THE SOCIAL WELFARE ACT (EXCERPT)
Act 280 of 1939

400.109i Locally or regionally based single point of entry agencies for long-term care.

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

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

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

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

(c) The provision of quality assistance and supports.

(d) That quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Consumer access to an independent consumer advocate.

(f) That data and outcome measures are being collected and reported as required under this act and by contract.

(g) That consumers are able to choose their supports coordinator.

(3) The department of community health shall establish and publicize a toll-free telephone number for areas of the state in which a single point of entry agency is operational as a means of access.

(4) The department of community health shall require that single point of entry agencies for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with unbiased information promoting consumer choice for all long-term care options, services, and supports.

(b) Facilitate movement between supports, services, and settings in a timely manner that assures consumers' informed choice, health, and welfare.

(c) Assess consumers' eligibility for all medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(d) Assist consumers in obtaining a financial determination of eligibility for publicly funded long-term care programs.

(e) Assist consumers in developing their long-term care support plans through a person-centered planning process.

(f) Authorize access to medicaid programs for which the consumer is eligible and that are identified in the consumer's long-term care supports plan. The single point of entry agency for long-term care shall not refuse to authorize access to medicaid programs for which the consumer is eligible.

(g) Upon request of a consumer, his or her guardian, or his or her authorized representative, facilitate needed transition services for consumers living in long-term care settings if those consumers are eligible for those services according to a policy bulletin approved by the department of community health.

(h) Work with designated representatives of acute and primary care settings, facility settings, and community settings to assure that consumers in those settings are presented with information regarding the full array of long-term care options.

(i) Reevaluate the consumer's eligibility and need for long-term care services upon request of the consumer, his or her guardian, or his or her authorized representative or according to the consumer's long-term care support plan.

(j) Except as otherwise provided in subdivisions (k) and (*l*), provide the following services within the prescribed time frames:

(*i*) Perform an initial evaluation for long-term care within 2 business days after contact by the consumer, his or her guardian, or his or her authorized representative.

(*ii*) Develop a preliminary long-term care support plan in partnership with the consumer and, if applicable, his or her guardian or authorized representative within 2 business days after the consumer is found to be eligible for services.

(*iii*) Complete a final evaluation and assessment within 10 business days from initial contact with the consumer, his or her guardian, or his or her authorized representative.

(k) For a consumer who is in an urgent or emergent situation, within 24 hours after contact is made by the

consumer, his or her guardian, or his or her authorized representative, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative.

(*l*) Except as provided in subsection (20), for a consumer who receives notice that within 72 hours he or she will be discharged from a hospital, within 24 hours after contact is made by the consumer, his or her guardian, his or her authorized representative, or the hospital discharge planner, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian, his or her authorized representative, or the hospital discharge planner.

(m) Initiate contact with and be a resource to hospitals within the area serviced by the single point of entry agencies for long-term care.

(n) Provide consumers with information on how to contact an independent consumer advocate and a description of the advocate's mission. This information shall be provided in a publication prepared by the department of community health in consultation with these entities. This information shall also be posted in the office of a single point of entry agency.

(o) Collect and report data and outcome measures as required by the department of community health, including, but not limited to, the following data:

(*i*) The number of referrals by level of care setting.

(*ii*) The number of cases in which the care setting chosen by the consumer resulted in costs exceeding the costs that would have been incurred had the consumer chosen to receive care in a nursing home.

(*iii*) The number of cases in which admission to a long-term care facility was denied and the reasons for denial.

(*iv*) The number of cases in which a memorandum of understanding was required.

(*v*) The rates and causes of hospitalization.

(*vi*) The rates of nursing home admissions.

(*vii*) The number of consumers transitioned out of nursing homes.

(*viii*) The average time frame for case management review.

(*ix*) The total number of contacts and consumers served.

(*x*) The data necessary for the completion of the cost-benefit analysis required under subsection (11).

(*xi*) The number and types of referrals made.

(*xii*) The number and types of referrals that were not able to be made and the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(p) Maintain consumer contact information and long-term care support plans in a confidential and secure manner.

(q) Provide consumers with a copy of their preliminary and final long-term care support plans and any updates to the long-term care plans.

(5) The department of community health, in consultation with the office of long-term care supports and services, the Michigan long-term care supports and services advisory commission, the department, and the office of services to the aging, shall promulgate rules to establish criteria for designating local or regional single point of entry agencies for long-term care that meet all of the following criteria:

(a) The designated single point of entry agency for long-term care does not provide direct or contracted medicaid services. For the purposes of this section, the services required to be provided under subsection (4) are not considered medicaid services.

(b) The designated single point of entry agency for long-term care is free from all legal and financial conflicts of interest with providers of medicaid services.

(c) The designated single point of entry agency for long-term care is capable of serving as the focal point for all individuals, regardless of age, seeking information about long-term care in their region, including individuals who will pay privately for services.

(d) The designated single point of entry agency for long-term care is capable of performing required consumer data collection, management, and reporting.

(e) The designated single point of entry agency for long-term care has quality standards, improvement methods, and procedures in place that measure consumer satisfaction and monitor consumer outcomes.

(f) The designated single point of entry agency for long-term care has knowledge of the federal and state statutes and regulations governing long-term care settings.

(g) The designated single point of entry agency for long-term care maintains an internal and external appeal process that provides for a review of individual decisions.

(h) The designated single point of entry agency for long-term care is capable of delivering single point of entry services in a timely manner according to standards established by the department of community health and as prescribed in subsection (4).

(6) A single point of entry agency for long-term care that fails to meet the criteria described in this section or other fiscal and performance standards prescribed by contract and subsection (7) or that intentionally and knowingly presents biased information that is intended to steer consumer choice to particular long-term care supports and services is subject to disciplinary action by the department of community health. Disciplinary action may include, but is not limited to, increased monitoring by the department of community health, additional reporting, termination as a designated single point of entry agency by the department of community health, or any other action as provided in the contract for a single point of entry agency.

(7) Fiscal and performance standards for a single point of entry agency include, but are not limited to, all of the following:

(a) Maintaining administrative costs that are reasonable, as determined by the department of community health, in relation to spending per client.

(b) Identifying savings in the annual state medicaid budget or limits in the rate of growth of the annual state medicaid budget attributable to providing services under subsection (4) to consumers in need of long-term care services and supports, taking into consideration medicaid caseload and appropriations.

(c) Consumer satisfaction with services provided under subsection (4).

(d) Timeliness of delivery of services provided under subsection (4).

(e) Quality, accessibility, and availability of services provided under subsection (4).

(f) Completing and submitting required reporting and paperwork.

(g) Number of consumers served.

(h) Number and type of long-term care services and supports referrals made.

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

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

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

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

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

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

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

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

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

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

(a) The written report is submitted as provided under subsection (13).

(b) Twelve months have passed since the submission of the written report required under subsection (13).

(c) The legislature appropriates funds to support the designation of additional single point of entry agencies.

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

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

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

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

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

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

(23) For the purposes of this section:

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

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

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

(*ii*) Personnel management and payroll administration.

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

(A) Utilities.

(B) Office supplies and equipment.

(C) Information technology.

(D) Data reporting systems.

(E) Postage.

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

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

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

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

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

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

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

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

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

History: Add. 2006, Act 634, Imd. Eff. Jan. 4, 2007.

Popular name: Act 280