coordinator mails the Non-Compliance Letter and highlighted Rights and Responsibilities to the participant or responsible party.
- Supports Coordinator uploads a copy of both documents and attaches them to the Participant's record in COMPASS. A hard copy of the documents is placed in the Participant's chart.
- Supports Coordinator determines if the situation warrants the completion of the Informed Risk Agreement Form. [Refer to ***Policy Number: 2022-18 Participant Management of Risk*** for process]
- Supports Coordinator documents all communication in COMPASS

If the Supports Coordinator determines that the participant **did not** violate program rights and responsibilities:

- Supports Coordinator notifies contracted provider of the determination
- Supports Coordinator documents all communication in COMPASS

If the complaint comes from any other source:

- Supports Coordinator requests documentation, if applicable
- Supports Coordinator contacts the participant and informs of observation or allegation, obtains participant feedback, and reviews program rights and responsibilities.

If the Supports Coordinator determines that the participant **did** violate program rights and responsibilities:

- Supports Coordinator prints the Rights and Responsibilities, as outlined in the Participant Handbook, and highlights the areas of participant non-compliance.
- Supports Coordinator completes the Non-Compliance Letter, summarizing the violation and issue as it pertains to the Rights and Responsibilities.
- Supports Coordinator mails the Non-Compliance Letter and highlighted Rights and Responsibilities to the participant or responsible party.
- Supports Coordinator uploads a copy of both documents and attaches them to the Participant's record in COMPASS. A hard copy of the documents is placed in the Participant's chart.
- Supports Coordinator determines if the situation warrants the completion of the Informed Risk Agreement Form. [Refer to ***Policy Number: 2022-18 Participant Management of Risk*** for process]
- Supports Coordinator documents all communication in COMPASS

If the Supports Coordinator determines that the participant **did not** violate program rights and responsibilities:

- Supports Coordinator documents all communication in COMPASS

If, after the above process is completed, the participant violates the program rights and responsibilities a second time, the Supports Coordinator contacts the Regional Supervisor and/or Director of Long-Term Care Programs to discuss the situation and determine the next steps. The Regional Supervisor and/or Program Director will determine if a mutual meeting between the participant/representative, provider, supervisor, and Supports Coordinator is appropriate. The Program Director will also determine if program disenrollment due to continued violation of participant rights and responsibilities is appropriate.

At any point in the investigation of participant non-compliance, the participant/representative or the contracted provider are not satisfied with the process, they have the right to file a formal grievance or complaint to be reviewed by UPCAP's Grievance and Appeals Committee. The Supports Coordinator is responsible for providing the information needed to file a grievance, if requested.

[Refer to ***Policy Number: 2022-37 Grievances-Complaints*** for more information]

	# Charting Examples		
Policy Number: 2022-26	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022	
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC	

Policy

It is the policy of UPCAP Services, Inc. to ensure all Supports Coordinators are charting their progress notes appropriately and including language as required by the ACLS Bureau and MDHHS. All notes should include specific information for each participant. If the participant is not currently enrolled in Medicaid, the progress note should include discussion of financial eligibility criteria, review of finances and plan for the filing of a Medicaid application if applicable.

Prior to Assessment

Call participant and/or guardian prior to assessment to confirm visit. This call must be documented in progress notes.

Charting Example: [Standard Note]

Spoke with potential participant and confirmed scheduled assessment time and place. Confirmed potential participant's understanding that they are able to have any other individuals present of their choosing at the assessment.

Assessment

Initial assessment progress note must include:

- SC review of participant handbook, receipt of the UPCAP Informational folder, and review of its contents. Must include review of critical incidents
- Review the Self Determination option and make sure it is charted.
- If requesting Waiver services, need explanation as to why other third-party resources would not meet the participant's needs.
- Brief explanation of why the participant is being enrolled in the Waiver program.
- NFLOC door participant scores under with brief explanation.
- If temporary door, discussion of discharge plan.
- Review of person-centered care planning and choice of service providers.

Charting Example: [Standard Note]

RN & SW Supports Coordinators met with potential participant and daughter in participant home for assessment. Reviewed Participant Handbook, provided participant with UPCAP Information Folder, and reviewed its contents. Reviewed participant rights and responsibilities and HIPAA privacy information. Reviewed critical incidents and the need to report them. Participant signed consent forms and receipt of handbook acknowledgement. Completed NFLOCD. Participant scores under Door 1 for assistance with toileting and transfers in/out of bed. Completed FOC and received participant signature. Participant requests enrollment in waiver program. Participant would not be eligible for Adult Home Help program and Grant services would not meet participant needs. Participant is currently enrolled in Medicaid

per CHAMPS Eligibility Report. Confirmed income and asset requirements for financial eligibility. Reviewed PCP with participant and explained that SC will always follow principles of PCP when care planning. Participant does not desire formal PCP meeting at this time. SC assured participant they could ask for meeting at any time. SC explained SD program option to participant they do/do not wish to participate at this time. Reviewed participant needs and services being requested. Provided list of service providers available to participant. Participant chose (detail services) for services. Reviewed care planning process and if they would like anyone other than themselves to have a copy of their PCSP, they do not.

PCP Meeting

If Participant does desire a formal PCP meeting, a note should be added that includes who will be at meeting, what will be discussed, what won't be discussed, when it will take place, who will record meeting, who will invite people.

Charting Example: [Person Centered Planning Meeting Note]

SC asked participant if they wanted to review some PCP tools that are available that include a questionnaire for participant's family or friends to complete, and a tool for helping participant decide what is important for them. Discussed who will be at meeting, what will be discussed, what won't be discussed, when it will take place, who will record meeting, who will invite people.

Self Determination

If the participant would like to participate in the self-determination program for service delivery, a note should be added regarding review of the SD program at the initial visit or a separate SD meeting should be scheduled at a different time and documented in the note.

Charting Example: [Standard Note]

SC explained SD program option to participant and they do wish to participate. SC will mail educational material to participant for their review. Explained to participant they can choose a representative if they do not feel they can manage the employer responsibilities. Participant may choose to manage employees through a Fiscal Intermediary (GT Financial) or an Agency with Choice (Northern Home Care). SC gave comparison sheet to participant to assist in making decision on best option for managing employees. Completed the SD Enrollment Agreement form. Participant chose to utilize (*SD provider*). Participant would like her daughter to be her employee. SC discussed application process and provided the participant and daughter with a copy of the employee application and directions for submission. SC explained that SD enrollment process could take several weeks to complete.

Scheduling the Reassessment

Call the participant and/or guardian to schedule at least a day before the reassessment. This contact MUST be charted in the participant file and must include:

- That participant was given the choice to have others present at the reassessment.
- Offer the participant the choice of setting for the visit.

Charting Example: [Standard Note]

Spoke to participant to schedule reassessment. Participant requested that SC come out on Thursday afternoon this week. Scheduled reassessment for xx/xx/xx at 1:00pm at the participant's home, per the participants request. Reminded the participant that they can have others present at the reassessment.

90-day Reassessment

- Document the participant's continued NFLOCD eligibility and Door
- Document ongoing Medicaid eligibility
- Document that you reviewed the PCSP and participant goals and signature
- Document you reviewed the Participant Handbook, Medicaid appeals procedure, rights and responsibilities, critical incidents, and ask participant if they still have the UPCAP folder and contents in the home. If you are providing an updated handbook, document and get signature on receipt of handbook acknowledgement form. Ask if they would like to review anything in the folder.
- Document that you reviewed the backup plan and if there were any changes that needed to be made.

Charting Example: [Person Centered Planning Meeting Note]

90-Day reassessment completed with participant at their home. SC reviewed the participant handbook including the MA appeals process, participant rights and responsibilities, critical incidents and the need to report them. Reviewed NFLOCD and functional eligibility status. Participant remains eligible under Door 1. No changes reported to Medicaid eligibility. Completed PCSP review. Participant is happy with current formal and informal services – amount, type and frequency. No changes requested at this time. Reviewed participant goals. Goals and outcomes updated. Participant does not want copy sent to anyone. Participant signed and dated care plan. No interest in a formal PCP meeting at this time but participant is aware they can request one at any time. Reviewed Back up plan, no changes requested.

Reassessment

- Document the participant's continued NFLOCD eligibility and Door
- Document participant signature on FOC, if applicable
- Document ongoing financial eligibility.
- Document that you reviewed the PCSP and participant goals and signature
- Document participant signature on consent forms, if applicable
- Document you reviewed the Participant Handbook, Medicaid appeals procedure, rights and responsibilities, critical incidents, and ask participant if they still have the UPCAP folder and contents in the home. If you are providing an updated handbook, document and get signature on receipt of handbook acknowledgement form. Ask if they would like to review anything in the folder.
- Document that you reviewed the backup plan and if there were any changes that needed to be made.

Charting Example: [Person Centered Planning Meeting Note]

Annual reassessment completed with participant at their home. SC reviewed the participant handbook including the MA appeals process, participant rights and responsibilities, critical incidents and the need to report them, and asked participant if they still had the UPCAP informational folder and contents in the home. He/she does. Participant does not feel the need to review anything in the folder at this time. Completed annual NFLOCD. Participant remains eligible under Door 1. Completed FOC. Participant requests continued enrollment in MI Choice, participant signature received. Reviewed participant finances and confirmed ongoing financial eligibility for Medicaid. Reviewed annual Consent and Authorization and Medical consent forms; participant signed and dated. Completed PCSP review. Participant is happy with current formal and informal services – amount, type and frequency. No changes requested at this time. Reviewed participant goals. Goals and outcomes updated. Participant does not want copy sent to anyone. Participant signed and dated care plan. Reviewed the back-up plan, no changes requested. No interest in a formal PCP meeting at this time but participant is aware they can request one at any time.

Two-Week Service Follow-Up

- Must be completed within 14 days of the start date of services after the participant's initial assessment
- Select a response for each of the Two-Week Service Follow-up Questions and complete the note sections.
- Document the participant's services and satisfaction with the type, amount, and frequency

Charting Example: [Two Week Service Follow-up Note]

Two Week Service Follow-up completed with participant. Participant received their PERS unit in the mail and was able to set up on their own. SC confirmed that they tested the unit and reminded them to test their unit monthly. Home Delivered meals started on 5/14/22. Participant reports that they are happy with their meals. Participant still has not received the World Point materials. SC will follow up and check on status of order.

Monthly Monitoring Contact

- Document the participant's services and their satisfaction with the type, amount, and frequency
- Select a response for each of the monitoring contact questions.
- If "yes" is selected for any monitoring contact questions, provide further information in the Notes
- Follow up with any outstanding issues from previous monitoring contacts and document progress.
- If a new Waiver service has been added to PCSP since last monitoring contact, make sure to document follow up.

Charting Example: [Monitoring Contact Note]

Monthly monitoring contact completed with participant. No new health concerns reported. Participant reports that they had a recent physician appointment and their medication dosage was increased. Participant is now taking 10 mg Wellbutrin daily instead of 5mg. Start date of new medication was 5/14/2022. Medication reconciled and list updated in COMPASS. Participant is satisfied with current care plan and Waiver services – amount, type and frequency. Participant is currently receiving HDM, CLS, PERS; Supports Coordination.

Unable to Contact

- See "Unable to Contact" policy for specific process and contact attempt requirements
- Document whether or not you were able to leave a voicemail message

Charting Example: [Unable to Contact Note]

Attempted to contact participant for monthly monitoring contact. Left voicemail message providing participant with SC name, purpose of call, and contact information. Requested a return phone call.

Scheduling 6-Month PCSP Review

Call the participant and/or guardian to schedule at least a day before the PSCP Review. This contact MUST be charted in the participant file and must include:

- That participant was given the choice to have others present at the reassessment.
- Offer the participant the choice of setting for the visit.

Charting Example: [Standard Note]

Spoke to participant to schedule 6-month PCSP review. Participant requested that SC come out on Wednesday morning. Scheduled visit for xx/xx/xx at 10:00am at the participant's home, per the participants request. Reminded the participant that they can have others present for the review.

6-Month PCSP Review

Document review of current PCSP including:

- Current services
- Participant goals and progress
- Additional needs or concerns

Charting Example: [Person Centered Planning Meeting Note]

Completed 6-month PCSP review with participant at their home. Reviewed PCSP, including current services and interventions, formal and informal. Participant is happy with services – amount, type and frequency. No changes requested at this time. Reviewed participant goals. Goals and outcomes updated. Participant signature received on PCSP. Participant does not want copy sent to anyone else.

Home Health Services/Skilled Nursing

Initial and ongoing contact is required with the Home Health agency providing skilled services to a participant.

Charting Example: [Standard Note]

Spoke to primary RN with skilled agency. Reviewed what services are currently being provided to participant through skilled. Participant has RN twice per week to set up meds and monitor vitals, physical therapy twice per week, and home health aide twice per week for bathing. MD has not ordered any other services at this time and RN does not feel any other issues are present. SC reviewed services waiver would be providing and requested RN contact SC if any issues arise and when they are preparing to discharge participant from skilled. Requested copy of 485.

Communication with MDHHS

Policy Number: 2022-27	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Communication and collaboration with the Michigan Department of Health and Human Services (MDHHS) is vital to ensuring appropriate participant enrollment and continued eligibility. Supports Coordinators are responsible for building positive working relationships with their local office's Long-Term Care Medicaid Eligibility Specialists, as well as notifying the local office of any information that may affect the participant's eligibility.

Policy

Supports Coordinators are responsible for following up with MDHHS regarding any Medicaid applications or Initial Asset Assessments submitted on behalf of the participant. Supports Coordinators are responsible for assisting the participant with gathering verifications and submitting information as requested by the local MDHHS office.

Supports Coordinators are responsible for notifying MDHHS of any significant changes to the participant's finances that may impact Medicaid eligibility while enrolled in the Mi Choice Waiver, as this will prompt MDHHS to complete a re-determination of financial eligibility.

MI Choice Waiver Enrollment and Disenrollment

Supports Coordinators are responsible for submitting the appropriate Waiver enrollment and disenrollment forms to the Medicaid specialist. The Medicaid Specialist is responsible for submitting all enrollment and disenrollment information into CHAMPS as well as monitoring CHAMPS daily for changes to participant enrollment statuses. The Medicaid Specialist is also responsible for notifying MDHHS through the MDHHS Geo Group Email for each county office when a Waiver Enrollment has been entered and is pending Medicaid review.

If during the enrollment or disenrollment process, the Medicaid Specialist encounters an issue within CHAMPS that directly affects eligibility, the Medicaid Specialist will notify the primary Supports Coordinator and Waiver Director of the issue. Depending upon the issue, the Supports Coordinator may be required to contact MDHHS directly.

If there is an issue that requires assistance at the State level, the Waiver Director will notify the appropriate entities/contacts and submit the necessary information for assistance in CHAMPS/Siebel CRM utilizing the service request option.

[Refer to ***Policy Number 2022-15 - Participant Enrollment***]

Demographic Changes

Supports Coordinators are responsible for notifying MDHHS of any changes to the participant's status or demographic information – i.e. address change, marital status, etc. The Supports Coordinator should also assist the participant in contacting MDHHS to verify or update their contact information in MIBridges. Those who are unable to update their information in MIBridges can contact the Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656).

Critical Incidents

Policy Number: 2022-28	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

A Critical Incident is defined by MDHHS in Attachment K as any actual, alleged or suspected event or situation that occurs as a result of abuse, neglect, exploitation, or any event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.

Policy

It is the policy of UPCAP Services that Supports Coordinators have the first line responsibility for identifying, investigating, evaluating, and following up on Critical Incidents that occur with program participants. All critical incidents must be reported to the Michigan Department of Health and Human Services utilizing the Critical Incident Portal. Critical Incident Portal

Types of Reportable Critical Incidents

1. Exploitation * - An action that involves the misuse of an adult's funds, property, or personal dignity by another person.
2. Illegal activity in the home with potential to cause serious or major negative event * - Any illegal activities in the home that puts the participant or the workers coming to the home at risk.
3. Neglect *- Harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care.
4. Physical Abuse * - The use of unreasonable force on a participant with or without apparent harm
5. Provider no shows – Instances when a provider is scheduled to be at a participant's home but does not come and back up service plan is either not put into effect or fails to get an individual to the participant's home in a timely manner. This becomes a Critical Incident for those participants who are bed bound all day or have a critical need for services as indicated by a 1A, 1B, or 1C service need level.
6. Sexual Abuse *
    a. Criminal sexual conduct as defined by sections 520b to 520e of the 1931 PA 318, MCL 750.520B to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient
    b. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
    c. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
7. Theft – A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use.
8. Verbal Abuse *- Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

9. Worker consuming drugs and/or alcohol on the job – Use of any illegal drugs or alcohol on the job, or any medications that would affect the abilities of the worker to do his or her job.
10. A suspicious or unexpected death that the waiver agency, or other entity, reports to law enforcement and that is related to providing services, supports, or care giving.
11. Medication error – Wrong medications, wrong dosage, double dosage, or missed dosage which resulted in hospitalization, emergency treatment or death.
12. Injuries requiring medical treatment.
13. Hospital and ER visits within 30 days of a previous hospitalization due to neglect or abuse.
14. Suicide attempts
15. Use of restraints, restrictive interventions, or seclusion.
16. Other – Other events that create a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant not already listed (fire, drive by shooting, car accident, etc.)

* Denotes incidents that must also be reported to Adult Protective Services

Mandated Reporting

All Supports Coordinators and UPCAP staff have a legal obligation to report any suspicions regarding vulnerable adults believed to have been harmed or are at risk of harm from abuse, neglect or exploitation. In addition to reporting a Critical Incident, Supports Coordinators may also need to call and file a report with MDHHS Adult Protective Services (APS). Reports made to APS on behalf of a participant will also need to be documented within the participant record and the corresponding Critical Incident report.

MDHHS Adult Protective Services **1-855-444-3911**

Critical Incident Reporting

UPCAP utilizes the Critical Incident Reporting Portal to report and manage all Critical Incidents as it allows for the automatic reporting of Critical Incident information directly to MDHHS. The Waiver Director arranges for each Supports Coordinator to have access to the Critical Incident Reporting Portal upon hire.

When a Critical Incident occurs, Supports Coordinators must investigate and evaluate the incident within two (2) business days becoming aware of a situation. Supports Coordinators 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 Critical Incident report must include the following information:

1. A description of each incident
2. Investigations and strategies implemented to reduce, ameliorate, and prevent future incidents from occurring; and
3. Follow-up activities conducted through the resolution of each incident. Critical Incidents should be resolved within two months unless there are extenuating circumstances, or an investigation is ongoing. If the Critical Incident is not resolved within two months, the notes should be updated frequently until the Critical Incident is resolved.

Supports Coordinators shall enter the required information regarding the Critical Incident into the Critical Incident Reporting Portal, and then notify the Regional Supervisor and/or the Waiver Director by e-mail that a Critical Incident has occurred and has been entered. The Waiver Director has thirty (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 to MDHHS contract managers within 48 hours.

During the investigation period, the Critical Incident shall be classified as “Unresolved” in the Critical Incident Reporting system. If during the course of the investigation the Supports Coordinator 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, Supports Coordinators shall change the case status to “Resolved” and notify the Regional Supervisor and/or Waiver Director. The Regional Supervisor or Waiver 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 Supports Coordinator to resolve the Critical Incident, shall be maintained in the Participant file.

Participant Education

To ensure that all potential Critical Incidents are being reported and addressed appropriately, Supports Coordinators must provide education to the Participant and their informal supports on what constitutes a Critical Incident, the importance of reporting it, and the process of reporting it to UPCAP, APS, and/or local law enforcement agencies. Information regarding Abuse and Neglect is included in the Participant Handbook provided to the participant and their informal supports at the initial assessment. Supports Coordinators should also provide additional information and discussion of Critical Incident reporting at this time. Ongoing training for participants and their informal supports on abuse and neglect, reporting, and Critical Incidents should take place at the time of MI Choice enrollment, during the initial care planning process, and then annually thereafter. Supports Coordinators may provide training more frequently when circumstances indicate that the participant needs it.

Provider Responsibilities

All UPCAP contracted providers are required to report any Critical Incidents to UPCAP or the participant’s Supports Coordinator within twenty-four (24) hours of the Critical Incident.

References

Medicaid Provider Manual - MI Choice Waiver
www.michigan.gov/MDHHS
Compass Critical Incident User Guide

Reassessment

Policy Number: 2022-29	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

The Michigan Department of Health and Human Services (MDHHS) requires that Supports Coordinators provide a scheduled, periodic in-person reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlines in the participant PCSP.

Policy

It is the policy of UPCAP Services, Inc. to perform a periodic in-person reexamination of participant functioning through a formal reassessment. The purpose of the reassessment is to identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant PCSP. The reassessment is comprehensive and includes all of the items reviewed at the previous assessment.

Procedures

Supports Coordinators must input all assessment data in the participant's next assessment record in COMPASS system in a timely manner. All sections of the InterRAI-HC must be reviewed and completed. The Supports Coordinators may only copy and paste information that has not changed from a previous assessment to the new assessment when the information is still relevant.

Supports Coordinators are responsible for confirming the participant's ongoing eligibility at each reassessment. Supports Coordinators will review the participant's functional eligibility for the MI Choice Waiver program through a review of the participant's NFLOCD and the information gathered at the assessment. The participant's case record must reflect documentation that the participant continually meets the NFLOC. The record must indicate the appropriate door through which the participant meets the NFLOC criteria based upon the current assessment. If the Supports Coordinator does not complete a paper copy of the NFLOCD tool, the corresponding assessment data MUST support the door through which the Supports Coordinator indicates the participant meets NFLOC criteria.

If a Supports Coordinator suspects the participant no longer meets the nursing facility level of care, the Supports Coordinator must conduct a face-to-face NFLOCD and input the data into the LOCD application in CHAMPS. When CHAMPS confirms the individual no longer meets NFLOCD criteria, the Supports Coordinator initiates program discharge procedures and provides the participant with notice and information on appeal rights. See Action Notices and Appeal Rights.

Either an interdisciplinary Supports Coordinator team or an individual Supports Coordinator can perform reassessments. A team is not required to perform reassessments. However, when one Supports Coordinator completes an assessment, that Supports Coordinator should consult with a Supports Coordinator of the other discipline to assure all relevant issues have been updated and properly addressed. If during this consultation, it is determined that follow up is needed by the other discipline, the Supports Coordinator will contact the participant to discuss any concerns and assist in properly

addressing the issue. If needed, the other discipline may schedule a home-visit within seven (7) days to review and verify the first Supports Coordinator's findings and assure the record properly reflects and addresses all issues.

In order to schedule the reassessment, the Supports Coordinator is responsible for contacting the participant prior to the reassessment due date. The reassessment should be scheduled on a date and time that is most convenient to the participant. The Supports Coordinator must also confirm that the participant understands that they may have any other individuals of their choosing to be present at the reassessment. Supports Coordinators will document this contact in the participant record. Supports Coordinators will call the participant on the same day as the scheduled visit to confirm that the participant is still available. If the participant needs to reschedule, the Supports Coordinator will coordinate with the participant to schedule another day and time. This new date and time will be recorded in the participant record.

Participants may refuse a reassessment. Supports Coordinators must document this refusal in the participant's case record. The Supports Coordinator should also confirm that the participant understands that to maintain program eligibility for the MI Choice Waiver, UCPAP must assess them on an annual basis. A refusal which prevents a timely redetermination is cause for termination from the program.

90-Day Reassessment

Supports Coordinators complete a comprehensive in-person reassessment with all new participants within 90 days of the initial assessment by updating the participant's next assessment record in COMPASS. At the 90-day reassessment, the Supports Coordinator will complete the full InterRAI-HC assessment in COMPASS. The person-centered care plan will be reviewed, adjustments to the care plan made only at the participant's request, and a review of the participant's goals.

Supports Coordinators will also provide a more thorough explanation of the Participant Handbook and review of materials in the Client Informational Folder provided at the initial assessment.

Change in Condition Reassessment

If the participant has experienced a significant change to their health or functional status OR there has been a significant change in the participant's support system (i.e. death of a primary caregiver), the Supports coordinator must complete an in-person reassessment. The Supports Coordinator will complete the full InterRAI-HC assessment in COMPASS as well as a person-centered care plan review.

Return Reassessment

Supports Coordinators must complete a return reassessment when an existing participant returns to the MI Choice program after a nursing facility discharge, hospitalization lasting more than 30 days, or has been out of the service area for more than 30 days. The return reassessment consists of the full InterRAI-HC assessment in COMPASS and must be completed by a SW/RN Supports Coordinator team. The previous person-centered service plan will be reviewed for appropriateness and adjustments made to the care plan as needed, with participant approval.

Annual Reassessment

Supports Coordinators must complete a comprehensive in-person reassessment with all participants no less than annually following the 90-day reassessment. The Supports Coordinator will complete the full InterRAI-HC assessment in COMPASS. The person-centered care plan will be reviewed, adjustments to the care plan made only at the participant's request, and a review of the participants goals.

Supports Coordinators will request to view the Client Informational Folder provided to the participant at the initial assessment. Supports Coordinators will review the contents and the participant handbook, making specific note of the participant's rights and responsibilities. If the participant no longer has their Client Informational Folder, the Supports Coordinator will provide them with a new one. If there have been any updates or changes to the participant handbook,

a new copy of the handbook will be provided to the participant at the reassessment and the acknowledgement of handbook signed and dated. Receipt and/or review of the materials will be documented in the participant's file.

The Supports Coordinator is also responsible for updating all consent and authorization documents on an annual basis. Although these documents can be signed any time to extend the authorization period, it would behoove the Supports Coordinator to coordinate the due dates of all forms and documents with the date of the annual assessment for consistency and continuity. Receipt of annual consent and authorization, and any other consent forms, will be documented in the participant's file.

References

Medicaid Provider Manual - MI Choice Waiver

Care Transitions

Policy Number: 2022-30	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Due to the complex care and support needs of many MI Choice Waiver participants, transitions of care can increase the risk of adverse events to the participant's health and functional status. A transition of care is the movement of a participant from one setting of care to another. Settings of care may include hospitals, long-term care facilities, home health, and rehabilitation facilities. Ensuring effective transitions of care is essential to the participant's health and safety, and will aid the participant in reducing their incidence of injury and avoiding or reducing hospital and nursing facility readmissions.

Policy

Supports Coordinators play a vital role in ensuring a safe and effective transition of care. Supports Coordinators will act as a liaison and are responsible for maintaining regular contact with appropriate care setting personnel (Social Workers, Discharge Planners, RNs, etc), the participant, and the participant's informal support network, as desired by the participant, by providing ongoing support throughout the process. Supports Coordinators should request supporting documentation at discharge in order to facilitate a safe transition back into the community setting. Supports Coordinators will be responsible for reassessing the participant and adjusting the participant's care plans, as needed, at discharge to support the participant's goals of returning to the community setting of their choice.

Procedures

ADT/CCD Notices

Supports Coordinators have access to real-time notifications within the COMPASS Next Dashboard that provide detailed information on participant admissions and discharges from acute and primary care. These notifications are referred to as ADT and CCD Notices. Admission Discharge Transfers (ADT) are files that include information about participant's admissions, discharges, and transfers from hospitals, nursing homes and home health agencies. Consolidated Clinical Documents (CCD) are files that include detailed information about the participant's medications, diagnoses, history, physicals, progress notes, care plans, etc. The ADT and CCD notices are tools to be utilized by the Supports Coordinator to track unplanned participant admissions so that they may begin tracking and supporting the participant through the transition of care settings.

Supports Coordinators are expected to check their ADT and CCD notices daily and follow up with the participant or care setting (hospital, nursing facility, etc.) within one (1) business day of notification. Once the ADT or CCD notice is reviewed, the Supports Coordinator will be responsible for archiving the notice within COMPASS so it is no longer on the current list.

ADT and CCD notices are received and coordinated through the MiHIN – Michigan Health Information Network. Hospitals, nursing facilities, and other applicable care settings enter into a contractual relationship with MiHIN in order to participate in the sharing of files and participant encounter data. It should be noted that not all hospitals and/or care settings participate, therefore Supports Coordinators should not rely solely on these notifications to provide notice of transitions of care.

COMPASS ADT/CCD User Guide

Hospitalizations

Unplanned Admission

When a participant enters a hospital, their services must be placed on hold. The Supports Coordinator must:

1. Update the participant's Status Report care setting to indicate the participant is in the hospital, making sure to note that it was "unplanned". Submit completed form to the appropriate Case Tech.
2. Notify the service provider(s) by phone immediately, within the same business day, of the participant's hospitalization and indicate the date to start holding the service(s).
3. Complete a Work Order or note "Service Hold" on the participant's current Service Summary and submit to the appropriate Case Tech. Vendor View Providers will receive a Hold Notice and Care Setting Change via Vendor View. Supports Coordinators shall fax or mail Work Orders to providers not utilizing Vendor View.
    - Since hospital admissions are not considered enrollments in a benefit plan or LTSS service, Supports Coordinators may authorize the continuation of the following service(s) while the participant is hospitalized to ensure a safe transition at discharge:
        - Personal Emergency Response System (PERS)
        - Snow Removal – if applicable
        - Supports Coordination
4. Complete and mail an Adverse Benefit Determination (ABD) to the participant and retain a copy for the participant file. The ABD must indicate each service, service provider, and frequency of service being temporarily suspended as a result of the hospitalization. No abbreviations may be used on the Adverse Benefit Determination.

The Supports Coordinator will be expected to follow up with the admitting hospital and the participant, if appropriate, within one (1) business day of the hospitalization to discuss the participant's current health issues, reason for admission, and to notify the necessary staff of the participant's involvement in the MI Choice Waiver program. The Supports Coordinators should request a copy of the admission paperwork from the admitting hospital and maintain regular contact with appropriate hospital staff. The Supports Coordinator will be responsible for tracking the participant's status throughout the extent of their hospitalization and coordinate the participant's discharge with the hospital social worker or discharge planner.

There may be times that a Supports Coordinator is not notified of a hospitalization until after the participant returns home. Supports Coordinators must still make note in the participant record of the dates of hospitalization and follow the above steps to ensure that the care plan authorizations in the system are accurate. The Supports Coordinator will still need to contact the hospital discharge planner to request the documents and orders provided at the participant's discharge.

Planned Admissions

When the Supports Coordinator is aware of a scheduled participant hospitalization, the Supports Coordinator should take all necessary steps to ensure a smooth transition of care. Supports Coordinators are required to notify the participant's service providers ahead of time to coordinate the hold and resume dates of service. Once the Supports Coordinator confirms that the participant has been admitted for a planned procedure or treatment, they must:

1. Update the participant's Status Report care setting to indicate the participant is in the hospital, making sure to note that it was "planned". Submit completed form to the appropriate Case Tech
2. Complete a Work Order or note "Service Hold" on the participant's current Service Summary and submit to the appropriate Case Tech. Vendor View Providers will receive a Hold Notice and Care Setting Change via Vendor View. Supports Coordinators shall fax or mail Work Orders to providers not utilizing Vendor View.
    - Since hospital admissions are not considered enrollments in a benefit plan or LTSS service, Supports Coordinators may authorize the continuation of the following service(s) while the participant is hospitalized to ensure a safe transition at discharge:
        - Personal Emergency Response System (PERS)
        - Snow Removal – if applicable
        - Supports Coordination
3. Complete and mail an Adverse Benefit Determination (ABD) to the participant and retain a copy for the participant file. The ABD must indicate each service, service provider, and frequency of service being temporarily suspended as a result of the hospitalization. No abbreviations may be used on the Adverse Benefit Determination.

For situations where a Supports Coordinator 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), Supports Coordinators will need to coordinate the hold and resume dates of service with providers ahead of time.

Discharge

When the participant is hospitalized for less than thirty (30) days, the participant's services may restart upon discharge from the hospital. Once the Supports Coordinator is made aware of the participant's discharge date, the Supports Coordinator should contact all service providers by phone to notify them of the resume date and coordinate services to start once the participant returns home.

Upon discharge from the hospital, the Supports Coordinator will need to resume all services that were in the home prior to hospital admission:

1. Submit Status Report denoting change in care setting to the appropriate Case Tech
2. Update work orders to RESUME service OR note RESUME on the service summary used to HOLD services at the participant's admission and submit to the appropriate Case Tech. Vendor View Providers will receive a Resume Notice and Care Setting Change via Vendor View. Supports Coordinators shall fax or mail Work Orders to providers not utilizing Vendor View.

Supports Coordinator should request a copy of the discharge instructions, including information regarding medication and durable medical equipment orders from the discharge planner. Supports Coordinators will contact the participant within one (1) business day of notification of hospital discharge. The Supports Coordinator will review the discharge instructions with the participant and discuss any concerns or questions the participant may have. The Supports Coordinator will review any medication changes and document all new and existing medications. If there are any concerns or discrepancies between the medication list and documented medications, the Supports Coordinator will contact the participant's primary physician. The Supports Coordinator will also review any new physician orders for home health service, durable medical equipment, outpatient therapies, etc, and monitor the care plan to ensure that the services and/or equipment is received in a timely manner.

The Supports Coordinator will also need to assess the person-centered service plan for appropriateness based on the functional status of the participant following discharge. If the participant has experienced a significant change of condition, the Supports Coordinator will need to schedule an in-home visit and reassessment within seven (7) calendar days of discharge.

Hospitalization Over 30 Days

When a Mi Choice participant is hospitalized, planned or unplanned, the participant's case does not have to be closed if the participant's stay does not exceed thirty (30) days. The Supports Coordinator is responsible for tracking the participant's total days of hospitalization. Supports Coordinators are able to track the number of days a participant has been hospitalized within COMPASS Next. Supports Coordinators can view all current hospitalized participants as well as the date of their admission and total days of institutionalization within the "Monitors" tab.

If the participant's stay exceeds thirty (30) days, the participant will need to be disenrolled from the Mi Choice Waiver. The disenrollment or Waiver closure date occurs after the thirty (30) day waiting period, on day thirty-one (31), as closure is not retroactive to the first day of hospitalization. The Supports Coordinator will send a Notice of Adverse Benefit Determination to the participant on day nineteen (19) of the hospitalization stipulating that if the hospitalization is over thirty (30) days, the participant will be disenrolled from the MI Choice Waiver and all MI Choice Waiver services will be discontinued. The participant's program status must be changed to Waiver-Ineligible. Once the Participant is ready for discharge back to the community, the Supports Coordinator will coordinate the participant's re-enrollment into the Waiver.

Nursing Facility - Admissions

When a participant enters a nursing home, for a permanent stay or short-term rehabilitation, all services must be stopped immediately. The Supports Coordinator must:

1. Complete the Participant Status Report and submit to the appropriate Case Tech
    - If the participant is admitted for a permanent stay, the Supports Coordinator will close the participant's file completely on the day of admission.
        - The Supports Coordinator will update the participant's Status Report to denote Mi Choice Waiver closure on the day BEFORE the day of admission to the nursing facility.
        - A program status of "Waiver Ineligible" will be assigned for the day that the participant enters the Nursing Facility to ensure that any services provided on the day of admission can be purchased using alternative funds.
    - If the participant is admitted for a short-term stay and is planning on returning to the community and re-enrolling in the MI Choice Waiver upon discharge, the Supports Coordinator will update the program status to Waiver-Ineligible as of the day of admission. The Waiver end date must be the day BEFORE the day of admission. Care Setting status must also be updated on the Status Report to reflect "Nursing Home"
2. Notify the provider(s) by phone immediately, same day, indicating the date services are to stop due to nursing facility admission.
    - Complete a Work Order(s) signifying the stop date for each service and submit to the appropriate Case Tech
    - If a Waiver service was required and authorized on the same day, immediately before a participant's admission to a nursing facility, UPCAP must reimburse the service provider. The work order re-coded to 221 fund code for the day of admission for any approved and required service.
3. Complete and mail an Adverse Benefit Determination (ABD) to the participant and retain a copy for the participant file. The ABD must indicate each service, service provider, and frequency of service being stopped as a result of the nursing facility admission. It should also note that the participant will be disenrolled from the MI Choice Waiver while they are in the nursing facility. The ABD should also provide information regarding re-enrollment at the time of discharge, if applicable. No abbreviations may be used on the Adverse Benefit Determination.

4. Complete a Waiver Disenrollment Notification Form and submit to the Medicaid Specialist for entry into CHAMPS within five (5) business days.

For participants who are planning to return to the community and re-enroll in the MI Choice Waiver upon discharge, Supports Coordinators are responsible for maintaining contact with both the nursing facility and the participant on a regular basis, no less than every thirty (30) days, to ensure a smooth transition upon discharge. Supports Coordinators will be able to track the number of days a participant has been in a nursing facility within COMPASS Next. Supports Coordinators can view all current participants in a nursing facility as well as the date of their admission and total days on institutionalization within the "Monitors" tab.

Supports Coordinators should make initial contact with the nursing facility within one (1) business day or notification of the admission to discuss the participant's current health issues, reason for nursing facility admission, and to notify the necessary nursing facility staff of the participant's involvement in the MI Choice Waiver program. Supports Coordinators should provide details about the services provided and the potential services available upon discharge. Each nursing facility is different in how they work with residents, so the Supports Coordinator should make sure that they are communicating with the most appropriate facility staff person(s) – Social Worker, Discharge Planner, RN Supervisor, etc.

Supports Coordinators will also be required to communicate with the participant and/or their designated representative to discuss the transition of care process. Supports Coordinators will be required to complete monthly monitoring contacts with the participant or the participant's preferred representative throughout the extent of the participant's stay at the nursing facility. Participant preference for contact should be noted in the participant record.

Supports Coordinators should be available to meet with the participant and facility staff in person, if warranted or requested, to discuss the discharge plan and address any potential needs of the participant once they return to their community setting. If no in-person meeting is able to be scheduled, Supports Coordinators will need to document contact with the appropriate nursing facility staff where potential needs and concerns are discussed prior to discharge.

There may be instances where the nursing facility and staff are difficult to reach and coordinate transitions of care. In these cases, the Supports Coordinator should continue to make attempts for contact and document them in the participant record. Supports Coordinators will then rely on the participant and the participant's informal supports to provide information regarding discharge and potential needs.

Discharge

For participants who enroll in MI Choice upon discharge from a nursing facility or hospital, the Supports Coordinator must ensure the participant's necessary services or supplies are in place prior to discharge. Once the Supports Coordinator is notified of the participant's discharge date, the Supports Coordinator will coordinate the completion of a NFLOCD and FOC prior to, or on the day of, discharge to begin the process of re-enrollment into the MI Choice Waiver. Depending upon the length of time between notification and discharge, the Supports Coordinator may choose to complete the NFLOCD in person at the facility or adopt an existing NFLOCD.

[Refer to ***Policy Number: 2022-09 Nursing Facility Level of Care Determination*** for more information regarding completing and adopting NFLOCDs.]

Supports Coordinators will need to discuss necessary services and/or supplies needed by the participant to ensure their safety upon return home. Supports Coordinators should notify preferred providers ahead of time to coordinate the start date of services to be the date of discharge.

After the NFLOCD is completed or adopted and the discharge date has been confirmed, the Supports Coordinators will:

1. If the Supports Coordinator completed the NFLOCD and FOC to the appropriate Case Tech for entry into CHAMPS. The NFLOCD can only be entered into CHAMPS on the day of discharge or within fourteen (14) days of discharge.

2. Update the participant Status Report to reflect Waiver-Pending as of the day of discharge. The Waiver-Ineligible program designation will end on the day BEFORE discharge.
3. Submit the MI Choice Waiver Enrollment Notification Form to the Medicaid Specialist for entry into CHAMPS within five (5) business days.
4. Complete Work Orders for any necessary services needed by the participant upon discharge and submit to the appropriate Case Tech for entry.

After the participant's discharge, the Supports Coordinator must contact the participant within twenty-four (24) hours of discharge, or notification of discharge, to ensure immediate needs are being met. Within seven (7) days of the discharge, the Supports Coordinator(s) must conduct an in-person meeting (home visit) with the participant to complete a NFLOCD, if one was adopted prior to discharge, and a full return reassessment. The return reassessment must be completed by a RN/SW Supports Coordinator team, in addition to the completion of a new person-centered service plan (PCSP). The Supports Coordinator will also review any medication changes and document all new and existing medications. If there are any concerns or discrepancies between the medication list and documented medications, the Supports Coordinator will contact the participant's primary physician. The Supports Coordinator will also review any new physician orders for home health service, durable medical equipment, outpatient therapies, etc., and monitor the care plan to ensure that the services and/or equipment is received in a timely manner.

In the event that only one Supports Coordinator is able to schedule the home visit within seven (7) days of discharge, the one Supports Coordinator may start the reassessment process to assure the participant meets MI Choice eligibility requirements and to develop a temporary PCSP. The Supports Coordinator of the other discipline will be required to complete the in-person reassessment within seven (7) days of the time the reassessment process began.

Swing Bed/Rehabilitation

In some cases, small rural hospitals may use its beds, as needed, to provide either acute or skilled nursing facility (SNF) care. Therefore, a participant might receive their post-acute hospitalization rehabilitation in a "swing bed" while remaining at the hospital. The Supports Coordinator will be responsible for determining whether the services provided during the participant's swing bed classification are being billed to Medicare or Medicaid. If Medicaid is being billed, this care is considered to be skilled nursing facility care, so admissions and discharges to a "swing bed" are to be treated as nursing facility admissions and discharges.

When a Supports Coordinator is notified of the client's transition from acute care to a swing bed, the Supports Coordinator will be required to contact the discharge planner or appropriate staff person at the hospital within one (1) business day to confirm payor source. The Supports Coordinator will also be required to run a CHAMPS Eligibility Report for the participant to confirm payor source.

If the hospital is billing Medicaid for the skilled rehabilitation stay, it will reflect on the Eligibility Report. If the Nursing Facility PET code is present on the Eligibility Report, the Supports Coordinator will proceed with procedures outlined for nursing facility admissions and discharges.

If it is confirmed, through contact with hospital staff and the participant's eligibility report, that the hospital is billing Medicare for the participant's care, the Supports Coordinator will treat the stay as a continuation of the participant's hospital stay, paying close attention to the participant's total days of institutionalization. If the participant remains in the hospital setting for more than thirty (30) days, the Supports Coordinator will follow procedures as outlined in for hospitalizations over thirty (30) days.

Home Health Services

Supports Coordinators are required to contact Home Health providers when they become aware that a participant is receiving Home Health services in their home. Supports Coordinators should request a copy of the current Home Health providers plan of care (485 form) to add to the participant file and discuss any needs or supports that should be addressed by the Home Health provider.

Mi Choice is the payor of last resort and in the event that a participant is receiving Home Health services, the Supports Coordinator will need to coordinate with the Home Health provider to ensure that the appropriate payment source is being utilized for services provided. Nursing Services, including medication management, and assistance with personal care are to be provided by the Home Health provider. Supports Coordinators will need to adjust the participant's care plan to ensure that these services are being billed to the appropriate payor source for as long as the home health case is open. Supports Coordinators will need to:

1. Submit a HOLD work order for any duplicate Mi Choice Waiver Nursing Services and/or a DECREASE work order for any Community Living Supports services being provided for personal care and submit to the appropriate Case Tech for entry.
2. Supports Coordinators will need to communicate this to the participant as well as provide an Adverse Benefit Determination for decrease in Mi Choice Services, specifying that the specific services being decreased and services are currently being provided through Home Health. The participant's preference for a certain provider is not grounds for declining another payor source. The participant should not experience a decrease in overall services, but an adjustment in the provider/payor source.
3. Add all arranged Home Health services to the COMPASS PCSP with start dates and frequency of each provided service.

Monthly contact with the Home Health RN must be documented in the participant file. Ongoing contact will also be vital in ensuring a seamless transition once the participant is discharged from Home Health. The Supports Coordinator should periodically reach out to other disciplines providing care to the participant through the home health provider - Physical Therapists, Occupational Therapists, Speech Therapists, Social Worker, etc. - to ensure that all the participant's needs are being met at least once every sixty (60) days. It is understood that contact with therapists and other disciplines providing care can be difficult to achieve. Supports Coordinators should document all contact attempts in the participant record.

Upon discharge from Home Health services, the Supports Coordinator will adjust the care plan to ensure that the participant will continue to receive the previously decreased services under the MI Choice Waiver.

1. Submit a RESUME work order for any service previously held or an INCREASE work order for any service previously decreased and submit to the Case Tech for entry.
2. Update the PCSP with the stop date for all home health services no longer being provided.

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. Supports Coordinators must seek prior approval from the Waiver 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 out of the service area.

When a Supports Coordinator is notified that a client is out of the service area:

1. Update the participant's Status Report care setting to indicate the participant is "Out of Service Area". Submit completed form to the appropriate Case Tech.
2. Notify the service provider(s) by phone immediately, within the same business day, for any services not being provided while the client is out of the service area and indicate the date to start holding the service(s).
3. Complete a Work Order for any services not authorized while the participant is out of town and submit to the appropriate Case Tech. Vendor View Providers will receive a Hold Notice and Care Setting Change via Vendor View. Supports Coordinators shall fax or mail Work Orders to providers not utilizing Vendor View.
    - If the participant plans to return home within 30 days, the Supports Coordinators may authorize the continuation of the following service while the participant is out of town ensure a safe transition home:
        - Personal Emergency Response System (PERS)
        - Snow Removal – if applicable
        - Supports Coordination
4. Complete and mail an Adverse Benefit Determination (ABD) to the participant and retain a copy for the participant file. The ABD must indicate each service, service provider, and frequency of service being temporarily suspended as a result of the participant being out of the service area. No abbreviations may be used on the Adverse Benefit Determination.

When a Participant returns home within thirty (30) days the Supports Coordinator will need to resume all services that were in the home prior to the participant going out of the service area:

1. Submit Status Report denoting change in care setting to the appropriate Case Tech.
2. Notify all service providers, by phone, to coordinate services and notify them of the resume date.
3. Update work orders to RESUME services that were previously on HOLD when the participant went out of the service area and submit to the appropriate Case Tech. Vendor View Providers will receive a Resume Notice and Care Setting Change via Vendor View. Supports Coordinators shall fax or mail Work Orders to providers not utilizing Vendor View.

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. Supports Coordinators must contact the Participant or responsible party fifteen (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 fifteen (15) calendar days, the Supports Coordinator shall obtain a mailing address so as to send an Adverse Benefit Determination with advance notice.

The Supports Coordinator will mail the Adverse Benefit Determination (ABD) to the Participant and retain a copy for the participant file. The ABD must indicate each service, service provider, and frequency of service being stopped as a result of being out of the service area for more than 30 days. It should also note that the participant will be disenrolled from the Mi Choice Waiver at that time. The ABD should also provide information regarding re-enrollment, if applicable. No abbreviations may be used on the 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. The Supports Coordinator will:

1. Update the Participant Status Report and submit to the appropriate Case Tech for entry. The Waiver end date will be on Day 30.
2. Complete a Work Order(s) signifying the stop date for each service and submit to the appropriate Case Tech

3. Complete a Waiver Disenrollment Notification Form and submit to the Medicaid Specialist for entry into CHAMPS within five (5) business days.

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 NFLOCD shall be completed, and if 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 waitlist placement.

Hospice

A participant in the MI Choice Waiver or Care Management program may receive Hospice services simultaneously when in a home and community-based setting. The participant must not reside in a nursing facility or hospice residential facility to be eligible to receive MI Choice services. If a participant enters a nursing facility or hospice residential facility to receive hospice services, the participant will need to be closed from the MI Choice Waiver, following the nursing facility admission process within this policy. Participants who are enrolled in both MI Choice and Hospice will have a PET code indicating this on their CHAMPS Eligibility Report.

Participants who receive both MI Choice and Hospice or Palliative Care services must have a coordinated person-centered service plan (PCSP). Duplication of services shall be avoided through early and ongoing communication and coordination between the Supports Coordinator and the Hospice Agency. The Hospice Program is considered the primary payor of services and the MI Choice Waiver or Care Management program secondary. The participant's available hospice services must be used to the fullest capacity before Waiver services are initiated.

MDHHS may employ a post-payment review to monitor services. If MDHHS finds that inappropriate (i.e., duplicative) services were authorized, MDHHS will seek recovery of Medicaid funds paid for duplicative services from the waiver agency. 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 participant's terminal diagnosis.

Hospice Admission/Enrollment:

When a participant is initially enrolled in hospice or palliative care services, the Supports Coordinator should contact the participant within one (1) business day of notification to discuss any concerns, as well as explain the transition of care process as it relates to their services. The Supports Coordinator will also need to:

1. Contact the Hospice or Palliative Care Agency within two (2) business days of notification and complete a "case conference" to determine which services will be put into place for the participant. Supports Coordinators should request a copy of the agency's care plan and add it to the participant case file.
2. Complete a full reassessment and PCSP review - Being enrolled in a hospice or palliative care program is considered a significant change of condition and warrants a full reassessment and care plan review. Supports Coordinators will schedule a reassessment with the participant, and requested informal supports, within seven (7) calendar days of notification of hospice enrollment.
    - The Supports Coordinator will need to update the COMPASS PCSP to include all arranged hospice services, including start date and frequency.
3. Complete applicable work orders for any services being decreased or stopped as a result of hospice services authorized. Submit the work order to the appropriate Case Tech for entry.
4. Complete and mail the participant the Adverse Benefit Determination noting the specific services previously provided by the MI Choice Waiver that will now be provided by the Hospice Program. The participant is not to experience an overall decrease in the care plan, rather a change in payor source.

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. Supports Coordinators have 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 and if it is or is not available to the Waiver Participant, along with the reason why, before approving MI Choice Waiver funds to fill in the gap.

The Supports Coordinator is required to maintain ongoing contact with the Hospice Agency and/or assigned Registered Nurse to ensure the participant's needs are being met, no less than monthly.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C

Coordination with Medicare/Medicaid Hospice Programs

Policy Number: 2022-30-01	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Participants enrolled in UPCAP Services, Inc.'s Long-Term Care Programs can be dually enrolled in a Medicare or Medicaid Hospice Program. The Hospice Program is considered the primary payer of services, with Mi Choice Waiver or Care Management being the secondary payer. Duplication of services shall be avoided through early and ongoing communication and coordination between the Supports Coordinator and the Hospice Agency.

Policy

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 Supports Coordinator 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 Mi Choice Waiver and a Hospice Program:

- The Participant remains classified in CHAMPS as "MI Choice" even if dually enrolled in a Hospice Program.
- 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. Supports Coordinators 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.

References

Medicaid Provider Manual - MI Choice Waiver

Action Notices and Appeal Rights

Policy Number: 2022-31	Effective Date: 05/01/2022	Revision Date(s): 01/12/2022 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

All Medicaid applicants and Medicaid recipients have the right to a fair hearing. Waiver agencies, as a Medicaid managed care provider, have certain responsibilities related to the rights of persons applying for or receiving MI Choice services. This includes providing the applicant or participant with appropriate notice of their right to request an appeal when the waiver agency takes an adverse action against them.

Policy

It is the policy of UPCAP Services, Inc. to adhere to all requirements regarding action notices and appeal rights according to the ACLS Bureau and the Michigan Department of Health and Human Services.

Procedures

It is the responsibility of the Supports Coordinator to provide any Mi Choice Waiver applicant or recipient with the appropriate notice and their right to appeal any service-related decision made by the Waiver agency.

The participant initiates an appeal with the MDHHS Field Office when the participant disagrees with a financial eligibility determination, as only MDHHS is responsible for determining a participant's financial eligibility.

The participant initiates an appeal with MDHHS and an Administrative Law Judge when the participant disagrees with a determination of functional eligibility based on the NFLOCD.

The participant initiates an appeal with the waiver agency when the participant disagrees with any decision or action made by the program, other than a decision of functional eligibility based on the NFLOCD.

**Please note, these policies and procedures DO NOT pertain to individuals who do not have Medicaid or have not submitted an application for Medicaid. These only apply to individuals who currently have Medicaid or are in the process of applying for Medicaid.*

Adverse Action

For applicants and participants of MI Choice, an adverse action occurs when a Supports Coordinator or UPCAP makes a determination regarding the participant's access to MI Choice Waiver services. An adverse action includes, but is not limited to, situations where the Supports Coordinator:

- Suspends or terminates participation in MI Choice;
- Denies an applicant's request for participation in MI Choice;
- Reduces, suspends, terminates, or adjusts MI Choice services currently in place;

- Denies an applicant's or participant's request for MI Choice services that are not currently provided; or
- Denies a participant's request for additional amounts of currently provided services.

Adverse Benefit Determination Notice

Supports Coordinators must send an Adverse Benefit Determination notice to a MI Choice participant each time a decision is made associated with an adverse action. Each Adverse Benefit Determination sent to the participant must be in writing and meet the language needs of the individual so the recipient understands the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency). Adverse Benefit Determinations must NOT use abbreviations or acronyms in any way.

The Adverse Benefit Determination notice must include the mailing date, participant's name, participant's Medicaid number, and the Supports Coordinator issuing the notice. The Supports Coordinator must list out each Mi Choice Waiver service affected by the adverse action, as well as the frequency and provider of each service. The Supports Coordinator must also provide a clear, written rationale for why the action is being taken and the date that the action is effective.

The Adverse Benefit Determination notice must also include information regarding UPCAP's appeal process, directions on how to appeal the determination, and the forms necessary to file the appeal. A copy of the Adverse Benefit Determination must be kept for the participant file and documented in the participant record.

Adverse Benefit Determination UPCAP

Advance Notice of Adverse Action

There are situations in which a participant requires advance notice of adverse action in relation to service delivery. A participant must be informed in advance for any termination, suspension, or reduction of previously authorized or purchased MI Choice Waiver services. Supports Coordinators must issue an Adverse Benefit Determination at least ten (10) days before the date of the action.

In the following scenarios the Adverse Benefit Determination can sent without advance notice, but no later than the date of the intended action:

- The Supports Coordinator has been notified of and confirmed the participant's death.
- The participant has been admitted to an institution where they are ineligible for services – i.e. hospitalization; nursing facility admission; inpatient hospice; inpatient mental health facilities; etc.
- The participant's whereabouts are unknown and the post office returns agency mail directed to them indicating no forwarding address.
- It is established that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
- A change in the level of medical care is prescribed by the enrollee's physician
- The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or
- The date of action will occur in less than 10 days.

The notice of Adverse Benefit Determination may be given within five (5) days before the date of action if the agency has facts indicating that action should be taken because of probable fraud by the participant and the facts have been verified, if possible, through secondary sources.

The participant's signature on the Person-Centered Service Plan, populated by COMPASS, acknowledges that the participant understands their right to refuse, end, or suspend services at any time by calling their Supports Coordinator and requesting a change. If a participant requests a service be decreased, placed on HOLD, or terminated, the Supports Coordinator may take action immediately as the participant's signature qualifies as the required "written" acknowledgement as outlined by MDHHS Managed Care Requirements for advance notice.

Internal Appeal Process

Participants, their designees, appointed representatives, or providers acting on the participant's behalf, may challenge an **Adverse Benefit Determination**. Participants have the right to appeal decisions made by UPCAP Long-Term Care Programs staff, whether it is related to care plan reduction, service delivery, service(s) termination or suspension, and/or termination (case closure) from the program. Participants shall be informed of this right at the time of the initial assessment and enrollment into the MI Choice program and anytime a Supports Coordinator makes a service-related determination.

The internal appeal process applies only to MI Choice Waiver-enrolled participants and in the following situations:

- The Supports Coordinator is denying a requested service that is not already in place,
- The Supports Coordinator is terminating, suspending or reducing a service that is already in place,
- The Supports Coordinator or UPCAP is taking action or making an adverse determination based on suspicion of fraud, or
- In areas with only one waiver agency, the denial of a participant's request to exercise his/her right to obtain services outside the network.

Participants have sixty (60) calendar days from the date of the Adverse Benefit Determination to request an internal appeal in writing. Those expressing a verbal appeal shall be handled as a formal appeal request but will need to follow up the verbal request in writing.

Appeals must be sent to UPCAP's Grievance and Appeals Committee within sixty (60) calendar days of the date the Notice is issued. Unless an Expedited Resolution is requested, the Appeal must include in writing:

- Participant Name and Address
- Participant Signature and Signature Date
- The Participant's Member and/or Beneficiary ID number (Medicaid ID Number)
- Reason for asking for the Internal Appeal
- If the participant wants a standard or expedited appeal. Reasoning must be included if an expedited request is being requested, as well as a letter from their physician to support this request.
- Participants may choose to submit any supporting documentation with their appeal request, including medical records, letters from physicians, or other information that supports the need for denied service or item.
- If the participant would like services to continue during the appeal process, the participant must complete a formal, written, request within ten (10) days of the date on the Adverse Benefit Determination.

Standard Request Process

- The assigned Committee member shall issue Notice of Receipt of Appeal form within three (3) business days receipt of the written appeal.
- The 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.

- The Committee has thirty (30) calendar days from the date of the Notice of Receipt of Appeal 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 Supports Coordinators and the Participant and conduct the hearing with the parties involved.
- Participants have 120 calendar days from the date of the Notice of Internal Appeals Denial to request a formal State Appeals Hearing.

Expedited Request Process

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 requests 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 fourteen (14) calendar days by promptly notifying the Participant verbally and in writing within two (2) calendar days of the request. 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.

Participants appealing the reduction, suspension, or termination of previously authorized services, must file for continuation of services within ten (10) calendar days of the Notice of Adverse Benefit Determination.

If the internal appeal decision upholds the action described in the Adverse Benefit Determination and the participant remains unsatisfied, the participant or legal representative may request a State Fair Hearing.

State Fair Hearing

Applicants for the MI Choice Waiver may request a State Fair Hearing if the Supports Coordinator makes an adverse determination regarding the potential participant's functional eligibility on the NFLOCD. When an applicant or participant does not meet the NFLOCD, waiver agencies will bypass the Internal Appeal process and provide the individual with the necessary State Fair Hearing request forms pertaining to NFLOCD. Applicants have ninety (90) calendar days of the date of the action notice to file an appeal for a State Fair Hearing.

Existing MI Choice Waiver participants may request a State Fair Hearing if UPCAP issues an internal appeal decision that upholds the action described in the Adverse Benefit Determination. A State Fair Hearing may also be requested by a participant if UPCAP does not adhere to the above time frames when reviewing and making a determination on an internal appeal.

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.

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 Waiver Director or the Regional Supervisor 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 fourteen (14) calendar days of receipt of the hearing request from MDHHS.

The Hearing Summary is prepared in cooperation with Long-Term Care Programs 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 Long-Term Care Programs 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 (Waiver Director or Regional Supervisor) will be responsible for presenting the agency's case unless it is determined that the primary Supports Coordinators 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 Waiver).
- The facts which led to the action by the Supports Coordinator.
- 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 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. If a Supports Coordinator believes that a request for an appeal hearing is inappropriate or if the request was filed beyond the required deadline, the Supports Coordinator, 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 Supports Coordinator 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 Supports Coordinator, the Hearings Coordinator must discuss the case with the Waiver 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 Supports Coordinator to bring the necessary evidence to the Hearings Coordinator and the Waiver Director. Supports Coordinators 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.

NFLOCD Ineligibility

If a Medicaid applicant or Medicaid recipient does not meet NFLOCD criteria for Doors 1 through 7, the Supports Coordinator must provide notice to the existing or potential Mi Choice Waiver participant. The individual may request a Secondary Review from MDHHS or its designee and request a Medicaid Fair Hearing before an Administrative Law Judge.

When the Supports Coordinator determines that either an existing or potential participant does not qualify for MI Choice Waiver services based on the online NFLOCD, and the Supports Coordinator does not contact the MDHHS designee to request a Secondary Review, the Supports Coordinator must issue an action notice to the participant or their legal representative. The Supports Coordinator must also offer the individual referral information about other services that may meet their needs.

Waiver agencies must use the version of the State Fair Hearing Request Form (DCH-0092)with the "EDW-LOCD" code entered in the "State Program or Service being provided to this client" field. Supports Coordinators will be required to provide the potential participant with a copy of the appropriate hearing request form at the time of notice. [MDHHS - Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services]

Waiver agencies must also utilize the Adequate Action Notice instead of the Notice of Adverse Benefit Determination. Applicants or participants must be made aware that they have the option to request a Secondary Review as identified on the hearing notice.

Adequate Action Notice

For potential participants who are not currently receiving MI Choice Waiver services, an adequate action notice is provided when the initial NFLOCD completed by the Supports Coordinator does not meet NFLOCD criteria. The adequate action notice must include all the language in the sample adequate action notices for LTSS available on the MDHHS NFLOCD website. [Long Term Care Adverse Action Notices - MDHHS - State of Michigan]

Advance Action Notice

For participants who met functional eligibility through their initial NFLOCD and are receiving MI Choice Waiver Services, but based upon a significant change in condition, did not meet their subsequent NFLOCD, the advance action notice is provided. The advance action notice must include all of the language in the sample advance action notices for LTSS available on the MDHHS LOCD website. [Long Term Care Adverse Action Notices - MDHHS - State of Michigan]

NFLOCD Secondary Review

Only existing participants, or potential participants that are also current Medicaid beneficiaries, are eligible for a secondary review. The Supports Coordinator or the participant (or their legal representative) may request an NF LOCD Secondary Review. This review is completed by MDHHS or its designee (MPRO) to ensure full consideration of LOCD

eligibility options. The Secondary Review is available only when an NFLOCD is entered in CHAMPS and results in a Door 0, indicating ineligibility. The review is a secondary review of documentation for all NFLOCD Doors, including Door 8.

NFLOCD Secondary Review Process

- A Secondary Review may be initiated by the Supports Coordinator, participant, or their legal representative after an adverse action notice is issued based on a finding of NFLOCD ineligibility.
- In the action notice, the Supports Coordinator who conducted the ineligible NFLOCD must provide the participant with information on how to timely request a Secondary Review following an ineligible NFLOCD (provided in the notice).
- This secondary review will be conducted by MDHHS or its designee (MPRO). The participant will have three (3) business days to make a request following written notice of the adverse action.
- Following the participant's request for review, the MDHHS designee (MPRO) will contact the Supports Coordinator who conducted the NFLOCD and inform them to upload documentation in CHAMPS for review.
- The Supports Coordinator who conducted the NFLOCD will upload the relevant documentation in CHAMPS within one (1) business day of being notified to do so.
- The MDHHS designee (MPRO) will review the documentation, obtain information from the participant or their legal representative, if requested, and notify the provider and the individual or their legal representative of the decision.
- If the Secondary Review determines that the participant is eligible, MDHHS or its designee will contact the provider and the individual or their legal representative.
- If the Secondary Review determines that the participant is ineligible, MDHHS or its designee will issue an adverse action notice and inform the individual of their appeal rights. MDHHS or its designee will enter the appropriate NFLOCD in CHAMPS.

Financial/Medicaid Ineligibility

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. As mentioned previously, Supports Coordinators are expected to assist participants 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. If a person is found financially ineligible during the initial assessment process, MI Choice Waiver enrollment stops.

- If the Supports Coordinator presumed the participant "financially eligible" at the time of the initial assessment but MDHHS subsequently denies Medicaid eligibility, MI Choice services must be terminated. MDHHS will issue the denial to the participant and they will have the opportunity to appeal the decision through MDHHS.
    - If the participant does not appeal the decision, any costs associated with the participant's care plan will need to be re-coded to a different payor source. Supports Coordinators will need to inform the Waiver Director. The participant's status must be changed from "Waiver-pending" to "Waiver-Financially Ineligible" for the entire period of time.
    - If the participant does appeal the decision within the ten (10) day standard of promptness time period, MI Choice Services will remain in place until the Fair Hearing has been conducted and the Administrative Law Judge issues a finding on the appeal.
- 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 participant has been determined financially ineligible, Supports Coordinators 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.
- Supports Coordinators are to ensure the participant (or authorized representative) understands the reason for closure and is documented in the participant record. A **Notice of Adverse Benefits Determination** shall then be issued and services terminated immediately.
- If the Supports Coordinator is unable to discuss closure due to financial ineligibility, an **Advance 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 ten (10) 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, Supports Coordinators are, again, required to ensure the Participant (or authorized representative) understands the reason for closure and is documented in the participant record. A **Notice of Adverse Benefit Determination** shall then be issued and services terminated immediately. This action is not appealable as it is based on a MDHHS determination and/or Administrative Law Judge ruling.

When a beneficiary is determined to no longer be eligible for Medicaid-funded services and an appeal is requested, Medicaid will continue to pay for services if the beneficiary appeals within required program timeframes. If the beneficiary does not appeal the decision, the provider is eligible for Medicaid reimbursement through the effective date of the advanced action notice, or the date in which the beneficiary stopped receiving services, whichever is first. When the beneficiary appeals the decision in compliance with MDHHS policy, MDHHS will reimburse the provider for services throughout the appeal process. If the beneficiary's appeal is denied, MDHHS will reimburse the provider for up to 30 days from the date of issuance of the hearing decision and order.

References

Medicaid Provider Manual - MI Choice Waiver
Mi Choice Contract - Attachment C
MDHHS Long Term Care Adverse Action Notices
Michigan Office of Administrative Hearings and Rules for MDHHS

Case Closure/Disenrollment

Policy Number: 2022-32	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Participants who no longer qualify for the MI Choice Waiver or Care Management must be closed out of the program. There are many different reasons a participant should be closed, with specific requirements for each reason.

Policy

Participant cases will be closed for rationale that is case specific. Closed status will be designated by the Supports Coordinator for the following reasons:

- Death - The last date of waiver enrollment cannot exceed the date of death.
- Nursing Home Placement
    - Mi Choice Waiver – The last date of waiver enrollment will be the day prior to nursing home placement. The day of nursing home placement should be listed as Waiver-Ineligible and services recoded to 221 fund code for that day
    - Other programs – The date of closure can be the day of nursing home placement.
- Not Medically Eligible - If a participant is not found medically eligible, the date of closure should be the same date the determination was made.
- Not Financially Eligible – Only used for potential Mi Choice Waiver participants under the age of 60 who are not financially eligible for Mi Choice. If over the age of 60, they should be offered the Care Management program. We never use not financially eligible for potential participants over the age of 60.
- Not Medically or Financially Eligible – Only used for potential MI Choice Waiver participants under the age of 60 who are not medically or financially eligible for Mi Choice. If over the age of 60, should use not medically eligible as the closure reason.
- No service needs/needs being met – This is to be used for an individual that it was determined there are no service needs or needs are being met elsewhere.
- Hospitalized more than 30 days – This is to be used as a closure reason for Mi Choice Waiver participants only when they are hospitalized more than 30 days.
- Refused Services – To be used for any participant that refuses participation in any programs.
- NFT Transitioned – DO NOT USE
- NFT Transitioned to another agent – DO NOT USE
- NFT Not Transitioned – DO NOT USE
- Moved, transferred to another agent – DO NOT USE
- Moved, Not Transferred to another agent – Use for individuals that move out of the Upper Peninsula and do not transfer to another Mi Choice Waiver or Care Management agency within the State.
- Moved to AASA/CM program – This is to be used for a Mi Choice Participant that no longer financially qualifies, no longer in need of two or more Mi Choice Services and is over the age of 60, but wishes to be enrolled in Care Management
- Moved to Waiver Program – DO NOT USE
- Chose DHS Home Help Services – To be used for any participant that wishes to be closed and is choosing DHS Home Help Services.

- Chose MI Health Link – To be used for any participant that chooses to enroll in MI Health Link
- Transferred to PACE Program – Only to be used for an individual moving to another area of the State and wishes to participate in their local PACE Program
- Transferred to another Agent in Region – DO NOT USE we do not have another Agent in our Region
- Hospice Residence Placement – To be used for any participant that is closing due to being placed in a hospice residence program.
- ICF/MR Institution Placement – Not used very often, if at all. Prefer use of Nursing Home Placement reason. If using, follow instructions under nursing home placement reason.
- Hearing Decision – Only to be used for Mi Choice Waiver participants that appealed a decision, had a hearing and determination was made closure is appropriate.
- For Cause – DO NOT USE
- Administrative Close – DO NOT USE unless directed by Program Director
- Options Counseling – DO NOT USE
- Opted-out/termed – To be used for MHL individuals who are no longer enrolled in MHL.
- Unable to contact/exhausted attempts – To be used for any participant when appropriate actions were taken for unable to contact/exhausted attempts.
- Other – Use for any other closure reasons not listed above. Must provide an explanation in the "notes" section.

Procedures

Supports Coordinators are responsible for determining the closure reason as well as the effective closure date. Supports Coordinators may choose to review or discuss the case closure with their Team Leader, Regional Supervisor, or Waiver Director, if necessary.

Required Documentation

- Supports Coordinator must document the closure reason and date in the Participant record.
- Supports Coordinator must inform the current service providers of the case closure date. Supports Coordinators should attempt to provide as much advance notice to the service provider as possible in situations where the Supports Coordinator has prior knowledge of an upcoming closure date. In situations where a participant case is closed due to unforeseen circumstances, i.e. participant death, the Supports Coordinator must notify the service provider immediately upon notification.
- Supports Coordinator must update the Compass Status Form to reflect the case closure date and submit it to the appropriate Case Tech for entry.
    - If the Participant is being closed from the Mi Choice Waiver Program but is transferring to another UPCAP Program (Care Management; VA; etc.), the Supports Coordinator must update the Participant Status Report to reflect the MI Choice Waiver program closure date and the start date of the new program.
- Supports Coordinator must update all Work Orders to reflect the service STOP date and submit it to the appropriate Case Tech for entry.
- Supports Coordinator must complete and send the appropriate Action Notice with Appeal Rights (if applicable) to the Participant and/or guardian. A copy of the Action Notice must be placed in the file.
- For participants enrolled in the Mi Choice Waiver program and will be closing, Supports Coordinators must complete and submit the MI Choice Disenrollment Notification Form to the Medicaid Specialist for entry into CHAMPS within five (5) days of case closure determination. This notifies MDHHS of the MI Choice Waiver disenrollment effective date and reason.
- All paperwork (status, work orders, disenrollment, adverse benefit determination, etc.) is to be filed in the participants chart.
- Submit the Participant's chart to the appropriate Case Tech. The Case Tech will breakdown the chart and file it appropriately. All files will be saved for ten years from the date of closure.

Re-Enrollment Process

Policy Number: 2022-33	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Policy

A re-enrollment occurs when a previous MI Choice participant seeks enrollment in the MI Choice program again. This happens EVERY time the participant's status changes from Waiver/Yes to a non-waiver program (Waiver/Ineligible, Waiver/No, Waiver Financially Ineligible, or Closed) and then back to Waiver/Yes.

Procedures

All eligibility requirements for the MI Choice Waiver program must be met and confirmed prior to the participant's re-enrollment. An NFLOCDand FOC must be completed and entered into CHAMPS for each re-enrollment regardless of the participant's functional eligibility prior to the status change. Supports Coordinators should perform all other activities associated with MI Choice Waiver Enrollment and reassessments.

When ALL eligibility criteria are met, a return reassessment is required if:

- The participant was completely closed to all agency services, regardless of the length of time between closing and re-enrolling the participant.
- The participant experienced a change in status. A change in status includes but is not limited to a medical event (such as a heart attack, stroke, broken bone, or organ transplant) that changed the participant's functional ability, a change in the availability of the participant's informal supports, a noticeable change in the participant's cognitive ability, or a change in the participant's financial situation.
- The participant has been ineligible or otherwise out of the MI Choice program for more than one month but remains an open participant with the agency.

Supports Coordinators may perform assessments for a re-enrollment alone or using a RN/SW team. However, MDHHS requires an RN/SW team in the following situations:

- The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
- The participant experienced a change in status related to a decline in the participant's functional ability, informal support availability, or cognitive ability.
- The participant has been ineligible or otherwise out of the MI Choice program for at least 90 days.

In situations when the waiver agency cannot schedule a team reassessment and re-enrollment is scheduled to occur, one Supports Coordinator may start the reassessment process to assure the participant meets MI Choice eligibility requirements and to develop a temporary PCSP. The Supports Coordinator of the other discipline will be required to complete the in-person reassessment within seven (7) days of the time the reassessment process began. See Care Transitions for more specific procedures.

References

Medicaid Provider Manual - MI Choice Waiver

Transferring MI Choice Participants to Another Waiver Agency in Michigan

Policy Number: 2022-34	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

MDHHS ensures participants have a choice of a waiver agency, as available, to coordinate MI Choice services. A participant may choose to transfer enrollment from one waiver agency to another, as available within the region where the participant lives, or a participant may move to another region of the State. Waiver agencies are responsible for managing transfers of participants to other agencies or accepting transfers from another agency.

Policy

It is the policy of UPCAP Services, Inc. to have procedures in place for a participant wishing to transfer from one Waiver agency to another to be a seamless transition with little to no disruption in services.

Procedures

Transferring MI Choice Participant

When a Supports Coordinator is notified that a current MI Choice Participant will be moving out of UPCAP's Waiver service area, they will be responsible for coordinating the transfer to the appropriate Waiver agency, if needed and requested by the participant.

The Supports Coordinator will refer to the Waiver Agency Region Map with list of Waiver Agents to determine the appropriate Waiver agency to contact based on where the participant will be moving. The Supports Coordinator is responsible for notifying the appropriate Waiver agency once they know that participant's potential move date, so as to ensure a smooth transition from one agency to another.

The Supports Coordinator will provide the Waiver agency with any pertinent participant information, including the most current COMPASS iHC assessment and Person-Centered Service Plan. The Supports Coordinator is responsible for sending these via the secure file exchange or other appropriate means of sharing protected information.

Once the participant has moved and the receiving Waiver agent has completed their assessment, the Supports Coordinator will be responsible for closing the participant's file and submitting the disenrollment notification so that it may be entered

into CHAMPS. The Supports Coordinator will need to coordinate these dates with the receiving agency as the participant will need to be disenrolled in CHAMPS prior to the receiving agency entering their enrollment information in CHAMPS.

Receiving MI Choice Participant

Once UPCAP is notified of a MI Choice Participant that is transferring to UPCAP's service area, the Waiver Director will notify the Care Management office assigned to the participant. The participant will be assigned to a Supports Coordinator, who will be responsible for coordinating the transition to ensure that there is no lapse in service.

The Supports Coordinators assigned to the participant will contact the transferring Waiver agency to request the most recent assessment and person-centered service plan. The Supports Coordinators will also contact the participant to coordinate and schedule the participant's in-home visit and assessment. This assessment is considered an initial assessment and will need to be completed by a Supports Coordination team, RN and SW. Supports Coordinators will do their best to schedule the participant's home visit and assessment as close to their transfer date as possible to ensure a seamless transfer.

The Supports Coordinators will conduct a new NFLOCD and FOC as well as a complete COMPASS iHC assessment. Supports Coordinators will follow the process for assessing and enrolling a new participant. Supports Coordinators will notify the transferring agency once the initial assessment has been completed and the enrollment date has been determined so that the agency can disenroll the participant in CHAMPS prior to UPCAPs enrollment date.

A new Person-Centered Service Plan must be developed utilizing UPCAP contracted service providers. Supports Coordinators cannot authorize or reimburse MI Choice Services provided by a previous waiver agency.

References

Medicaid Provider Manual - MI Choice Waiver

Twenty-Four (24) Hour Care

Policy Number: 2022-35	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Policy

Twenty-four-hour care is defined as the provision of continuous care and/or supervision throughout a 24-hour period. Neither the Care Management nor the Mi Choice Waiver Program are designed to provide long-term 24-hour care and are intended to supplement the informal support services available to the participant.

There may be situations where a participant may not have the informal supports available to contribute to the provision of 24-hour care. In these situations, Supports Coordinators would attempt to secure in-home services through contracted agencies. In situations where 24-hour care will need to be considered for a participant, the Supports Coordinator must consult with the Regional Supervisor and Waiver Director to review the Person-Centered Service Plan and discuss the long-term needs and goals of the participant.

Suicide Policy

Policy Number: 2022-36	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

Supports Coordinators can play an important role in preventing suicide by identifying at-risk older adults and taking appropriate follow-up actions. The goal of assessing suicide risk in participants is to help determine the most appropriate actions to keep the older person safe.

Policy

Supports Coordinators should be able to recognize the warning signs of suicide and provide the most appropriate actions in order to keep the participant safe. If at any time during an assessment a participant answers "YES" to questions pertaining to Self-Injury in Section G: Mood and Behavior Patterns, the following actions should be taken:

1. Assess for immediate risk/danger of attempting suicide.
    a. If immediate risk is determined, call 911 and stay with them until help arrives.
    b. If there is no immediate risk/danger, continue to the next step.
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?
3. Encourage participant to seek help and provide them with contact information for their local Mental Health Agency, Dial Help (1-800-562-7622) or the 988 Suicide & Crisis Lifeline (text or call 988 or call 1-800-273-8255). If necessary, the Supports Coordinator should advocate on the participants behalf and call, with their permission.

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

4. Advise Regional Supervisor or Waiver Director of the situation, including next steps to be taken or required.

References

Suicide Prevention Hotline Website
National Council on Aging

Grievances (Complaints)

Policy Number: 2022-37	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC, Admin

Scope

This policy applies to all UPCAP Services, Inc. Long-Term Care Program participants/applicants that wish to file a grievance. A grievance is an expression of dissatisfaction with any aspect of a participant/applicant's involvement in any of UPCAP's Long-Term Care Programs.

Policy

UPCAP's Grievance & Appeals Committee is composed of the Compliance Officer, Regional Supervisor, Quality Assurance Manager and the Medicaid Specialist. Any alternate individual may be designated by the Director of Long-Term Care Programs, if needed. It is the responsibility of the Compliance Officer to assign a committee member to a grievance once it is received. Grievances (Complaints) are prioritized by the date on which they are received.

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

Procedures

Participant Grievance (Complaint)

Participants, Applicants, their caregivers, supports, guardian, or Appointed Representative 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 Regional Supervisor or Director of Long-Term Care Programs, 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 this intervention does not quickly remedy the situation, the Supports Coordinator should advise the individual to contact UPCAP's Grievance & Appeals Committee by phone, in person or in writing. The Committee Member assigned to the case will:

1. Document details of the Complaint or request are submitted in writing depending on seriousness or complexity.
2. Issue a 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 issue identified in the grievance/complaint
4. Respond in writing within thirty (30) calendar days of receipt of the grievance/complaint. The letter will summarize the results of the investigation and any action that will be, or has been, taken, and/or recommendations or 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 & Appeals Committee. The Grievance & Appeals Committee should keep a spreadsheet of all grievances, which include the date received, the date a notice of receipt was submitted, the date the response was submitted and any further action that might be taken.

UPCAP Internal Grievance Process

Grievances that cannot be resolved satisfactorily with the UPCAP Grievance & 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.

- The assigned committee member shall submit the Grievance to the Director of Long-Term Care Programs in writing within thirty (30) calendar days of the Grievance & Appeals Committee's final response. The Director shall respond in writing to the grievance within ten (10) business days.
- Those not satisfied with the response of the Director of Long-Term Care Programs may forward their grievance in writing to UPCAP Services, Inc.'s Chief Executive Officer (CEO), within ten (10) business days of receipt of the Director of Long-Term Care Program's response. UPCAP's CEO shall respond in writing within ten (10) business days of receipt of the grievance.
- Participants/Applicants not satisfied with the response of UPCAP's CEO may forward their grievance in writing to UPCAP's Executive Committee within ten (10) business days of the UPCAP CEO response. UPCAP's Executive Committee shall review the appeal at its next regularly scheduled meeting.

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.

References

Medicaid Provider Manual - MI Choice Waiver

Supervisory and Peer Reviews

Policy Number: 2022-38	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC

Scope

This policy applies to all new MI-Choice enrollments and existing participants receiving MI Choice services.

Policy

It is the policy of UPCAP Services, Inc. that all new MI-Choice participants have a supervisory chart review completed by the Regional Supervisor or designee. It is also required that each Supports Coordinator completes one peer chart review for an existing participant on a monthly basis.

Procedures

Supervisory Reviews

All newly enrolled participants shall be reviewed by the Regional Supervisor to ensure that the assessment and associated paperwork are complete and accurate. The Supports Coordinator is required to send a completed care plan cost review to their Team Leader, the Regional Supervisor or the Director. Once the care plan cost review is signed, it is submitted to the Regional Supervisor, which will confirm the case is ready for review. The Regional Supervisor can also run a list of the previous month's participant client enrollments to ensure all new participant charts are reviewed. The Regional Supervisor utilizes the Supervisory Review form (see attached). The review consists of a review of the entire chart, with focus being on the following:

- Reviewing for missing data
- Ensure care plan is appropriate to meet the identified needs in the assessment
- PCSP and Service Summary comparison to verify it lists the services that have been arranged
- Verification that NFLOCD completed accurately and data within the assessment matches the NFLOCD entered in CHAMPS

The Regional Supervisor will provide feedback to the Supports Coordinator(s) on things that need to be reviewed, updated or improved upon within 90 days of the initial assessment. The Supports Coordinator will be required to make any required changes within two (2) business days of receiving the feedback. Once corrections are completed, both disciplines will sign the supervisory review form and send it back to the Regional Supervisor.

The Regional Supervisor will also review a random sampling of annual NFLOCD's throughout the year for accuracy and ensure Supports Coordinators are conducting NFLOCD's properly.

Inter-Office Peer Reviews

Supports Coordinators are required to participate in inter-office peer reviews on a monthly basis. Each Supports Coordinator professional discipline conducts reviews of their counterpart's case work utilizing a standardized review form. A random sample method shall be used, with the sample size based on 10% of the current open caseload.

Supports Coordinators will review each item listed on the standardized form, including review of the Interventions in the PCSP and compare with the service summary in place to look for discrepancies as well as ensuring the NFLOCD was conducted accurately. Both the reviewer and the primary Supports Coordinator, of the case being reviewed, are required to sign the form once completed.

If significant problems or issues are identified, they are to be presented to the Regional Supervisor and/or the Director for review. All completed forms should be sent to the Director.

Intra-Office Peer Reviews

Intra-office peer reviews will be conducted on a semi-annual basis. Each Support Coordinator will be required to complete an intra-office peer review on a case from another field office. Supports Coordinator teams cannot conduct a review of their own cases and must alternate reviews among various teams.

Prior to each intra-office peer review a quality indicator report will be generated for each office to identify additional issues that may require person-centered planning efforts. Inter-office peer reviews will also include drill down activities, if needed, related to Performance Improvement Projects identified in the Quality Management Plan.

References

Peer Review Form

	# Supports Coordinator Training		
Policy Number: 2022-39	Effective Date: 05/01/2022		Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave		Category: SC, Admin

Scope

All MI-Choice Waiver staff are expected to 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 to ensure that individual backgrounds and beliefs are respected in all aspects of Supports Coordination activities. MDHHS requires that Supports Coordinators be Licensed Registered Nurses and Licensed Social Workers in the State of Michigan.

Policy

It is the policy of UPCAP Services, Inc. that Supports Coordinators 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. A copy of licensure is maintained in the employee file.

At hire, Supports Coordinators will have one-on-one training for the first three months of employment regarding all aspects of the position as outlined in the training checklist. Newly hired Supports Coordinators will be required to meet 90-day, 6-month and 12-month benchmarks as defined in the Supports Coordinator benchmark checklist.

When funds are available, Supports Coordinators will be allowed/encouraged to register for conferences and workshops which lend themselves to supporting the mission of the organization, improving job related skills, and assisting employees in meeting CEU requirements. When feasible, UPCAP will cover the costs involved including registration, mileage, and meals within the guidelines of the UPCAP personnel policy.

Supports Coordinators are also required to participate in monthly peer reviews, semi-annual in-services, and any other training determined by the Director.

Training topics include, but are not limited to:

- Alzheimer's Disease Dementia
- Cultural Diversity & Sensitivity
- Universal Precautions
- Disability Sensitivity
- Elder Abuse and Neglect
- Person-Centered Planning (yearly requirement)
- Critical Incidents (yearly requirement)
- Care Coordination (yearly requirement)
- Fraud, Waste and Abuse (At hire and annually thereafter)
- HIPAA (At hire and annually thereafter)
- Cyber Security (At hire and annually thereafter)

UPCAP also utilizes a web based software (Question Pro) for creating and distributing surveys to Supports Coordinators. These surveys are designed like a quiz to help identify areas that need improvement or additional training as well as increase the knowledge and skills of Supports Coordinators. Surveys are sent on a quarterly basis and include topics such as: critical incidents, NFLOCD scenarios, care planning, supports coordinator functions and more.

A list of all trainings and completion dates are maintained by the Director to ensure they are completed within required timeframes.

Privacy & Confidentiality

Policy Number: 2022-40	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: SC

Scope

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. It is the policy of UPCAP Services, Inc. that all staff receive HIPAA training upon hire and then annually.

Policy

Participants shall be given a copy and brief verbal overview of UPCAP's Notice of Privacy Practices at the initial assessment. 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 Supports Coordinator must enter the Annual Release of Information Due Date in COMPASS to ensure that a reminder for renewal is populated for the Supports Coordinator. 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. Supports Coordinators are mandatory reporters of suspected abuse, neglect, or exploitation; therefore, no release is needed in such instances.

In approved sharing situations, Supports Coordinators 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.

Technology and Protected Health Information

Supports Coordinators will follow the UPCAP Employee Policy 1.12 - Information Technology Resources Policy and are required to provide signature of receipt and understanding at hire. Supports Coordinators must exercise caution and safety measures when using technology that may contain or provide access to a Participant's electronic record and protected health information.

Emailing, Texting, Document Sharing

General email and texts are not secure methods of communication. Supports Coordinators and Long-Term Care Program staff are required to access and send emails through their UPCAP-provided email address. UPCAP currently utilizes a GSuite encryption service to protect sensitive information contained within employee emails. Sensitive information of any kind should not be in the subject line, nor identifying information be used in the name of attached files. 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 or transmitted through secure file exchange applications such as COMPASS, or Altruista. Texting sensitive information of any kind, including participant names, between Supports Coordinators or contracted providers is not appropriate and prohibited.

Participants have the right to request unencrypted email or text communication with Supports Coordinators. The Participant Consent Form for Email Communication or Consent Form of Text Communication shall be used to inform Participants of the risks of using these communication methods. The completed consent form must be filled out completely, including all email addresses or phone numbers to be used, before any communication through these formats may occur. The signed consent forms must be kept in the Participant's file as well as a copy sent to UPCAP's Privacy and Compliance Manager and to the Participant.

HITECH Act: Security Breach Notification Law

All Long-Term Care Program 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's Privacy and Compliance Manager and the Program Director. The Program Director and/or Privacy and Compliance Manager will notify UPCAP's Security Officer (UPCAP CEO).

The Privacy and Compliance Manager 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 been satisfactorily lessened or mitigated.

If it is determined that a security breach occurred, the Privacy and Compliance Manager 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

References

Medicaid Provider Manual - MI Choice Waiver

Case Records Maintenance

Policy Number: 2022-41	Effective Date: 05/01/2022	Revision Date(s): 10/06/2021
Reviewed by: NCQA/AQAR Team & SC Review Group	Approved by: Theresa LaFave	Category: SC & Case Tech

Policy

It is the policy of UPCAP Services, Inc. that Supports Coordinators 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
- Person Centered Service 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 (if applicable)
- 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.
- Back-Up Plan
- Self Determination Forms (if applicable)
- Contact Key
- Care Plan Cost Review (Budget)
- Plan of Care Signature Page
- Participant registration form (if applicable for Care Management participants)
- Residential Services (if applicable)

Participant charts should be set up consistently utilizing the chart set up key.

All forms must contain either the signature or the initials of the person completing such forms. Participant signatures are required by the ACLS Bureau and Michigan Department of Health and Human Services for the following forms:

- Handbook acknowledgement form
- Freedom of Choice
- Consent and Authorization
- Medical Release
- Text/Email Consent (if applicable)
- Plan of Care Agreement
- Person Centered Service Plan

To protect the privacy of all Participants, case files are to be kept in a locked filing cabinet or in a room with a locking door that is not accessible by unauthorized personnel or visitors. Electronic files stored on a computer or other devices are to be password protected and never left opened or unattended. Staff are required to adhere to UPCAP's Information Technology Resources Policy (Section 1.12).

Supports Coordinators are not to shred or remove any of the above documents or forms from the Participant's chart. Overflow charts may be utilized when the original chart becomes too thick or cumbersome. Overflow charts must be kept in a locked filing cabinet and all documents must be retained.

Case records, including referrals, are to be **saved for a minimum of ten (10) years** as required by ACLS Bureau and Michigan Department of Health and Human Services.

References

Medicaid Provider Manual - MI Choice Waiver

Timely Reports and Documentation

Policy Number: 2022-42	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: Admin, Case Tech

Policy

It is the policy of UPCAP Services, Inc. to submit all required reports accurately and timely as required by the Michigan Department of Health and Human Services (MDHHS) and the Bureau of Aging, Community Living, and Supports (ACLS Bureau).

Procedures

Administrative Expense Reports

Administrative Expense Reports are due 30 days after the close of each calendar month. The Chief Financial Officer is responsible for completing and submitting the report to MDHHS-MICHOICEREPORTS@michigan.gov, with a copy sent to the Director of Long-Term Care Programs.

Provider Network List

Provider Network lists, utilizing the excel spreadsheet required by MDHHS and the ACLS Bureau, are due annually within 60 days of the effective date of the Mi Choice Agreement with updated reports being due 30 days from the date of change. The Director of Long-Term Care Programs is responsible for maintaining, updating and submitting the provider network list to MDHHS-MICHOICEREPORTS@michigan.gov.

Waiver Personnel

The list of all UPCAP Services, Inc. staff paid for out of MI Choice Waiver funds, utilizing the excel spreadsheet required by MDHHS and the ACLS Bureau, is due within 90 days of the effective date of the Mi Choice Agreement and within 30 days of any personnel changes. Contact information must include telephone numbers, fax numbers, e-mail addresses and professional licensure numbers (nurses and social workers). The Director of Long-Term Care Programs is responsible for maintaining, updating and submitting the waiver personnel list to MDHHS-MICHOICEREPORTS@michigan.gov.

Provider Monitoring Schedule

Provider monitoring schedules are due by December 1st of each fiscal year. It is the responsibility of the Quality Assurance Supervisor to complete the monitoring schedule and submit to the Director of Long-Term Care Programs. The Director of Long-Term Care Programs is responsible for reviewing the schedule to ensure the list meets requirements and submitting it to MDHHS-MICHOICEREPORTS@michigan.gov.

Provider Monitoring Reports

Provider Monitoring Reports are due upon completion of each report throughout the contract period. It is the responsibility of the Quality Assurance Supervisor to submit reports to MDHHS-MICHOICEREPORTS@michigan.gov.

Quality Management Progress Summary Report with Quality Indicator Results

The Quality Management Progress Summary Report with Quality Indicator Results are due by January 15th of each year. It is the responsibility of the Director of Long-Term Care Programs to submit the report to MDHHS-MICHOICEREPORTS@michigan.gov.

Net Asset Reports

Net Asset Reports are due within 30 days of the start of the Mi Choice Agreement. It is the responsibility of the Director of Finance to submit the reports to MDHHS-MICHOICEREPORTS@michigan.gov.

Audited Financial Reports

Audited Financial Reports are due on an annual basis and must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. It is the responsibility of the Director of Finance to submit the audited financial reports as soon as they are received from the accounting firm to MDHHS-MICHOICEREPORTS@michigan.gov.

Medical Loss Ratio Report

The Medical Loss Ratio Report is due no later than June 30th of year. The Medical Loss Ratio Report should be equal to or higher than 85%. The MLR experienced in a reporting year is the ratio of the numerator to the denominator. Refer to attachment C of the Mi Choice Contract for complete details. It is the responsibility of the Director of Finance to submit the medical loss ratio report to MDHHS-MICHOICEREPORTS@michigan.gov or as instructed on the directions.

Recoveries and Overpayments

A report of all recoveries and overpayments are reported on the Program Integrity report on a quarterly basis as follows:

- October through December Due February 15th
- January through March Due May 15th
- April through June Due August 15th
- July through September Due November 15th

It is the responsibility of the Director of Long-Term Care Programs to submit reports to the MDHHS-OIG sFTP.

Verification of Costs

Verification of costs is due on a monthly basis utilizing the encounter submission option in Compass. It is the responsibility of the Director of Long-Term Care Programs to process the encounters, correct errors and submit through Compass.

Caseload Ratio Report

The Caseload Ratio Report is completed on a monthly basis by the Director of Long-Term Care Programs. This report is given to field office Team Leaders and the Executive Director for review. The average caseload is 25-30 for each Supports Coordinator. Caseloads consist of Mi Choice Waiver, Care Management, Targeted Care Management, Local Care Management (under 60 but not eligible for Mi Choice), Veterans, UPHP C-Waiver and Nursing Facility Transitions.

The Caseload Ratio Report is used to determine if Supports Coordinators are at their capacity, if more Supports Coordinators need to be hired or if caseloads need to be redistributed.

Mi Choice Eligibility Reports

Mi Choice Eligibility reports are run on a monthly basis, or more frequently if needed utilizing Compass. These reports identify if the Mi Choice enrollment in Compass matches Mi Choice enrollment in CHAMPS. More information on the details of these reports can be found in the Compass Eligibility Requests User Guide. It is the responsibility of the Director of Long-Term Care Programs or the Medicaid Specialist to run these reports.

Office of Inspector Reporting

Program Integrity Annual Report

The Mi Choice Program Integrity Annual Report is due by March 15th of each year. It is the responsibility of the Director of Long-Term Care Programs and the Compliance Officer to complete and submit the report. This report is submitted to MDHHS-OIG sFTP.

Fraud Compliance Program

The Mi Choice Fraud Compliance Program Report is due by May 15th of each year. It is the responsibility of the Director of Long-Term Care Programs and the Compliance Officer to complete and submit the report to MDHHS-OIG sFTP.

Quarterly Program Integrity Reports (Recoveries and Overpayments)

A report of all recoveries and overpayments are reported on the Program Integrity report on a quarterly basis as follows:

- October through December Due February 15th
- January through March Due May 15th
- April through June Due August 15th
- July through September Due November 15th

It is the responsibility of the Director of Long-Term Care Programs to submit reports to the MDHHS-OIG sFTP.

Annual Program Integrity Plan

The Annual Program Integrity Plan is due by January 15th of each year for the upcoming fiscal year. It is the responsibility of the Director of Long-Term Care Programs and the Compliance Officer to complete and submit the report to MDHHS-MICHOICEREPORTS@michigan.gov.

Program Integrity – Grantee Screening and Disclosure Attestation

The Program Integrity – Grantee Screening and Disclosure Attestation is due by July 15th of each ear. It is the responsibility of the Director of Long-Term Care to obtain necessary signatures and submit to MDHHS-MICHOICEREPORTS@michigan.gov.

Clear Access Scripts/Queries, MICIS Reports, Compass Reports

On a monthly basis the following scripts, queries and reports are run:

- **Non NFT-SSP** – This report is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs. The report identifies individuals who may qualify for SSP status based on the last assessment
- **Participant Not Closed, no opened Status** – This report is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs or the Compliance Officer. This report identifies an individual with an open episode in Compass, but not having a status associated with it. The list is reviewed and compared to the

existing waiting list. Discrepancies on the list are discussed with Supports Coordinators and Case Techs to determine the status of the referral.

- **Vendor Careplan/Billing Variance Report** – These reports are run for each batch of bills (by provider) that are entered or reviewed in Vendor View Billing from MICIS by the Case Tech assigned to that particular provider. The Vendor Careplan/Billing Variance report shows the total amount of service authorization in the careplan compared to what was entered in MICIS or Vendor View.
- **Compass Participant Care Plan/Bills Comparison Reports** - These reports are run on a monthly basis for all program participants by the Director of Long-Term Care Programs out of Compass/Reports/Services. The report is reviewed to ensure the accuracy of service delivery by comparing what was authorized to what was billed concentrating on anything billed less than 80% of what was authorized as well as reviewing anything billed at 100% consistently for all services to ensure providers are only billing for authorized amounts.
- **Ultimate Champs Query** – This query is run on a weekly basis by the Medicaid Specialist or the Director of Long-Term Care Programs utilizing ClearAccess scripts. The results of the query show the MA type, Program Code, Pet Code, BP code, date ranges, NFLOCD status, Enrollment status and Compass Program Status. This report will help identify individuals that may have issues related to their program enrollment, which need to be investigated.
- **Waiver Pending/Enrollment Comparison** - This report is run on a monthly basis by the Medicaid Specialist out of Compass/Reports/Enrollment. The Medicaid Specialist reviews the report to ensure Mi Choice enrollments have been submitted and entered into CHAMPS for individuals listed as Waiver pending.
- **NFLOCD Due Dates** – This script is run on a monthly basis by the Director of Long-Term Care Programs out of ClearAccess. The results of the script show the NFLOCD due dates for the time period the report was run for. Reports are then shared with all Supports Coordinator.
- **Passive NFLOCD's** – This information is run on a monthly basis out of CHAMPS by the Director of Long-Term Care Programs. The results are exported to an excel spreadsheet and sorted by passive enrollment and modified date. The list of NFLOCD's that had a passive NFLOCD based on the last assessment are sent to Supports Coordinators as well as have the NFLOCD due date and application ID updated in Compass.
- **Bills on Dates Not at Home** – This script is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs or the Compliance Officer. The results are reviewed for services that were billed on a date the participant was in the hospital, out of town or in a nursing facility.
- **Excessive Units** – This script is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs or the Compliance Officer. The results are reviewed for services that are billed at more than 1 unit per day or per month (Chore, PERS, etc.).
- **Bills on Nursing Home Days** – This script is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs or the Compliance officer. The results are reviewed for services that are billed on the da of Nursing Home placement.
- **Provider Rate Verification** – This query is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs. The results are reviewed against contracted rates to ensure providers are billing the appropriate rates.
- **Expenditure Reports** – This report is run on a quarterly basis out of Compass/Reports/Services by the Director of Long-Term Care Programs. The report is reviewed to ensure bills were coded to the appropriate program type fund code.
- **Non-Service Report** – This report is run on a monthly basis out of Compass/Reports/Services by the Director of Long-Term Care Programs. The results of the report are reviewed for vendors that have more than 5% non-service reasons.
- **T2022 Bills Posted or Missing** – This script is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs. The results are viewed to ensure no T2022 services were overbilled or not billed.
- **Cost Reconciliation** – This report is run on a monthly basis out of Compass/Reports/Services by the Director of Long-Term Care Programs. The results are provided to accounting where they compare the totals by fund code to what they have paid providers through that date to be sure the amounts match.
- **Recent Address Changes** – This script is run on a weekly basis out of ClearAccess by the Director of Long-Term Care Programs. This report identifies participants that had a recent address change and a home visit is due.

- **Days Between Waiver Start Date and Services** – This script is run on a weekly basis out of ClearAccess by the Director of Long-Term Care Programs. This report shows the number of days from the Mi Choice Waiver start date to the service start date. For those Participants who do not have services within the required timeframe the Supports Coordinators are contacted to determine the reason for the delay or non-service.
- **Missing Counties** – This query is run on a monthly basis out of ClearAccess by the Director of Long-Term Care Programs. This report identifies participant records that have no county listed.

References

MI Choice Contract – Attachments E & D
Compass User Guides

	# CHAMPS Enrollment/Disenrollment Process		
Policy Number: 2022-43	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022	
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: Admin	

Before entering any information into CHAMPS, all dates and identifying information must be confirmed in COMPASS. Make note and confirm the following Participant information before entering any data in CHAMPS:

- Medicaid Number
- Date of Birth
- Last 4 digits of Participant's Social Security Number
- Participant Status Report
    - Confirm Program Start/End Dates
    - Confirm SSP/SMOU Status

If there is conflicting information, notify the appropriate Case Tech and/or Supports Coordinator for assistance.

New Enrollments

Enrollment – No Medicaid Number

- Check LOCD system to see if MA ID has been assigned yet
- If there is no Medicaid Number linked with the participant, the enrollment cannot be entered
- Add to Enrollment Spreadsheet & Make Note
  - Check CHAMPS daily for changes
- Enter progress note in COMPASS
    - "Attempted entry of Mi Choice Enrollment in CHAMPS. No Medicaid ID number available. Will continue to monitor."

Enrollment – w/ Medicaid Number

- Click Add Enrollment/Admission
    - Enter Medicaid number – all other information should populate. Make sure all required data is there and correct.
    - Enter Waiver Enrollment date and Assessment Date
        - Assessment date cannot be AFTER the enrollment date
    - Skip Responsible Party Section – no need to enter information
    - Check address section
        - If no address, add it.
        - Must verify and save address before submitting
    - Skip Previous Provider/Facility Information section – no need to enter information

- Skip Other Insurance Section – no need to enter information
- Skip Upload Documents – no need to enter information
- Enter Certification Information
    - Click first box
    - Enter “Signature on File” to both Signature fields
    - Click second box
    - Enter First and Last Name in Signature fields
- Submit
    - Review pop up box to make sure dates and info are correct
- Print completed form and attach to Enrollment form
    - Save a PDF copy
    - Take note of Transaction ID

- If Status shows **“COMPLETED”**
    - Check CHAMPS eligibility report to confirm Mi-Choice and start date
    - Go into participant status in COMPASS
    - Edit Waiver Pending and change to Waiver Yes
        - Save PDF of status
    - Save PDF version of status and send copy to primary CM and case tech
        - “See attached. Showing MI-Choice in CHAMPS. Changed status from Waiver-Pending to Waiver-Yes”
    - Enter Progress note into COMPASS
        - “Entered MI Choice enrollment in CHAMPS. CHAMPS shows MI Choice. Changed status from pending to yes and notified CM”
        - Don’t need to do anything on the spreadsheet if it’s a new enrollment that shows completed. Just file

- If Status shows “**COMPLETED – WAITING FOR MA**”
    - Email regional MDHHS Office the PDF Enrollment form to notify of new Waiver Enrollment
        - Print copy of sent email for file
    - Enter Progress note into COMPASS
        - “Entered MI Choice enrollment in CHAMPS. Status shows "Completed-Waiting for MA". Emailed PDF enrollment to MDHHS. Will continue to monitor.”
    - Enter participant name and information onto “Waiting on MA” spreadsheet

Re-Enrollment/Nursing Home Discharge

- Check status to confirm enrollment date matches nursing home disenrollment date
- Treat Like an Enrollment w/ Medicaid Number and follow same steps
    - Make sure to check status for SMOU status – once SMOU, always SMOU
        - If SMOU, check SSP box under enrollment date
- If denied due to auto-enroll to UPHP, make note of enrollment date, and call or email primary care manager directly.
    - Let the Supports Coordinator know that they need to contact the participant and let them know what is happening
        - If they would like to stay in the MI-Choice waiver, they will have to call and dis-enroll immediately
    - Enter Progress Note into COMPASS
        - Attempted to enter MI Choice enrollment in CHAMPS. Status shows "Scheduled to enroll in UPHP MHL on XX/XX/XXXX". Notified Care Manager to notify participant of choice and if they choose to enroll in MI Choice they will need to call MI Enrolls. Will continue to monitor.

- Enter participant name and information on “Waiting on MA” spreadsheet under other eligibility issues.
- Check every day to see if there are any changes

When Status Changes to “Completed”

- Select “View eligibility” for the participant located in the drop-down menu on the left
- Change the inquiry start date to the date on the Waiver enrollment and hit submit
- Print CHAMPS report showing Mi-Choice and attach to original enrollment form
    - Staple and put in enrollment file
- Go into the participant status in COMPASS
    - Edit status
    - Change participant program from WA-P to WA -Y
- Save PDF version of status and send copy to primary CM and case tech
    - “See attached. Showing MI-Choice in CHAMPS. Changed status from Waiver-Pending to Waiver-Yes. ”
- Enter progress note in COMPASS
    - “Verified MI Choice in CHAMPS. CHAMPS shows Waiver. Changed status from pending to yes and notified CM”
- Update “Waiting on MA” spreadsheet – Copy row and put onto corrected tab and note “Showing MI Choice xx/xx/xxxx”

No change to Enrollment Status

- If no change to enrollment status, document in COMPASS (2-3x/wk) “Checked CHAMPS. Status still shows "Completed-Waiting on MA". Will continue to monitor"

Program Enrollment Type/Benefit Plan Conflict

UPHP MI Health Link Auto Enrollment

- Notify Supports Coordinator of issue with entering enrollment. Supports Coordinator will need to notify participant of issue and assist with disenrolling from UPHP MI Health Link.
- Enter Progress Note into COMPASS
- Attempted to enter MI Choice enrollment in CHAMPS. Status shows "scheduled to enroll in UPHP MHL on XX/XX/XXXX". Notified Supports Coordinator to notify participant of choice and if they choose to enroll in MI Choice they will need to call MI Enrolls. Will continue to monitor.
- Enter participant name and information on “Waiting on MA” spreadsheet and list participant under Eligibility Issues
- Check every day to see if there are changes
- Once participant is officially disenrolled, follow steps under Enrollment w/ Medicaid number

Program Enrollment Types

Hospice Enrollment

An exception to the single LOC rule is enrollment in both MI Choice and Hospice. A participant in the MI Choice program may receive Hospice services simultaneously. Individuals who are enrolled in both MI Choice and Hospice will have a PET

code indicating this. PET codes for MI Choice are available in MDHHS policy bulletin 17-40. For additional information, refer to the Hospice chapter of the Medicaid Provider Manual, section 5.6.D. Participants who receive both MI Choice and Hospice and/or Palliative Care services must have a coordinated PCSP. MDHHS may employ a post-payment review to monitor services. If MDHHS finds that inappropriate (i.e., duplicative) services were authorized, MDHHS seeks recovery of Medicaid funds paid for duplicative services from the waiver agency.

Medicaid Qualified Health Plans (QHP)

An applicant enrolled in a Medicaid Qualified Health Plan (QHP) must choose between MI Choice services or the QHP. A Medicaid recipient cannot receive MI Choice services and enroll in the Medicaid QHP. When an applicant chooses MI Choice the waiver agency will enter MI Choice enrollment information directly in CHAMPS.

Nursing Facility Admissions

When a MI Choice participant is admitted to a nursing facility from MI Choice, the waiver agency will enter the disenrollment information in CHAMPS. The MI Choice end date will be the day before the nursing facility admission. Waiver agencies are encouraged to verify nursing facility admission dates with the nursing facility. When a previous MI Choice participant is discharged from the nursing facility, the waiver agency may reenroll the participant on the day of the nursing facility discharge through the enrollment process in CHAMPS. This change does not affect the NFLOC determination requirements.

Hospital Admissions

A hospital admission is not an enrollment in a LOC service. Generally, waiver agencies do not provide MI Choice services, other than SC and possibly continuation of a personal emergency response system, to participants while hospitalized.

A MI Choice participant admitted to a hospital may remain enrolled in MI Choice for up to 30 days. The waiver agency must provide the participant with an adverse benefit determination upon notification of a hospitalization if it is necessary for the agency to suspend MI Choice services during the hospitalization. When the participant is hospitalized for less than 30 days, the participant's services may restart upon discharge from the hospital. If the participant is discharged after 30 days, the participant may re-enroll in MI Choice using standard enrollment procedures. If a participant is admitted to a nursing facility from a hospital before the 30th day of hospital stay, the last MI Choice eligibility date is the day before the date of nursing facility admission.

Enrollment in MI Health Link

Individuals enrolled in MI Health Link cannot also enroll in MI Choice. Refer individuals to a Medicare/Medicaid Assistance Program counselor for options counseling before deciding to opt-out or disenroll from MI Health Link. Michigan ENROLLS handles all enrollments, disenrollments and opt-outs for MI Health link. All MI Health Link disenrollments are effective on the last day of a month. Normally this is the last day of the month of request. For requests made later in the month, the disenrollment may not take effect until the last day of the month following the month of request. Eligible individuals may enroll in MI Choice after the effective date of the MI Health Link disenrollment.

MI Health Link has nine PET codes depending upon the living arrangement of the individual. The PET codes and description are as follows:

- ICO-COMM: Enrolled in MI Health Link and residing in the community
- ICO-HCBS: Enrolled in the MI Health Link HCBS Waiver and residing in the community
- ICO-NFAC: Enrolled in MI Health Link and residing in a nursing facility (not a County Medical Care Facility)
- ICO-CMCF: Enrolled in MI Health Link and residing in County Medical Care Facility

- ICO-HOSH: Enrolled in MI Health Link and receiving hospice at home
- ICO-HOSR: Enrolled in MI Health Link and residing in hospice residence facility
- ICO-HOSW: Enrolled in MI Health Link HCBS Waiver and receiving hospice services at home
- ICO-HOSN: Enrolled in MI Health Link and receiving hospice services in a nursing facility
- ICO-HOSC: Enrolled in MI Health Link and receiving hospice services in a County Medical Care Facility

Waiver agencies will need to coordinate enrollments with the MI Health Link discharge to ensure the proper MI Choice PET sets on the day of MI Choice enrollment. MI Health Link discharges will be effective on the last day of the month. Therefore, MI Choice should not enroll until the first day of the following month.

Disenrollment

Death

- Check participant status in COMPASS
- Confirm end date on status with the date on the disenrollment form – make sure dates match
- Search for participant using filters
- Select Discharge/Disenroll from participant's drop-down menu on left
- Complete disenrollment section
    - Reason – death
    - Confirm dates and submit
- Select view details from drop down menu and the print it out
    - staple to disenrollment and file it

Nursing Home Placement

- Check participant status in COMPASS
    - Confirm end date on status matches – must end the day before NF admission
- Search for participant using filters
- Select Discharge/Disenroll from participant's drop-down menu on left
- Complete disenrollment section
    - Reason – Involuntary
    - Select Nursing Facility for placement location
    - Confirm dates and submit
- Select view details from drop down menu and the print it out
    - Staple to disenrollment and file it

References

Mi Choice Contract - Attachment C
Enrollments and Disenrollment Forms Mi Choice

Vendor Billing

Policy Number: 2022-44	Effective Date: 05/01/2022	Revision Date(s): 10/06/2022
Reviewed by: NCQA/AQAR Team	Approved by: Theresa LaFave	Category: CT

Policy

It is the policy of UPCAP Services, Inc. that Case Techs process vendor billing according to procedures identified below. Vendors are required to follow the Purchase of Service Billing and Reimbursement section of their agreement.

A monthly report from the vendor is due at the local UPCAP Services, Inc. field office or via Vendor Billing from which the initial work order/service authorization originated no later than the tenth (10th) of each month following the month of service provision. Payments are made payable to the vendor within thirty (30) days of receipt of the vendors bill, provided it is received as specified and approved. Bills received after the tenth (10th) of the month may be delayed for one month and processed with bills received for the next month unless a special arrangement has been approved by the Director of Long-Term Care Programs.

Bills which are received in excess of three months from the month of service provision need approval from the Director of Long-Term Care Programs to be processed.

Vendors are required to maintain supporting documentation as defined in contract requirements for all services billed to UPCAP Services, Inc. and make such records available for review by UPCAP Services, Inc. upon request.

The amount to be reimbursed to the Vendor is established from the approved service authorization(s)/PCSP and contracted unit rates. At no time shall a Case Tech or other staff member approve billing above and beyond what is authorized without approval from a Supports Coordinator, followed up by a work order.

All Vendors are required to have an agreement and all required documentation on file prior to starting services for an individual.

Procedures

All bills from Vendors are sent to the local UPCAP Services, Inc. field office or via Vendor Billing as follows:

- Marquette Field Office – Alger, Delta, Marquette, Menominee and Schoolcraft Counties
- Iron Mountain Field Office – Dickinson, Iron, Gogebic and Ontonagon Counties
- Houghton Field Office – Baraga, Houghton and Keweenaw Counties
- Sault Ste. Marie Field Office – Chippewa, Luce and Mackinac Counties

Bills from Personal Emergency Response Vendors that serve all fifteen (15) counties of the Upper Peninsula are assigned to a Case Tech for processing by the Director of Long-Term Care Programs. Bills from Self-Determination Vendors are assigned to the Case Tech in Iron Mountain for Processing.

Paper Bills from Vendors

- For those Vendors that do not utilize Vendor Billing to process their billing, they are required to send paper invoices (approved by UPCAP, Services, Inc.) to the appropriate office. Once received the Case Tech must verify the bill contains the following information:

- Participant Name
- Month of service
- Breakdown of units on days services were provided
- Signature and date

For bills that are missing any of the above information the Case Tech is to contact the Vendor and request they resubmit a bill to include all required fields.

- Once bills are reviewed and contents are verified the Case Tech can enter the bills into MICIS.
  - All bills must have an invoice number assigned. If the bill contains its own invoice number, that can be used. If the bill does not contain its own invoice number then one should be assigned using the month, year and vendor code. Example: June, 2021 Bills from Arcadia would be 062021AH00.
  - Verify the month/year currently being processed.
  - Enter the vendor code into the appropriate field and click search.
  - Click on the name associated with the bill you are entering. The allowed amount in the service authorization will pop up. Compare to the bill submitted by the vendor. Make any necessary changes according to what was billed on the invoice.
  - Be sure to watch for error messages that indicate a participate was not home (Hospital, NH, etc.) on a certain day(s). If the vendor is billing for services while someone was not home, the Case Tech should verify with the Supports Coordinator that the data is correct. If it is correct the bills on those days must be zeroed out and the invoice total adjusted. We are allowed to pay for services on the day the person was identified as not home and the day they return home, except for nursing home placement. If nursing home placement, request a work order from the Supports Coordinator for one day of service utilizing 221 funds. The date of nursing home placement should be billed to the 221 fund code.
- Once all bills are entered the Case Tech must verify the amount in the system matches the amount of the invoice. This can be done one of two ways:
    - MICIS/Reports/Billing/Bill Posting, enter selection criteria and click run.
    - Compass/Reports/Expenditures, enter selection criteria and click run.
- Once it's verified the totals match what was invoiced the Case Tech can run the variance/exception report from MICIS. If the totals do not match the Case Tech will have to determine where the error occurred and correct it.
  - The Case Tech will need to run the variance/exceptions report from MICIS. This report will show a comparison of what is authorized in the careplan to what was billed. Identify those, if any, with a variance. If a variance is found the Case Tech must investigate the reason for the overage as follows:
    - Verify the work order entered was entered correctly. If not, make corrections as necessary
    - Contact the Vendor and request log sheets for the day of overage. The log sheets will verify services were rendered as billed. Log sheets should be sent to the Director of Long-Term Care to be reported on the Program Integrity Report as a random audit for a Vendor.
    - Notify the primary Supports Coordinator of the overage. It will be their responsibility to determine if it is approved or not. If approved the Supports Coordinator will provide a work order approving the overage. If not approved, adjust the bill to take off the extra units not authorized.
    - Notify the Vendor of any adjustments to bills.
- Once all bills are processed, reviewed and verified the Case Tech should run and print the expenditure reports from Compass (Reports/Services/Expenditures). Reports should include participant expenditures and expenditures by fund source and service. The reports are attached to the bills.
- Case Tech is to scan the reports and bills saving them using the month, year and vendor code (example: 062021AH00). The saved file is then sent to the Director of Long-Term Care Programs via secure email.
- The Director of Long-Term Care Programs reviews the bills submitted and then sends them to accounting for payment.

Vendor Billing System

- Once a vendor submits billing utilizing the Vendor Billing system, the assigned Case Tech will be responsible for reviewing the billing. Vendor Billing is set up to pull the authorized services and amounts from MICIS so when the Case Tech reviews the billing it will have a side-by-side view authorized units/cost and posted units/cost.
- All bills must have an invoice number assigned. Case Techs should utilize the batch number assigned as the invoice number.
- Case Techs should pay attention to the Care Setting column, which will identify if bills were posted on a day the participant was not home. If the vendor is billing for services while someone was not home, the Case Tech should verify with the Supports Coordinator that the data is correct. If it is correct the bills on those days must be zeroed out and a note added under "agent note" as to why an adjustment was made. We are allowed to pay for services on the day the person was identified as not home and the day they return home, except for nursing home placement. If nursing home placement, request a work order from the Supports Coordinator for one day of service utilizing 221 funds. The date of nursing home placement should be billed to the 221 fund code.
- Once a batch of bills are verified, The Case Tech will need to run the variance/exceptions report from MICIS. This report will show a comparison of what is authorized in the careplan to what was billed. Identify those, if any, with a variance. If a variance is found the Case Tech must investigate the reason for the overage as follows:
    - Verify the work order entered was entered correctly. If not, make corrections as necessary
    - Contact the Vendor and request log sheets for the day of overage. The log sheets will verify services were rendered as billed. Log sheets should be sent to the Director of Long-Term Care to be reported on the Program Integrity Report as a random audit for a Vendor.
    - Notify the primary Supports Coordinator of the overage. It will be their responsibility to determine if it is approved or not. If approved the Supports Coordinator will provide a work order approving the overage. If not approved, adjust the bill to take off the extra units not authorized.
    - Notify the Vendor of any adjustments to bills.
- Once all bills are processed, reviewed and verified the Case Tech should run and print the client service report and batch fund source report out of Vendor Billing. The reports are attached to the bills.
- Case Tech is to scan the reports and bills saving them using the month, year and vendor code and batch number (example: 062021AH00 Batch #123456). The saved file is then sent to the Director of Long-Term Care Programs via secure email.
- The Director of Long-Term Care Programs reviews the bills submitted for accuracy and then sends them to accounting for payment.
- Step-by-step instructions for utilizing Vendor Billing can be found in the Vendor Billing User Guide.

Cost Reconciliation

At the end of each month the Director of Long-Term Care Programs runs a year-to-date expenditure report by fund code for accounting. Accounting verifies the expenditures on the report to what was paid to vendors to ensure all amounts match. If amounts do not match accounting works with the Director of Long-Term Care to determine what is missing or if an overpayment was identified.

Record Retention

All bills, associated reports and documentation are to be saved on a secure drive by the Director of Long-Term Care Programs. Copies of bills processed by Case Techs can be shredded after three months.

APPENDIX

CHART SET UP KEY

SECTION 1

Case File Summary
Level of Care Determination
Freedom of Choice
Cost Share Form (if applicable)
Waiver Enrollment & Disenrollment Forms
Front page of MA Application – if SC filed
CHAMPS
Initial Assessment Confirmation Letter
Screen/Referral Information Sheet – including 211 screen and Compass report

SECTION 2

Back Up Plan
Action Notices/Adverse Benefit Determination
NAPIS Forms (if applicable)
Consent and Authorization
Medical Release
Handbook receipt acknowledgement
Follow-up letter – referral source

POCKET 1

Medicaid Paperwork
Client Labels

SECTION 3

Plan of Care Agreement
Supervisory Care Plan Review/Signed budget
(Optional – "Dirty" Statuses-stamped)

SECTION 4

Work Orders
Residential Services Form – if applicable

POCKET 2

"Clean" Current Status Form – MICIS
Miscellaneous

SECTION 5

PCSP Signature Page
Current Service Plan/PCSP
(Optional - "Dirty" Statuses – stamped)

SECTION 6

Physician Orders
Hospital Discharge paperwork
Important Medical Documents
DPOA/Guardianship Paperwork
SD Enrollment Form (one-page w/ start date of budget)
SD Employment Agreement/s
Back up Worker Agreement (if applicable)
SD Worker Training Sign Off
Chart Review
Contact Key

Changes to Participant's Services (PCSP)

Increasing an existing Mi Choice Waiver service:

- □ Contact Service Provider (s) to determine if increase in service is available:
- □ If available:
    - Update Work Order and submit to the Case Tech for entry
        - Note "Increase" in Reason for Work Order
            - Include the total hours and units for the service, not just the increased amount
            - Add the start date of the increase
            - Add progress note regarding reason for increase and submission of paperwork
        - Place date-stamped copy in UPCAP file

Adding New MI Choice Service:

- □ Contact Service Provider to determine if service is available:
- □ If service is available:
    - Update Work Order and submit to the Case Tech for entry
        - Note "New" in Reason for Work Order
            - Add the start date of the service
        - Place date-stamped copy in UPCAP file
    - Update Person-Centered Service Plan in COMPASS
        - Add new goal to address issue if not previously addressed
        - Add new service under Interventions and select the issues addressed
        - Add intended start date of new service
        - Print and send copy of PCSP and Service Summary to participant, informal supports, or any entity designated on PCSP
        - Copy for UPCAP file
    - Print Back-Up Plan

        - Send copy to participant, informal supports or any entity designated on PCSP
        - Copy for UPCAP file

**NOTE: If the participant requests a service but it is unavailable due to a provider staffing issue or lack of provider in a service area, an Adverse Benefit Determination does not need to be sent to the participant. However, the Supports Coordinator must note participant's understanding in the progress notes as well as ongoing attempts to secure the requested service, no less than monthly.

Reducing or Canceling Service:

- □ If participant requests decrease or cancellation
    - Send advance Adverse Benefit Determination to client
        - Must specify the date, service type, frequency, and provider being reduced or canceled and the reason (i.e. participant request)
        - Do not use abbreviations or acronyms
        - Keep copy for UPCAP file
    - Contact Service Provider, by phone, of the participant's request to decrease or cancel
        - Provide them with stop dates
    - Update Work Order and submit to Case Tech for entry
        - Note "Decrease" or "Stop" in Reason for Work Order
        - If decreasing a service, include the total hours and units being authorized to continue; note details of decrease in instructions
        - Keep date-stamped copy in UPCAP file
    - Update Person-Centered Service Plan in COMPASS
        - Update Goals and Interventions
            - Add Resolved and End Dates when canceling a service
        - Print and Send updated copy to participant, informal supports or any entity designated on PCSP
        - Copy for UPCAP file

- Print Back up Plan
  - Send copy to participant, informal supports or any entity designated on PCSP
  - Copy for UPCAP file

Denying Request for Increase or New Service:

- If the participant requests an increase in an existing service or a new service and the Supports Coordinator denies request:
  - Document contact in progress notes, making note that participant was informed of right to appeal decision.
  - Send Adverse Benefit Notice with internal appeal information to participant
    - Clearly identify reason for denial with supporting information
    - Do not use abbreviations or acronyms
    - Keep copy for UPCAP file

Initial Assessment/ New Participant Checklist (Mi-Choice Referrals)

Before Initial Assessment:

- □ Contact prospective participant BEFORE traveling to their home to confirm their availability and continued interest.
- □ Confirm prospective participant's understanding that they are able to invite anyone that they would like to have present for the assessment and care planning process.

At Initial Assessment:

- □ Introductions & Program Explanation
    - Verbal explanation of UPCAP & Mi-Choice Waiver Program
    - Review Eligibility Criteria:
        - Medical Eligibility
            - Must meet Nursing Facility Level of Care Criteria
            - Have needs that are consistent with nursing home level of care or risk of nursing home placement without services
        - Financial Eligibility
            - Review Income and Asset eligibility for Mi-Choice Waiver program
            - Review Estate Recovery pamphlet
            - If participant does not meet financial criteria for program, provide information on Care Management Program and/or private pay options
        - Need for at least 2 Waiver services, with one being Supports Coordination
            - If needs can be met through other available programs, these must be explored first (ex: Veterans Administration; Tribal Services; Adult Home Help) and documented

- □ Complete Nursing Facility Level of Care Determination (NFLOCD)
    - If participant meets medical eligibility criteria, complete Freedom of Choice Form (FOC) – signed by participant, or legal representative, designating Mi-Choice Waiver w/ date
    - If participant does not meet medical eligibility criteria, complete Freedom of Choice Form - (FOC) signed by participant or legal representative. Provide appropriate action notice and appeal information to participant, as well as optional resources if available.

If Eligible:

- □ Review Participant Handbook
    - Review Rights and Responsibilities
    - Review Service Providers; Self Determination program; HIPAA and Privacy; Person Centered Planning; Fraud, Waste, and Abuse; Critical Incident Reporting
    - UPCAP folder left w/ participant – remind them to keep and make note of location
- □ Complete Consent and Authorization Form
    - Signed by participant; spouse if applicable
    - Carbon copy left with participant; Original copy retained for UPCAP file
- □ Receipt of Handbook Signature Page
    - Signed by participant
    - Copy left with participant if requested; Copy retained for UPCAP file
- □ Medical Release Form
    - Signed by participant
- □ Confirm Information for UPCAP file:
    - Identification
    - Social Security Card
    - Medicare Card and/or other Insurance Card(s)

- □ Complete Full Assessment

- Social Work Section – completed by SW
- Registered Nurse Section – completed by RN
- Add Caregivers
- Add ALL active Medical Providers and Pharmacy
- Add ALL Medications – must physically see and record
- Add all DME Equipment
    - Tour Participant's home
    - Make suggestions for DME equipment if needed

□ Complete Person-Centered Service Plan (PCSP)

- Confirm that the participant understands that they may request a formal Person-Centered Planning meeting at any time
- Confirm that the participant understands that they have the right to designate individuals to receive a copy of their PCSP as well as individuals not authorized to receive a copy
    - Note preferences in COMPASS
- Review participant's needs identified during the assessment and the services and supports available to meet those needs
    - Discuss MIChoice Waiver services requested by participant – type, amount, and frequency
    - Review available service providers for each service and make note of participant preference/participant choice of provider
- Review available informal supports
    - If informal supports are available, confirm tasks and availability. Document agreement to continue informally without compensation. Confirm who is responsible for notifying informal supports of their responsibilities.
    - If no informal supports are available, note risks and discuss any concerns with participant
- Review any risks and note plan to mitigate them
- Note participant's preferences and strengths
- Discuss desired goals and outcomes

- Review all current services in the home – note type, amount, frequency, and provider
  - Grant-funded
  - Skilled services and therapies
  - Tribal services

□ Complete Care Plan Signature Sheet
- Signed, dated, and initialed by participant
- Signed and dated by informal support
- Signed and dated by RN & SW Supports Coordinators

□ If Participant Elects Self-Determination:
- Discuss difference between FI & AWC
- Complete Self-Determination Enrollment form and elect Representative if necessary
- Complete Participation Information Sheet
- Provide copies of Employee application for selected FI or AWC
  - Review need for copies of driver's license and social security card for potential employee
  - Provide potential employee with contact information and direction to send completed application directly to FI/AWC for processing
- Discuss and determine pay rate
- Discuss required SD employee trainings:
  - First Aid & CPR Training required – Training materials will be purchased by the Waiver
    - Explain that the participant is to keep and use the materials for any future employees as well
  - Fraud, Waste, and Abuse training required – Materials provided
  - Infection control training required – Materials provided; quiz
  - All trainings must be completed by SD employee within 30 days of hire.

Financial Eligibility/ Medicaid

If Participant has Medicaid:

- □ Confirm Medicaid eligibility/program via CHAMPS
- □ Must still confirm income and assets even if Medicaid is active
    - Recommended that copy of income statement and assets are obtained for file

If Participant does not have Medicaid:

- □ SW SC to assist with completing Medicaid Application and gathering verifications/supporting documentation:
    - Can be completed at initial visit or additional visit scheduled
        - **NOTE:** Participant cannot be opened to the Mi-Choice Waiver until completed application is filed with MDHHS
    - Application can be completed online via MIBridges or a paper copy to be submitted at local MDHHS office
- □ All applicable documents/forms and verifications scanned or copied
        - If more documents are requested by MDHHS, SW SC to assist with getting documents
- □ Participant or Representative Signatures required on paper application
- □ Submit Medicaid Application and verifications to MDHHS
    - Include letter on UPCAP letterhead notifying eligibility specialist of review for Mi-Choice Waiver eligibility
    - Retain copy of application and all verifications kept for UPCAP file
- □ Follow up with participant regarding supplemental questionnaire – sent out immediately following receipt of initial application
    - Assist with completion and submit to MDHHS
- □ Follow up with local MDHHS office/specialist

Nursing Home Admission/Discharge

Nursing Home Admission:

- □ Contact Nursing Facility and confirm participant's admission date within 1 business day of notification
  - ○ Review participant's need for admission with NF staff
    - ▪ Short Term/Rehabilitation stay vs long-term placement
- □ Contact Service Providers immediately, by phone
  - ○ Notify of service cancellation
- □ Update Status Report and submit to Case Tech for entry
  - ○ If a participant is closing due to long-term placement, Waiver closure date must be the day before admission. Participant must have status of Waiver-Ineligible for the day of admission/day of program closure.
  - ○ If a participant is closing due to short-term/rehabilitation stay, Waiver closure date must be the day before admission. Program status must be Waiver-Ineligible for the length of time the participant is in the nursing facility.
- □ Complete Waiver Disenrollment form and email to Medicaid Specialist
  - ○ Disenrollment date MUST be the day BEFORE admission to the Nursing Facility (must match COMPASS status report)
- □ Update work orders and submit to Case Tech for entry
  - ○ CANCEL services – must match Waiver disenrollment date
  - ○ If participant will be returning to the home (short-term stay) and would like to keep existing PERS unit, notify Waiver Director and request use of 221 funds
- □ Complete Adverse Benefit Determination
  - ○ Identify every Waiver Service being stopped, the provider, and the frequency as well as noting MI Choice Disenrollment.
  - ○ Do not use abbreviations or acronyms
  - ○ Mail copy to participant; place copy in UPCAP file

Participant Discharge Home (only existing participants):

- □ Coordinate with Nursing Home to determine discharge date and needs
    - ○ Request discharge paperwork and facility notes
    - ○ Meet with participant prior to discharge, if possible, to discuss services needed
- □ Contact Service Providers, by phone, to inquire re: available services
- □ NFLOCD and FOC must be completed and submitted to Case Tech to be entered on the day of discharge
    - ○ Existing NFLOCD can be adopted by UPCAP if Supports Coordinator is not able to complete a new NFLOCD before discharge
        - ▪ Must notify Case Tech of request to adopt NFLOCD in CHAMPS
        - ▪ CHAMPS FOC will be populated and must be signed by the participant before services can start
- □ Participant must be contacted within 24 hours of discharge, or notification of discharge
- □ Full Return Reassessment and new NFLOCD & FOC must be completed within 7 days of discharge home
    - ○ Reassessment must be completed by both SW and RN disciplines
    - ○ Note medication reconciliation and review
    - ○ Services can resume prior to the reassessment being completed to ensure safe transition home as long as NFLOCD and FOC have been completed and entered into CHAMPS
- □ Update Status Report and submit to Case Tech for entry
    - ○ Waiver-Pending program status starting day of discharge
- □ Complete Waiver Enrollment form and email to Medicaid Specialist.
    - ○ Waiver enrollment date is day of discharge (must match COMPASS status report)
- □ Complete START Work Orders and submit to Case Tech for entry
- □ Updated PCSP and Back up plan must be completed and mailed to participant and all other specified supports as outlined in the plan of care. Copy placed in participant file.

Participant Hospitalization

Participant Admission:

- Contact Hospital and confirm admission date within 1 business day
- Inform Agencies/Service Providers immediately, by phone, to Hold Services
  - Complete HOLD work orders or denote HOLD on current service summary and submit to Case Tech for data entry
  - Notify Skilled Agency - if applicable
- Complete Adverse Benefit Determination (ABD)
  - Identify and list each Waiver service, frequency of service, and service provider being placed on HOLD
    - List any services that will remain in place – ex: Supports Coordination; PERS; Snow Removal
    - No abbreviations may be used on ABD
  - Mail copy to client; place copy in participant's file
- Update Status Report and submit to Case Tech for data entry
  - Identify Care Setting as Hospital and whether admission was "planned" or "unplanned"

Participant Discharge:

- Request Discharge Summary from Hospital
- Contact Service Providers by phone to notify of need to resume services
- Complete RESUME Work Orders or service summary denoting RESUME and submit to Case Tech for entry
- Contact participant within 1 business day of discharge
  - Discuss discharge orders and instructions
  - Make note of medications in participant file and update as needed
  - If participant has experienced a change in condition, schedule full in-person reassessment within 7 days of discharge

Hospitalization exceeding 30 days:

- Participant must be closed from the Mi-Choice Waiver
- Send advance Adverse Benefit Determination to the participant on 19th day of hospitalization stipulating that if hospital stay exceeds 30 days, the participant will be closed from Waiver.
- Update Status Report and submit to Case Tech for data entry
    - Designation of WA-Ineligible for program status starting on day 31
- Update Work orders to CANCEL services and submit to Case Tech entry
- Complete Waiver Disenrollment form and email to Medicaid Specialist
- Continue to maintain contact with the participant and hospital staff to coordinate potential re-enrollment in the MI Choice Waiver upon discharge.

New Participant Checklist

After Initial Assessment: Waiver only

- □ Complete Assessment in COMPASS
    - Must be completed within 2 business days
    - Update Progress Notes w/ Summary
        - See charting examples
- □ Complete Person-Centered Service Plan in COMPASS
    - Must be completed within 5 business days of the COMPASS assessment
    - Services can NOT start before PCSP is finalized
    - Ensure all goals are linked to appropriate interventions
    - Make sure informal caregivers/supports are listed under Informal interventions
- □ Review with other SC discipline and finalize assessment
- □ Complete Participant Case File in COMPASS
    - Ensure Address, County, Phone Number, DOB, and Social Security Number are correct
        - Submit Data Base Change to update Social Security Number if incorrect
    - Complete Medicare Plan Information and Effective dates

- Enter due dates

□ Submit completed NFLOCD and FOC to Case Tech
- NFLOCD must be entered within 14 days of completion
  - If not submitted within 14 days of the completion of NFLOCD, a new NFLOCD & FOC must be completed before participant can be opened to the Mi-Choice Waiver

□ Submit completed MICIS Status Report to Case Tech:
- Waiver-Pending designation if participant is already on Medicaid
- Care Management designation if waiting for Medicaid application to be submitted to MDHHS

□ Email Waiver Enrollment form to designated staff person (Ellen Bernier)
- Do not submit until Mi-Choice Waiver date is confirmed
- Date of Waiver Enrollment must be the same as Waiver-Pending date
- Submit copy of emailed Waiver Enrollment to case tech with NFLOCD

□ Mail Referral Source Notification/Letter – place copy in file

□ Mail or fax Dr. Letter and Medical Release with copy of COMPASS Medication and Allergy Report

□ Contact Agencies for Service Availability

□ Submit Supervisory Care Plan Review/Budget to Regional Supervisor or Director
- SC can NOT start services until form is signed and returned
- Place signed copy in file

□ Once Care Plan Budget received:
- Submit Work Orders for data entry

□ Send Back-up Plan to participant and those designated on the care plan
- Place copy in file

□ Send finalized copy of the Person-Centered Service Plan to participant and those designated on the care plan

□ Participant must be contacted within 14 days of the start of services:
- Complete Two-week Service follow up in COMPASS progress notes
- Review service start dates and satisfaction

If Self Determination

- □ Forward Participant Information Sheet - if AWC
- □ Forward Self Determination Enrollment to FI or AWC
- □ Complete work order for World Point training materials and submit for data entry
- □ Once kick-off is completed and Employment Agreement (EA) is received, submit work order to Case Tech. Place EA in chart
- □ Request copy of employee training sign off sheet for file

New Participant Checklist

After Initial Assessment: Care Management

- □ Complete Assessment in COMPASS
  - Must be completed within 2 business days
  - Update Progress Notes w/ Summary
    - See charting example
- □ Complete Person-Centered Service Plan in COMPASS
  - Must be completed within 5 business days – cannot start services before finalized
  - Ensure all goals are linked to appropriate interventions
  - Make sure informal caregivers/supports are listed under Informal interventions
- □ Review with other SC discipline and finalize Assessment
- □ Complete Participant Case File
  - Ensure Address, Phone Number, DOB, and Social Security Number are correct
  - Complete Medicare Information and Effective dates
  - Enter due dates
- □ Submit completed MICIS Status Report to Case Tech
  - Care Management designation
- □ Submit completed NAPIS form to Mary Ross-Dubord
- □ Mail or fax Dr. Letter and Medical Release - * optional

- □ Mail Referral Source Notification/Letter – place copy in file
- □ Complete Cost Share Worksheet
    - Notify participant of cost share amount
    - Submit to Waiver Director for billing
- □ Request optional funding (202) funding if appropriate
- □ Contact agencies for available grant services or resources – make referrals
- □ Assist with creating budget and arranging for privately paid services if appropriate

Participant Re-Assessment/PCSP Review Checklist

At 90-day Reassessment:

- □ Review NFLOCD eligibility:
  - ○ If Medically Eligible
    - ▪ Continue with Reassessment, no need to complete new NFLOCD
  - ○ If No Longer Medically Eligible
    - ▪ Complete NFLOCD with participant
      - ● Write up Door 0 summary to be submitted with NFLOCD
    - ▪ Inform participant of closure and right to appeal decision through secondary review and/or State Fair Hearing
    - ▪ Mail Advance Action Notice citing closure due to NFLOCD
      - ● Case closure and service stop date is set 10 days from determination of ineligibility
    - ▪ Assist in discharge planning
      - ● Refer the participant to alternate agencies to assist with services. Make referrals on participant's behalf if requested
- □ Complete Assessment in COMPASS
  - ○ All Sections - RN & SW
- □ Review Person-Centered Plan of Care
  - ○ Review Goals – update with date
  - ○ Review Interventions
  - ○ Participant signs paper copy of current PCSP
- □ Plan of Care Signature Sheet
  - ○ Signed by both Participant and Supports Coordinator
- □ Review Client Handbook and discuss in more detail

At Annual Reassessment:

- □ Complete Annual NFLOCD
  - ○ If Medically Eligible
    - ▪ Submit Annual NFLOCD to Case Tech for data entry
    - ▪ FOC must be completed and signed by participant or legal representative
  - ○ If No Longer Medically Eligible
    - ▪ Write up Door 0 summary to be submitted with NFLOCD
    - ▪ Inform participant of closure and right to appeal decision through secondary review and/or State Fair Hearing
    - ▪ Mail Advance Action Notice citing closure due to NFLOCD
      - ● Case closure and service stop date is set 10 days from determination of ineligibility
    - ▪ Assist in discharge planning
      - ● Refer the participant to alternate agencies to assist with services. Make referrals on participant's behalf if requested
- □ Complete Assessment in COMPASS
  - ○ All Sections - RN & SW
- □ Review Person-Centered Plan of Care
  - ○ Review Goals – update with date of assessment
  - ○ Review Interventions
  - ○ Participant signs paper copy of PCSP
- □ Plan of Care Signature Sheet
  - ○ Signed by both Participant and Supports Coordinator
- □ Complete Annual Consent and Authorization
  - ○ Original Copy for UPCAP file
  - ○ Carbon copy provided to client
- □ Review Agency Folder and contents

- Review of Rights and Responsibilities and Participant Handbook
- Review Critical Incidents and how to report them

□ Review Back up Plan

Person Centered Service Plan Review

180 Day In-Person Review:

□ Review Person-Centered Plan of Care in person
- Review Goals w/ participant– update COMPASS PCSP with date
- Review Interventions with participant
- Participant signs paper copy of PCSP for Participant File

□ Provide Participant with paper copy of Person-Centered Service Plan and Service Summary

□ Update Progress Notes
- Type: Person-Centered Planning Meeting

DECISION GUIDE FOR NOTICES AND ADVERSE BENEFIT DETERMINATIONS

Action taken by Waiver Agency **Applicant = NOT ENROLLED IN MI CHOICE** **Participant = ENROLLED IN MI CHOICE**	**Adequate Notice**	**Advanced Notice**	**Adverse Benefit Determination** **Sent 10 Days Before Date of Action**	**Adverse Benefit Determination** **Sent By The Date of Action**
Applicant does not meet nursing facility level of care	X			
Applicant placed on the MI Choice waiting list	X			
Applicant not enrolled in MI Choice after an assessment (regardless of reason)	X			
Services terminated per participant request			X	
Services terminated per participant request and participant signs a written statement requesting termination				X
Services reduced after an assessment because no longer medically necessary			X	
Waiver agency does not honor participant request for additional services (either type or quantity)				X
Services terminated because of NF placement				X
Services terminated because no longer eligible for Medicaid				X
Enrolled participant no longer meets the nursing facility level of care. (See note on page 3 regarding special provisions during the COVID-19 Public Health Emergency.)		X		
Services terminated because no longer meet NFLOC			X	
Services terminated because participant died				X
Services suspended because waiver agency could not find a provider and the last provider quit			X	
Services reduced per participant request			X	
Services reduced per participant request and participant signs a written statement requesting the reduction.				X
Services suspended because participant in hospital				X
Services terminated because participant does not meet criteria for receiving them			X	
Services terminated because participant does not meet criteria for receiving them and the participant signs a written statement indicating they understand the reason for terminating the services.				X

DECISION GUIDE FOR NOTICES AND ADVERSE BENEFIT DETERMINATIONS

Action taken by Waiver Agency **Applicant = NOT ENROLLED IN MI CHOICE** **Participant = ENROLLED IN MI CHOICE**	**Adequate Notice**	**Advanced Notice**	**Adverse Benefit Determination** **Sent 10 Days Before Date of Action**	**Adverse Benefit Determination** **Sent By The Date of Action**
Services reduced for any other reason			X	
Services terminated for any other reason			X	
Services suspended because participant is temporarily leaving service area.			X	
Services suspended because participant is temporarily leaving the service area and signs a written statement that they understand services must be suspended for this reason.				X
Denial to furnish services outside of the provider network when no in network provider is available to deliver or furnish the service.			X	
Services terminated because the participant's address is unknown based upon returned mail with no forwarding address.				X
Waiver agency changes a service, but not the amount of service authorized (e.g. change Chores from snow plowing to lawn mowing or CLS from one agency to another)	n/a	n/a	n/a	n/a
Waiver agency denies a request to add a service to a self-determination budget and does not provide the service through traditional methods				X
Waiver agency reduces the amount of the self-determination budget before the budget period ends.			X	

DECISION GUIDE FOR NOTICES AND ADVERSE BENEFIT DETERMINATIONS

NOTES:

- Adverse Benefit Determinations allow 60 days for the individual to file an internal appeal.
- Services must continue until the waiver agency makes a hearing decision when **ALL the following occur:**
  - The participant files a request for an internal hearing before the date of action, **AND**
  - The appeal involves the termination, reduction, or suspension of services that are in place, **AND**
  - The period covered by the original authorization has not expired, **AND**
  - The participant requests that services do not change until after a decision is rendered.
- The waiver agency has 30 days from the date the appeal was filed in writing to make a hearing decision.
- If the waiver agency does not make a hearing decision within 30 days, the appellant may request a State Fair Hearing.
- The waiver agency must send the appellant a Notice of Resolution upon making a hearing decision.
- The participant will have 120 days from the date of the Notice of Resolution to file a Request for a State Fair Hearing.
- The participant can request that services continue while awaiting the State Fair Hearing.
- The appellant may request an expedited internal appeal. Waiver agency must have hearing within 72 hours.
- The waiver agency may request an extension on hearing decision. This must be in the appellant's best interest. Must get approval from MDHHS.
- **As a reminder, for the duration of the COVID-19 Public Health Emergency, please refer to Provider L-Letter 21-66 for details about using the LOCD Secondary Review Process for Door 0 LOCD's to establish the Door 8 COVID-19 frailty exception.**

L Letter 21-66.pdf

Acronym	Defintion
@	At
24/7	24 hours/7 days per week
4AM	Area Agencies on Aging Assn of MI
a	Before
A & O	Alert and Oriented
A.A.	Alcoholics Anonymous
a.c.	Before Meals
A.M. or a.m.	Morning
AAA	Area Agency on Aging
AASA	The Aging and Adult Services Agency (formely OSA)
AARP	American Assn of Retired Persons
Abd. or abd.	Abdomen
ABT	Antibiotic
acct.(s)	Account(s)
ACLS	Aging, Community Living, and Supports Bureau
AD	Alzheimer's Disease
Ad lib	As desired
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
adm	Admission
admn.	Administrative
ADP	Adult Day Program
ADRC	Aging and Disability Resource Center
ADS	Adult Day Service
AFC	Adult Foster Care
AG	Attorney General
AH	Administrative Hearings
AHH	Adult Home Help
AHR	Authorized Hearing Representative
AILS	Adult Independent Living Services
AIP	Annual Implementation Plan
AIS	Aging Information System
ALF	Assisted Living Facility
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclorosis
AMA	Against Medical Advice
AMAP	As much as possible
AMCAB	Alger Marquette Community Action Board
AmLeg	American Legion
amt	Amount
Ans	Answered
AoA	Administration on Aging
AP	Assistance Payment
appl.	Application
appt.	Appointment
APS	Adult Protective Services
AQAR	Administrative Quality Assurance Review
ASA	Aspirin or American Society on Aging
ASAP	As Soon As Possible
ASHD	Arteriosclerotic Heart Disease
ASL	American Sign Language
ASM	Autism Society of Michigan
ASW	Adult Services Worker
AT	Assistive Technology

Acronym	Defintion
ATT	At This Time
avail	Available
B or bro	Brother
b.i.d.	2x day or Twice a Day
b\4	Before
BAMC	Bay Area Medical Center
BCBSM	Blue Cross/Blue Shield of Michigan
BCHC	Baraga County Home Care
BCHH	Baraga County Home Helpers
BCMH	Baraga County Memorial Hospital
BEM	Benefit Eligibility Manual
BFD	Barrier Free Design
BI	Brain Injury
BIA	Bureau of Indian Affairs
BIA	Brain Injury Association
BKA	Below knee amputation
BM	Bowel Movement
BMH	Bell Memorial Hospital
BP	Blood Pressure
BR	Bathroom
BS	Blood Sugar
BSC	Bedside Commode
BSHN	Bay Shore Home Nursing
BSW	Bachelors in Social Work
c	With
C	Centigrade
C.B.C.	Complete Blood Count
c/o	Complained of or Care of
CA, Ca	Cancer
CAA	Community Action Agency
CAD	Coronary Artery Disease
cap	Capsule
CAP	Community Action Program
CAPS	Client Assessment protocols
CAR	Case Assessment Review
cath	Catheter
cc	Cubic Centimeters
CC	Care Conference
CC	Clinical Coordinator
CCC	Credit Counseling Center
CCHD	Chippewa County Health Department
CCMHS	Copper Country Mental Health Services
CCMPCB	Chippewa Co Multipurpose Coll Body
CCSS	Case Coordination & Support Standard
CD	Certificate of Deposit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulation
CHAMPS	Community Health Automated Medicaid Processing 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

Acronym	Defintion
CM	Care management
CM(s)	Care Manager(s)
CMH	Community Mental Health
CMIS	Client Mgt Information System
CMS	Congregate Meal Standard or Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
CNS	Central Nervous System or Corporation for National Service
CO	Carbon Monoxide
Co.	County or Company
COA	Commission on Aging/Council on Aging
Cont.	Continue
COPD	Chronic Obstructive Pulmonary Disease
CP	Care Plan
CP	Cerebral Palsy
CPHA	Community Public Health Agency
CPS	Child Protective Svc / Care Plan Sketch
CQAR	Clniical Quality Assurance Reviews
CR	Caregiver Respite (state)
CS	Chore Service
CSA	Commission on Services 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.c.	Discontinue
D/C or dc; dc'd	Discharge (d)
D/T	Due To
DC	Day Care
DCH	Dept of Community Health
DCHD	Dickinson County Health Department
DCHS	Dickinson Count Healthcare System
DCIS/CIS	Dept of Consumer & Industry Services
DCW	Direct Care Worker
DD	Developmentally Disabled
DDC	Developmental Disabilities Council
DDI	Developmental Disabilities Institute
DDS	Doctor of Dentistry
Dept.	Department
DHHS/HHS	U.S. Dept of Consumer & Industry Svc
DHS	Dept of Human Services (formerly FIA)
DHS AHH	Department of Human Services Adult Home Help
Diff.	Different
DIL	Daughter-In-Law
DJV	Degenerative Joint Disease
DM	Diabetes Mellitus
DMB	Department of Management and Budget
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DOB	Date of Birth
DoE	Department of Education
DOJ	Department of Justice
DoL	Department of Labor
DoT	Department of Transportation
DPH	Department of Public Health

Acronym	Defintion
DPOA	Durable Power of Attorney
DR	Dining Room
Dr.	Doctor
drsg. , dsg	Dressing
DSP	Direct Service Provider
dtr	Daughter
DV	Domestic Violence
Dx	Diagnosis
e.g. , Ex., ex	Example
EASS	Elder Abuse Service Standard
ECF	Extended Care Facility
ECG, EKG	Electrocardiogram
ED	Elderly & Disabled
EENT	Eye, Ears, Nose & Throat
EHHS	Expanded Home Help Services
EI	Emotionally Impaired
Elec. Med Disp.	Electronic Medication Dispenser
ELM	Elder Law of Michigan
ER	Emergency room
ES	Eligibility Specialist
et al.	And Others
F (F)	Father or Fahrenheit
F/U or f/u	Follow-up
FA	Family Assistance
FAP	Food Assistance Program
FAX	Facsimile
FBS	Fasting Blood Sugar
FC	Foster Care
FCC	Federal Communications Commission
FGP	Foster Grandparent Program
FHA	Fair Housing Authority
FI	Fiscal Intermediary
FIA	Family Independence Agency
FIL	Father-in-law
fld	Fluid
FOIA	Freedom of Information Act
FU	Finlandia University
FV	Face Value
FX	Fracture
FY	Fiscal Year
g'dtr	Granddaughter
g'son	Grandson
gal	Gallon
GAO	General Accounting Office
GF/GP	General Fund/General Purpose
GI	Gastrointestinal
GLHM, GL	Great Lakes Home Medical
Gm	Gram
GNHC	Great Northern Home Care
gr.	Grain
gtt(s)	Drop(s)
H & P	History and Physical
h (hr)	Hour
h.a.n.d.s.	HIV/AIDS Network & Direct Service
h/o	History Of
HA, HMK	Homemaker Aide
HAB	Habilitation Waiver

Acronym	Defintion
HAS	Health Systems Agency
Hb (Hgb)	Hemoglobin
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 Services
HCFA	Health Care Financing Administration, US Dept. of Health and Human Services
HCMCF	Houghton County Medical Care Facility
HCPCS	Health Care Procedure Codes
Hct.	Hematocrit
HDM	Home Delivered Meals
HFA	Home for the Aged
Hg	Mercury
HHA	Home Health Aide
HHAS	Home Health Aide Standard
HHS	Handheld Shower
HHS	Home Help Services
HI	Hearing Impaired
HIPPA	Health Ins Portability & Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HNJH	Helen Newberry Joy Hospital
HOH	Hard of Hearing
Hosp.	Hospital
HR	House Bill (federal)
HR	Hip Replacement
hr.	Hour
HS (h.s.)	Hour of Sleep or Homemaking Std
HSS	Health Screening Standard
ht	Height
HTN	Hypertension
HUD	Housing and Urban Development
HV, hv	Home Visit
Hx	History
I & O	Intake and Output
I & R	Information and Referral
I&A	Information and Assistance
I&R	Information and Referral
i.e.	That Is
I.M.	Intramuscular
IADL	Instrumental Activities of Daily Living
IADL	Independent Activities of Daily Living
IAW	In Accordance With
IC	In Compliance
ICHD	Iron County Health Department
ICU	Intensive Care Unit
ID	Identification
IDDM	Insulin Dependent Diabetes Mellitus
IL	Independent Living
ILP	Independent Living Plan
inct. Suppl.	Incontinence supplies
Ind.	Independent
inj	Injection
IoG	Institute of Gerontology
IPS	Individual Plan of Service
IRA	Individual Retirement Account
IV	Intravenous

Acronym	Defintion
IVP	Intravenous Pyelogram
K	Potassium
KBIC	Keweenaw Bay Indian Comm
Kg	Kilogram
KHN(H)	Keweenaw Home Nursing & Hospice
KMS	Kline Medical Supply
L	Left (Liter)
Lab	Laboratory
LAS	Legal Assistance Standard
lb.	Pound
LBSW	Licensed Bachelor Social Worker
LCA	Local Contract Agency
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
LOCD	Level of Care Determination
LOS	Length of Stay
LPN	Licensed Practical Nurse
LR	Living Room
LSP	Legal Services Program
LSSU	Lake Superior State University
LTC	Long Term Care
LTCOP	Long Term Care Ombudsman Program
LTML	Long Term Memory Loss
LV	Living Room
M	Mother
MA	Medicaid or Masters
MA	Medical Assistance
MA HMO	Medicaid Health Maintenance Organization
MA ID#	Medicaid Recipient Identification Number
MACIL	MI Association of Centers for Ind Living
MADSA	Michigan Adult Day Services Assn
MAS	Marquette Aging Services
MC	Medicare
MCB	Michigan Commission for the Blind
MCCA, MCCOA	Marquette Commission on Aging
MCDC	MI Commission on Disability Concerns
MCF	Medical Care Facility
MCO	Managed Care Organization
MCQC	Michigan Campaign for Quality Care
MD	Medical Doctor
MDHHS	Michigan Department of Health and Human Services
MDRC	Michigan Disability Rights Coalition
MDS-CAA	Menominee-Delta-Schoolcraft Community Action Agency
MDS-HC	Minimum Date Set for home care
meds	Medications
mEq	Milliequivalent
MFP	Money Follows the Person
mg	Milligram
MGHH(& H)	Mqt Genl Home Health (& Hospice)
MH	Mechanical Help or Mental Health **MHSCC**
MI	Myocardial Infarction or Mentally Ill
MIACoA	MI Indian Advisory Council on Aging
MICHOICE	MI Home & Community Based Waiver

Acronym	Defintion
MICIS	Michigan Choice Information System
MIL	Mother-in-law
min	Minute
MIS	Managed Information System
MIWorks!	Michigan Works
ml	Milliliter
MLSC	Michigan Legal Services Corporation
mm	Millimeter
MMAP	Medicare/Medicaid Assistance Program
MMIS	Medicaid Mgt Information System
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
MPRO	Michigan Peer Review Organization
MQCCC	MI Quality Community Care Council
MRSA	Methicillin-Resistant Staphylococcus Aureas
MS	Multiple Sclerosis
MSA	Medical Services Administration
MSAC	Michigan Senior Advocates Council
msg	Message
MSG	Michigan Society of Gerontology
MSH	Mackinaw Straights Hospital
MSHDA	MI State Housing Development Auth
MSW	Masters of Social Work
mtg.	Meeting
MTU	Michigan Technological University
MYP	Multi-Year Plan
N & V	Nausea & Vomiting
N/A, n\a	Not Applicable
N4A	Nat'l Assn of Area Agencies on Aging
NA	Narcotics Anonymous
NAPIS	Nat'l Aging Prog Information System
NAS	No Added Salt
NASUA	Nat'l Assn of State Units on Aging
NASW	National Association of Social Workers
NC	Not in Compliance
NCBA	National Center on Black Aged
NCOA	National Council on Aging
NCSC	National Council of Senior Citizens
neg	Negative
NF	Nursing Facility
NFA	Notification of Financial Assistance
NFCSP	Nat'l Family Caregiver Support Program
NFLOC	Nursing Facility Level of Care
NFLOCD	Nursing Facility Level of Care Determination
NFTI	Nursing Facility Transition Initiative
NFTS	Nursing Facility Transition Services
NG	Nasogastric
NH	Nursing Home
NIA	National Institute on Aging
NIDDM	Non-insulin Depdt Diabetes Mellitus
NISC	National Institute of Senior Citizens
NKA	No Known Allergies
NM	Never Married

Acronym	Defintion
NMU	Northern Michigan University
noct. (noc)	Night
NPO	Nothing By Mouth
NWHN	North Woods Home Nursing
O	Zero/None/No
O.R.	Operating Room
O2	Oxygen
OAA	Older Americans Act
OAVP	Older American Volunteer Program
OC	Option Counselor
OCR	Office of Civil Rights
OHDS	Office of Human Development Services
OIG	Office of Inspector General
OLOM	Our Lady of Mercy Nursing Home
OMH	Ontonagon Memorial Hospital
OOB	Out Of Bed
OOT	Out Of Town
OP	Out Patient
Ophth	Ophthalmology
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
p	After
P	Pulse
p.c.	After meals
P.C. (PCA), PC	Personal Care (Aide)
p.m. (PM) or p	Afternoon
p.o.	By Mouth
p.r.n., PRN	As needed
PA	Prior Authorization
PA	Public Act
PAM	Program Administrative Manual
PAS	Pre-Admission Screening
PASS	Plan to Achieve Self-Sufficiency
PCN	Penicillin
PCS	Personal Care Services (Standard)
PCSP	Person Center Service Plan
Pd or pd	Paid
PDN	Private Duty Nursing
PDS	Physical Disability Services
PERLA	Pupils Equal and Reactive to Light and Accommodation
PERS	Personal Emergency Response System
ph	Phone
PHI	Protected Health Information
PHR	Portage Health Resources
Phys.	Physician
PI	Participant Information or Program Instruction
POA	Power of Attorney
POC	Plan of Care
pos or +	Positive
postop	Postoperative
PPA	Patient Pay Amount

Acronym	Defintion
PPB	Prepaid Burial
preop	Preoperative
prep	Preparation
PRM	Program Reference Manual
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	Physical Therapy
PT	Prothrombin Time
pt.	Patient
PTS	Participant Tracking System
PVD	Peripheral Vascular Disease
PY	Program Year
Q	Every
q.h.s.	At Bedtime
q.i.d.	Four Times A Day
q.o.d.	Every Other Day
q.o.m.	Every Other Month
QA	Quality Assurance or Quality Analyst
QC	Quality Control
qh	Every Hour
QMB	Qualified Medicare Beneficiary
qowk	Every Other Week
qt.	Quart
R (Rt.), r	Right
R/C	Returned Call
R/O	Rule Out
R/T (r/t)	Related To
RAI-HC	Resident Assessment Instrument for Home Care
RBC	Red Blood Cell
RBS	Random Blood Sugar
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
RO	Regional Office
ROI	Release of Information
ROM	Range Of Motion
RSDI	Retirement, Survivors, Disability Insurance
RSVP	Retired & Senior Volunteer Program
RSW	Registered Social Worker
RT	Respiratory Therapist
RUG	Resource Utilization Group
Rx or trxt	Treatment or Prescription
s	Without
S & S (s/sx)	Signs and Symptoms
S (S)	Son or Sign
S/P	Status Post
SA	State Assistance
SAC	State Advisory Council
SAIL	Superior Alliance of Indepdent Living

Acronym	Defintion
SB	Senate Bill (state)
SBA	Skilled Bath Aide or Stand by Assistance
SC	Supports Coordinator
sc (sq) (sub q)	Subcutaneous
SC(s)	Supports Coordinators
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
SFH	St. Francis Hospital
SFHH	St. Francis Home Health
SGA	Statement of Grant Award
SIL	Son-in-law
SILC	State Independent Living Council
SLMB	Specified Low-Income Medicare Beneficiaries
SLP	Speech Language Pathologist or Speech Therapist
SNAFU	Situation Normal All Fouled Up
SNF	Skilled Nursing Facility
SNU	Skilled Nursing Unit
SOB	Shortness of Breath
spec	Specimen
SR	Senate Bill (federal)
SR	Service Request
ss or 1/2	One Half
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
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	Temperature
t.i.d.	Three Times Per Day
t.o.	Telephone Order
T/C (T.C)	Telephone Call
TA	Technical Assistance
TB	Tuberculosis
TBI	Traumatic Brain Injury
Tbsp. (T)	Tablespoon
TCM	Targeted Case Management
TIA	Transient Ischemic Attack
TIP	Temporarily Ineligible Participant
TLC	Tender Loving Care
TPL	Third Party Liability
TPN	Total Parental Nutrition
TPR	Temperature, Pulse, Respiration
TRC	Targeted Respite Care
TS	Transportation/Escort Standard

Acronym	Defintion
TSH	Thyroid Stimulating Hormone
tsp. Or t	Teaspoon
TSR	Tobacco Settlement Respite (state)
Tx	Treatment
UA	Urinalysis
UCP	United Cerebral Palsy
UMBHS	Upper MI Behavioral Health Services
UP	Upper Peninsula
UP 211	Upper Peninsula 2-1-1 Call Center
UPCAP	Upper Peninsula Commission for Area Progress
UPHN &H	UP Home Nursing & Hospice
UPHP	Upper Peninsula Health Plan
UPPCO	Upper Peninsula Power Company
UPPD	Upper Peninsula Private Duty
URI	Upper Respiratory Infection
USDA	United States Department of Agriculture
UTI	Urinary Tract Infection
v.o.	Verbal Order
VA	Veterans' Administration
Vag	Vaginal
Val	Value
VAMC	Veterans Administration Medical Center
VC	Vital Care
Vet	Veteran
Vet. A	Veteran's Affairs
VFD	Volunteer Fire Department
VFW	Veterans of Foreign Wars
Vit	Vitamin
VS	Vital Signs
W & F	Wright & Filippis
W.B.C	White Blood Cells
w/ or c	With
W/C (WC) w/c	Wheelchair
w/o, s	Without
WA	Waiver
WAP	Weatherization Assistance Program
wk.	Week
WMH	War Memorial Hospital
WNL	Within Normal Limits
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

INTERDISCIPLINARY CONSULTATION PROCESS

Inter-Disciplinary Consultations must be completed when only one discipline completes an assessment, reassessment or PCSP. Inter-Disciplinary Consultations are not only a requirement by MDHHS, but are designed to address the needs of participants through organized and documented communications between a RN's and SW's to be sure the assessment and PCSP meet the participants goals and needs in every aspect.

1. SW emails designated RN informing them an assessment, reassessment or PCSP has been completed.
2. Reviewer shall utilize the interdisciplinary consultation form.
3. For initial assessments, the designated RN shall review progress notes/comments, the RN Assessment, Diseases, Medications, Medical Providers, Pharmacy and DME sections of the assessment, as well as the PCSP Goals and Interventions.
4. For reassessments, the designated RN shall run the assessment comparison report from Compass and review any changes made since last assessment as well as the PCSP Goals and Interventions.
5. For PCSP's the reviewer shall review any updates to the goals and interventions.
6. Once reviewed, submit the form back to the Primary SW so they can review notes/comments, etc.
7. Interdisciplinary Consultations are to be done telephonically once a month.
8. For initial assessments the reviewer will add a progress note indicating what was reviewed and that an interdisciplinary consultation was completed.
9. For reassessments and PCSP's the primary CM will add a progress note indicating an interdisciplinary consultation was done.

INTERDISCIPLINARY CONSULTATION FORM

DATE:	CLIENT:
SW:	RN:
☐Initial Assessment ☐Reassessment ☐PCSP ☐Other	

RN Assessment

Ensure all sections of the RN assessment are completed and required documentation obtained. Examples: if a client is receiving nutritional supplements or nursing services for medication management a Rx must be obtained every 6 months. If a client is receiving skilled nursing/hospice services a 485 must be received and documentation entered regarding an interdisciplinary consultation was completed with staff.

Notes/Comments:	Follow Up Needed: ☐Yes ☐No

LOCD REVIEW

Please be sure to review which door the participant scored under and make sure corresponding section of assessment matches. Examples: If the client qualifies under a Door #1 make sure the selections marked on NFLOCD match to correct corresponding selections in section P: Physical Function of the RN assessment. If client meets under a Door #4 ensure corresponding documentation validates their need of daily oxygen use and a Physicians order has been obtained every 6 months.

Notes/Comments:	Follow Up Needed: ☐Yes ☐No

Other or Primary Diseases Ensure a Primary Diagnosis is listed along with any other pertinent health concerns.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
Medications Review Medication record and ensure all medications including the name, prescribing physician name (as indicated on the prescription bottle), purpose, strength dose, frequency, and route for all medications. Examples: If topical medication is listed where it is applied needs to be identified. If on inhalers how many puffs needs to be listed.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
Medical Providers Ensure Primary Physician is listed as well as any other providers seen on a regular basis.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
Pharmacies Ensure Pharmacy is listed.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
DME Review DME section to be sure everything is listed and completed as well a corresponds to information provided in the assessment.	
Notes/Comments	Follow Up Needed: ☐Yes ☐No

PCSP Review each goal and intervention ensuring they are appropriate as well as fully completed and updates as required.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
Additional Comments: Any other issues or concerns that need to be addressed.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No

INTERDISCIPLINARY CONSULTATION PROCESS

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1. RN emails designated SW informing them an assessment, reassessment or PCSP has been completed.
2. Reviewer shall utilize the interdisciplinary consultation form.
3. For initial assessments, the designated SW shall review progress notes/comments, the social work, caregiver and DME sections of the assessment, as well as the PCSP Goals and Interventions.
4. For reassessments, the designated SW shall run the assessment comparison report from Compass and review any changes made since last assessment as well as the PCSP Goals and Interventions.
5. For PCSP's the reviewer shall review any updates to the goals and interventions.
6. Once reviewed, submit the form back to the Primary RN so they can review notes/comments, etc.
7. Interdisciplinary Consultations are to be done telephonically once a month.
8. For initial assessments the reviewer will add a progress note indicating what was reviewed and that an interdisciplinary consultation was completed.
9. For reassessments and PCSP's the primary CM will add a progress note indicating an interdisciplinary consultation was done.

INTERDISCIPLINARY CONSULTATION FORM

DATE:	CLIENT:
SW:	RN:
☐Initial Assessment ☐Reassessment ☐PCSP ☐Other	

BENEFITS & INSURANCE

Notes/Comments:	Follow Up Needed: ☐Yes ☐No

FINANCIAL

If Waiver Pending, please be sure to review financial information to confirm financial eligibility requirements.

Notes/Comments:	Follow Up Needed: ☐Yes ☐No

LOCD REVIEW

Please be sure to review which door participant scored under and make sure corresponding section of assessment of assessment matches. Example: If the client was a door 2 for cognition, make sure the cognitive section of the SW assessment was written in a way that supports the findings in the LOCD.

Notes/Comments:	Follow Up Needed: ☐Yes ☐No

CAREGIVER Review caregiver section to be sure everything is completed and corresponds with any information in the informal supports section	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
DME Review DME's to be sure everything is completed and corresponds with any information in the environment section.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
PCSP Review each goal and intervention making sure the goals and interventions were appropriate and fully completed.	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No
Additional Comments: Any other issues or concerns that need to be addressed	
Notes/Comments:	Follow Up Needed: ☐Yes ☐No