

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Two new waiver services are requested for the Children's Waiver Program (CWP) in this renewal application. One service - "Family Support and Training" - is a family-focused service provided by a peer-parent who has completed specialized training. The other service - "Fiscal Intermediary Services" - is a service that handles the financial flow-through of Medicaid dollars for children using the Choice Voucher system. As part of Michigan's "Participant Direction" options, we are adding "Agency with Choice" as an alternative to the Choice Voucher system. In addition, provider qualifications for current services are updated as necessary to align with changes in licensing and certification.

Beginning in 2011, Michigan Department of Community Health (MDCH) CWP staff will no longer conduct a site review separate from that conducted by MDCH Quality Management Program (QMP) staff. The QMP site review protocol will incorporate CWP review standards and measures. CWP staff will join QMP staff and will conduct a clinical review of records every 2 years (with QMP staff conducting the administrative review of CWP records); one site review report will be issued to each CMHSP. In alternate years, QMP staff will conduct the follow-up review of both administrative and clinical records.

As instructed in the IPG Final Report, MDCH has implemented new cost reporting requirements that enable CMHSPs to distinguish administrative costs associated with being an Organized Health Care Delivery System (OHCDs) for the Children's Waiver Program (CWP) from administrative costs associated with directly delivering services to CWP-enrolled consumers as a service provider.

In addition to the changes identified above, concerns raised in the February 2010 IPG Final Report are incorporated in applicable sections throughout this application.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Michigan** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Children's Home and Community-Based Waiver for Children with Developmental Disabilities
- C. **Type of Request: renewal**

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number:

4119

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy)

10/01/10

Draft ID: MI.12.01.00**Renewal Number:** 01**D. Type of Waiver** (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

10/01/10

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

 Hospital

Select applicable level of care

 Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

 Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 **Nursing Facility**

Select applicable level of care

 Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

 Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

 Not applicable **Applicable**

Check the applicable authority or authorities:

 Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

 §1915(b)(1) (mandated enrollment to managed care) **§1915(b)(2) (central broker)** **§1915(b)(3) (employ cost savings to furnish additional services)** **§1915(b)(4) (selective contracting/limit number of providers)** **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously

approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Children's Waiver Program (CWP) is to provide community-based services to children under age 18 who are eligible for, and at risk of, placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The goal of the CWP is to enable children to remain in the community, residing in their parent's or legal guardian's home or returning to their parent's or legal guardian's home from out-of-home placements. The objective is to provide regular Medicaid State Plan services and waiver services that address the child's/youth's identified needs.

Waiver services include: family training (by a clinician), family support and training (by a trained peer parent), non-family training, specialty services (i.e., music, recreation, art and massage therapy), community living supports, fiscal intermediary services, enhanced transportation, respite care, environmental accessibility adaptations, and specialty medical equipment.

Oversight of the CWP is provided by Mental Health Substance Abuse Services, a division within the single State Medicaid Agency - the Michigan Department of Community Health (MDCH). The CWP is a Medicaid fee-for-service program administered locally by Community Mental Health Service Programs (CMHSPs) which meet the criteria for Organized Health Care Delivery Systems (OHCDS) and are under contract with MDCH. Services are provided by the OHCDS or its contracted entities.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities. *Appendix E is required.*
 - No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the

integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
 - No
 - Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
 - Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
As required per 6-J below, notification of intent to renew the Children's Waiver Program (CWP) was mailed to Tribal Chairs and Health Directors on April 24, 2010. Notification of intent and the approved CWP Waiver Application for 2005-2010 (last amended effective October 1, 2008) was posted on the Michigan Department of Community Health's (MDCH) web-site the same day. Tribal Chairs, Health Directors and other members of the public were invited to submit comments regarding the renewal application to MDCH Medical Services Administration (MSA).
- In addition, notices of intent to renew the CWP were put in Michigan's major newspapers, and emailed to Medical Care Advisory Council Members, with indication that the current CMS-approved CWP waiver could be viewed on the MDCH website. Again, the public were invited to submit comments regarding the renewal application to MSA.
- The CWP is fully described on the MDCH website, with links to the CWP Technical Assistance Manual. The website includes contact numbers and email addresses to request additional information and to provide feedback. The Michigan Medicaid Provider Manual also details the CWP and is available on the MDCH website. Proposed policy revisions to the CWP are published in "Medicaid Policy Bulletins", posted on the website and distributed to providers and the public for review, comment and concurrence.
- Elements of the CWP are covered in trainings, presentations, and conferences, which are conducted throughout the state on a regular basis to a variety of stakeholders including: Community Mental Health Directors, finance officers, clinical directors and administrative staff; representatives of Special Education; other service providers; advocacy groups; and consumers and their families. Additionally, site reviews by MDCH CWP staff include home visits, which provide a valuable opportunity for families to express their views about the waiver, its services, and the impact on their lives. Feedback from all these sources are used in developing amendments and renewal applications.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **Michigan**
Zip:
Phone: **Ext:** **TTY**
Fax:
E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **Michigan**
Zip:
Phone: **Ext:** **TTY**
Fax:
E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Last Name:

First Name:	<input type="text" value="Stephen"/>
Title:	<input type="text" value="Director"/>
Agency:	<input type="text" value="Medical Services Administration"/>
Address:	<input type="text" value="400 S. Pine St."/>
Address 2:	<input type="text"/>
City:	<input type="text" value="Lansing"/>
State:	Michigan
Zip:	<input type="text" value="48933"/>
Phone:	<input type="text" value="(517) 241-7882"/>
Fax:	<input type="text" value="(517) 335-5007"/>
E-mail:	<input type="text" value="fittons@michigan.gov"/>

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Michigan Department of Community Health (MDCH) - Mental Health /Substance Abuse Services Administration
(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

- a) Mental Health and Substance Abuse Services (MH/SA) staff perform the following operational and administrative functions:

Staff performs all administrative functions related to the CWP including review and approval of waiver applications submitted by CMHSPs, waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS' assurances, including financial accountability. Additionally MH/SA staff disseminate information concerning the waiver to potential enrollees and service providers; assist individuals in waiver enrollment; manage waiver enrollment against approved limits; monitor waiver expenditures against approved levels; monitor level of care evaluation activities; conduct site reviews; conduct utilization management functions; determine waiver payment amounts or rates; conduct training and technical assistance (including Maintenance of the Medicaid Provider Manual and the CWP Technical Assistance Manual) concerning waiver requirements and implementation.

b) The Memorandum of Understanding between the State Medicaid agency and Mental Health and Substance Abuse Administration outlines the responsibilities for administration and oversight of the waiver. The responsibilities of the Mental Health and Substance Abuse Administration include: monitoring and managing the annual CWP appropriation; managing waiver enrollment against approved limits; performing prior authorization of selected services for the CWP; establishing clinical eligibility for waivers; conducting and monitoring quality assurance at the PIHP and OHCDs/CMHSP levels; providing training and technical assistance concerning waiver requirements; completing waiver applications, renewals, amendments and 372 reports related to the CWP (which are then submitted to MSA for review and approval). The responsibilities of the Medical Services Administration include: establishing fee screens; setting and publishing Medicaid policy, including policy related to the CWP; determining Medicaid eligibility; reviewing, approving and submitting waiver applications, renewals, amendments and 372 reports to CMS; processing Medicaid claims and make payments based on established methodology. If the Medicaid Director has a concern as to how the Mental Health and Substance Abuse (MH/SA) Administration fulfills their responsibility as outlined in the MOU, he would take his concerns to the MH/SA Director.

c) While the administration of the waiver falls within the jurisdiction of the MDCH's Mental Health and Substance Abuse Administration, all reports, amendments, renewals, and applications for waivers are reviewed, approved, and then submitted to CMS by the Medicaid Director, within the Medical Services Administration.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MDCH contracts with local/regional non-state public entities known as Community Mental Health Service Programs (CMHSPs), all of which meet criteria for organized health care delivery systems (OHCDs), to conduct operational and administrative functions at the local level. MDCH monitors this through the site review process, financial reviews, and waiver enrollment oversight. The review protocols used by both the Quality Management Program (QMP) and the CWP staff are organized in a way that addresses the functions delegated by MDCH to the participating CMHSPs for the CWP. The delegated functions included in the protocol are: level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; provider qualifications and enrollment; and quality assurance and quality improvement activities. MDCH manages enrollment against approved limits by reviewing, approving and processing applications and renewal certifications submitted by CMHSPs and by processing terminations submitted by CMHSPs.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**

- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

MDCH-Mental Health/Substance Abuse Services Administration

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: MDCH houses the Bureaus of Mental Health / Substance Abuse Services (MH/SA), Medical Services Administration (MSA), and the Public Health Administration (DPH). MSA is the single State agency. A MOU between MSA and MH/SA specifies the functions delegated for administration and operation of the CWP. The Bureau of MH/SA is responsible for: monitoring and managing the CWP annual appropriation; managing waiver enrollment against approved limits; performing Prior Authorization of selected services for the CWP; establishing clinical eligibility for the waiver; conducting and monitoring quality assurance at the PIHP/CMHSP level;

providing training and technical assistance concerning waiver requirements; completing CWP waiver applications, renewals, amendments and 372 reports for submission to CMS.

The MDCH Division of Quality Management and Planning (QMP) conducts annual on-site visits to the PIHP/CMHSPs. During these visits, a detailed site review protocol is used to assure quality of services to consumers, compliance with the Michigan Mental Health Code and Administrative Rules, and conformance with all Medicaid requirements. In addition to site reviews completed by the QMP, the MDCH CWP staff complete tri-annual site reviews of the CMHSPs. These on-site reviews include home visits of selected Waiver participants and a full clinical review of selected records. The review protocol is specific to assuring compliance with Waiver requirements.

The review protocols used by both the QMP and the CWP staff are organized in a way that addresses the functions delegated by MDCH to the participating OHCDs/CMHSPs for the CWP. The delegated functions included in the protocol are: level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; provider qualifications and enrollment; and quality assurance and quality improvement activities. MDCH manages enrollment against approved limits by reviewing, approving and processing applications submitted by CMHSPs and by processing terminations submitted by CMHSPs.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the

following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of all policies and procedures governing the CWP are developed by the operating agency and approved by MSA, and published in the Michigan Medicaid Provider Manual through the established concurrence review process prior to implementation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Michigan Medicaid Provider Manual

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Medicaid Bulletins and instructional letters are issued continuously and ongoing. The Michigan Medicaid Provider Manual is updated quarterly to incorporate all published policies and procedures.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Prior to submission to CMS, MSA reviews and approves 100% waiver amendments and applications and annual 372 reports, which provide trend data and information regarding remediation efforts and system improvements.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Division of Quality Management and Planning (QMP) within MDCH monitors the implementation at the 18 PIHPs (comprised of all 46 CMHSPs), and sends a qualified site review team to each of the PIHPs/CMHSPs to complete a comprehensive review and a follow-up review on the alternate year. The site review process incorporates the rigorous standards for assuring the health and welfare of Waiver consumers and includes visits to provider sites / location, meetings with staff and consumers, and visits to consumers' homes. The comprehensive reviews include the following components:

Reviews of clinical records to determine that person centered planning (PCP)/family-driven/youth guided practice is being utilized, health and welfare concerns are identified and addressed, services identified in the plan of service are being delivered by qualified providers, and delivery of service meets program requirements as published in the Medicaid Provider Manual. The MDCH review team draws random samples of clinical records from encounter data in the MDCH warehouse. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs (including the CWP), all affiliates (if applicable), a sample of providers, and a sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

The comprehensive administrative review focuses on policies, procedures, and initiatives that are not otherwise reviewed by the External Quality Review (EQR) and need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:

- o PIHP/CMHSP Compliance with the Medicaid Provider Manual
- o Written agreements with providers, community agencies
- o The results of the PIHP/CMHSPs' annual monitoring of its provider network.
- o Adherence to contractual practice guideline
- o Sentinel event management

A report of findings from the on-site reviews is disseminated to the PIHP/CMHSP with the requirement that a plan of correction be submitted to MDCH within 30 days. On-site follow-up is conducted the following year, or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC), and CWP staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

The CWP staff site review team monitors the following:

- o Evaluation of level of care: assurance that enrolled participants are reevaluated at least annually, as documented by the completion of the Waiver Certification form by the Case Manager or other qualified provider, the responsible CMHSP designee, and that decisions are appropriate and well documented. When the level of care is not sufficiently documented, CWP staff follow-up with the CMHSP to request appropriate documentation and/or revision of the level-of-care if needed.
- o Individual plans of service are reviewed to ensure that: a PCP process is used to develop comprehensive plans that identify the participant's assessed needs (including health and safety), strengths, goals, and that the plan specifies the type, scope, amount, duration and frequency of service; plans are updated as needed, but at least annually; and that participants are given a choice of service providers and the choice between waiver services and institutional care (documented on the CWP Waiver Certification form).
- o Provider qualifications are reviewed to verify that providers meet all required licensing, certification and training requirements.
- o Health and welfare is monitored by reviews of recipient rights complaints, sentinel events, behavioral management plans when potentially seclusive and/or restrictive interventions are used, reviews of plans of service and consumer interviews to ensure that the child is receiving the services identified in the plan.
- o Financial Accountability involves a review of paid claims against services (type, frequency, duration) identified in the plan, prescriptions, and private insurance coverage.
- o Home visits are conducted to assess satisfaction with services and service providers, knowledge of recipient rights and administrative hearing rights, freedom of choice, and that staff have been trained in the plan of service.

An additional strategy employed by the State to discover problems is the EQR. EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being

implemented. One EQR component addresses PIHP compliance to Balanced Budget Act (BBA) requirements. The other two EQR activities - Performance Improvement Program Validation and Performance Measures Validation - provide a mechanism for discovering problems / issues related to PIHPs/CMHSPs.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

As described in a.ii. above, a standard site review protocol is used at the time of each site visit - whether the site review is conducted by QMP or CWP staff. The protocol is used to record and document findings during the site review. The findings are sent to the CMHSPs with the requirement that the CMHSP prepare and submit to MDCH plans of correction within 30 days. The plans of correction are reviewed by staff that completed the site review and are subsequently reviewed and approved by Mental Health / Substance Abuse administration. The remediation process continues until all concerns have been appropriately addressed.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	

	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
● Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
● Mental Retardation or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
● Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

b. Additional Criteria. The State further specifies its target group(s) as follows:

The following eligibility requirements must be met:

- 1) The child has a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services;
- 2) The child has a score on the Global Assessment of Functioning (GAF) Scale of 50 or below;
- 3) The child resides with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child;
- 4) The child meets criteria for ICF/MR admission and is at risk of being placed outside of the family home because of the intensity of his/her care needs and the lack of needed support;
- 5) The child meets Medicaid income and asset limits when viewed as a family of one (the parent's income is waived);
- 6) The child's intellectual or functional limitations indicate that he/she is eligible for health, habilitative and active treatment services provided at the ICF/MR level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Michigan believes that transition requires planning throughout a period of time, often starting years prior to the child's 18th birthday. Planning includes an assessment of the child's current circumstances, resources, service needs, what will be changing and the child's envisions for his/her future. Children / youth who age out of the CWP continue to have mental health service and support needs that require planning on the part of the consumer, family and responsible service agencies. It is the purpose of the waiver to provide services to increase the individual's ability to function independently or with supports in a community setting.

As a youth approaches his/her early adult years, the child, his/her family and the CMHSP focus on planning for this period of transition. There are many things to consider during this time. Some of the basic issues deal with housing, employment, vocational training or school status, emotional/behavioral health, physical health and safety. During this time it is common to focus on the life domain areas that will impact the youth's success as an adult. The team will focus on enhancing these skills utilizing Medicaid State Plan and waiver services, as well as by helping the youth and family identify and understand what services may be available post CWP. If the youth's disability impacts his/her ability to earn income, the team will work with the youth to apply for this benefit at age 18. The team will also work with the youth to identify other entitlements that would assist the youth post CWP.

This is also the time that the team will explore the services and supports the youth needs after his/her 18th birthday and start the transition process with adult services. Whenever possible we encourage the adult services staff to become part of the CWP planning team to assure a smooth transition to adult services.

Transitions are very different for each individual, but the PIHP/CMHSP assumes the responsibility that the child's/youth's needs are met post CWP. Children who meet ICF/MR eligibility criteria and continue to have documented habilitative service needs, are given priority to enroll in the Habilitation Supports Waiver (HSW), should the specialized supports and services available under that waiver be appropriate to the child's needs. This means the consumer aging off the CWP does not have to wait for needed services, even if the responsible PIHP/CMHSP has no "available" HSW slots. This assures a seamless transition of supports and services that enable the youth to remain in a community setting.

The purpose of the HSW is to enable people who have a developmental disability to live and participate as productive members of their communities instead of living in institutions. This waiver serves approximately 8000 people each year, statewide and has no age limits. HSW eligibility requirements that the individual must: have a developmental disability and without HSW services require ICF/MR level of care; be living in the community while receiving HSW services; be eligible for Medicaid; and receive at least one HSW service each month.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
 - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants.

Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

- The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

- Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

--

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	464
Year 2	464
Year 3	464
Year 4 (renewal only)	464
Year 5 (renewal only)	464

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

The CWP offers necessary services and supports beyond what is available under the Medicaid state plan to children with developmental disabilities whose needs have placed them at risk for health, safety and/or out-of-home placement. Prior to considering a request for CWP services, the PIHP/CMHSP must review and utilize all available and appropriate Medicaid state plan covered services appropriate for the child. If the PIHP/CMHSP determines that a child is at risk and a CWP pre-screen is appropriate, that child falls within the priority population mandated for service under the Michigan Mental Health Code (MMHC).

The MMHC, Section 330.1100c(6) defines "priority" as "preference for and dedication of a major proportion of resources to specified populations or services. Priority does not mean servicing or funding the specified populations or services to the exclusion of other populations or services." Section 330.1208 (3) of the Code further states: "Priority shall be given to the provision of services to individuals with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability. Priority shall also be given to the provision of services to individuals with a serious mental illness, serious emotional disturbance, or developmental disability in urgent or emergency situations." Section 330.1100 (14) of the Code defines "urgent situation" as a "situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment or support services."

A child identified as "at-risk" or "priority" must have their urgent care needs met by the PIHP/CMHSP to ensure health, welfare, and safety, while the child remains on the CWP Priority Weighing List. The PIHP/CMHSP must assess the child's needs and develop an Individual Plan of Service (IPOS) through the Person Centered Planning (PCP) process. This would apply to any child whether or not they are Medicaid eligible. For children who are not Medicaid eligible the MMHC, section 330.1124, states that "community mental health services programs maintain waiting lists if all service needs are not met, and that the waiting lists include data by type of services, diagnostic groups or program categories, age, and gender, and that they specify the length of time each individual has been on the waiting list from the date of the initial request for services. The order of priority on the waiting lists shall be based on severity and urgency of need. Individuals determined to be of equal severity and urgency of need shall be served in the order in which they applied for services." For children with Medicaid in need of mental health specialty services, the PIHP/CMHSP cannot place the child on a waiting list for services and must provide services and supports appropriate to need.

A request for CWP services begins with a pre-screen completed by the CMHSP case manager and the child's parent(s). Determination of severity of need is based on program-specific criteria. The CWP Priority Weighing Criteria provides a consistent and objective basis on which to determine the priority status of children who may be eligible for the program. The case manager must meet with the child's family and provide detailed information on CWP service parameters and program requirements. This includes eligibility requirements, services available, program criteria, requirements for family participation in planning and active treatment, and financial disclosure requirements. After this discussion, if the family wishes to have their child considered for the CWP, the case manager completes a pre-screen. The pre-screen identifies those services to be provided by the CMHSP, based on the child's identified needs. A parent must sign the completed pre-screen and a copy must be maintained in the child's record. The case manager, or other qualified provider chosen by the consumer or consumer's representative, then submits the pre-screen to the Michigan Department of Community Health (MDCH).

When reviewing a pre-screen, the MDCH-CWP staff determine the score for each factor based on the information submitted, using the Priority Weighing Criteria. The scores for each factor are then totaled and priority status for the CWP is based on this score. A cover memo and scoring form are completed for each pre-screen and copies are mailed to the case manager, or other qualified provider chosen by the consumer or consumer's representative, to review with the family. If the cover memo contains questions about the pre-screen or indicates the availability of other potential resources, the case manager, or other qualified provider chosen by the consumer

or consumer's representative, should follow up and provide updated information to MDCH. Re-scoring occurs when updated information is received by MDCH. If there are subsequent changes in the child or family's situation that would affect a child's score based on the Priority Weighing Criteria, the case manager, or other qualified provider chosen by the consumer or consumer's representative, should submit a brief update letter describing relevant changes. The CMHSP is responsible for updating the pre-screen at least annually in order for the child to remain on the Priority Weighing List.

The Priority Weighing List contains a sequential list of all pre-screen scores. The Priority Weighing List is updated each time pre-screens are scored. When a CWP opening becomes available, all pre-screens that have been received and date stamped at MDCH are scored before a determination is made as to who will receive priority status to apply for the CWP opening. The child whose pre-screen is current, and who has the highest score, is invited to proceed with the CWP application process. The case manager, or other qualified provider chosen by the consumer or consumer's representative, is notified by phone as soon as a child is given priority status to apply for the CWP.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
- SSI Criteria State
- 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
- Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):
- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (*select one*):**

- The following standard included under the State plan**

Select one:

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

- Other**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable (see instructions)**
- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

- Other**
Specify:

Level of care evaluations and reevaluations are performed by the participating CMHSPs under contract with MDCH Mental Health/Substance Abuse Services (the operating agency specified in Appendix A). MDCH staff review evaluations and reevaluations completed by the CMHSPs.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The Community Mental Health Services Programs (CHMSPs) complete a Children's Waiver Program (CWP) assessment to provide a child with an individual Level of Care (LOC) evaluation. CMHSP personnel conducting the LOC evaluations and reevaluations are qualified as physicians or Qualified Mental Retardation Professionals (QMRPs), as defined in 42 CFR 483.430 and the Michigan Medicaid Provider Manual (MPM). The MPM, section 1.7 states that: "A QMRP is a person who has specialized training or one year of experience in treating or working with a person who has mental retardation; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMRP prior to January 1, 2008."

For the CWP the person completing the level-of-care evaluation must also have completed Michigan Department of Community

Health (MDCH)-sponsored training in determining Category of Care (COC) and Intensity of Care (IOC). Prior to submission to MDCH, the CMHSP's designee reviews and approves the assigned level-of-care, as specified on the CWP Certification.

Documentation of the child's LOC, as submitted by the CMHSP, is reviewed and approved by the MDCH CWP Clinical Review Team (CRT). The CWP CRT is made up of a pediatrician who is an M.D., two limited licensed psychologists, a nurse consultant who is a certified pediatric nurse practitioner (CPNP), a specialist with a Masters in Public Health, and a Registered Occupational Therapist (OTR).

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Children evaluated for the Children's Waiver Program (CWP) must meet the admission criteria for an ICF/MR as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). Section 3.13 of the MPM states: "Beneficiaries must meet ICF/MR level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified mental retardation professional (QMRP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications."

Additionally, the MPM at Section 14.2 defines eligibility for the CWP. The eligibility requirements that relate to level of care include: the child must have a developmental disability (as defined in Michigan State law; be in need of habilitation services; have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below; be at risk of being placed into an ICF/MR facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/MR facility but, with appropriate community support, could return home; have intellectual or functional limitations that indicate he would be eligible for health, habilitative and active treatment services provided at the ICF/MR level of care.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Michigan Medicaid Provider Manual(MMPM), Section 2.5.A. defines Medical Necessity Criteria for mental health, developmental disabilities, and substance abuse services for supports, services, and treatment as follows: "Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity."

Section 2.5.B. defines the Determination Criteria of a medically necessary support, service or treatment as: "Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and for beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and made within federal and state standards for timeliness; and sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and documented in the individual plan of service."

The Community Mental Health Services Programs (CHMSPs) complete a CWP assessment, as described above, to provide a child with an individual Level of Care (LOC) evaluation to determine if the child meets admission criteria for an ICF/MR, and if so, is at risk of placement without home and community based waiver services. The evaluators then use a Category of Care Decision Guide

(Section 3.2 of the MPPM) which has seven categories of care (COC)/Intensity of Care (IOC) under the waiver. The Category of Care Decision is used to help identify the amount of staffing that can be provided through the waiver for an individual child. The CMHSP uses a Waiver Certification Form to document the child's LOC, as well as the COC or IOC. A copy of the Waiver Certification form is sent to the Michigan Department of Community Health (MDCH) and is reviewed by the CWP Clinical Review Team (CRT) described in c., above.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The Michigan Department of Community Health's Clinical Review Team (CRT) reviews waiver participants' files to ensure that the child's level of care has been reevaluated at least annually and that the child's Waiver Certification form has been updated accordingly. The Children's Waiver Program database provides a "tickler" letter that is sent out to the responsible Community Mental Health Services Program (CMHSP) 60-90 days prior to the reevaluation due date. Additionally, the MDCH's Division of Quality Management and Planning (QMP) and the CWP site review teams have responsibility for monitoring all PIHPs / CMHSPs. During on-site reviews by both teams, the CWP participant clinical files are reviewed to confirm that reevaluations have been completed in the required time frame.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The local Community Mental Health Services Programs maintain clinical records that include the Children's Waiver Program (CWP) initial and reevaluation / re-certification packets, along with supporting documentation. The Michigan Department of Community Health maintains copies of the initial and re-certification packets and approval letters. The Medicaid agency maintains a copy of notification of both the initial and continuing eligibility for the CWP.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

- i. Sub-Assurances:**

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and

assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Level of Care evaluations are completed for 100% of applicants prior to their enrollment in the waiver.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: at time of application	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

100% of initial eligibility determinations are made by MDCH staff within seven (7) working

days of submission of the Waiver Certification form.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Level of Care determinations are reevaluated for 100% of enrolled participants within twelve (12) months of their initial level of care evaluation or their last annual level of care reevaluation.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Each child's needs are continually assessed. This can result in a redetermination of LOC anytime within the waiver year, but at least within 365 days of the last LOC determination.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Other
Specify:

Performance Measure:

Assessments, quarterly reports, data sheets, and plans of service are reviewed quarterly by MDCH-CWP staff for 100% of the children with the highest level of need, as indicated by the highest category of care / intensity of care.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and*

according to the approved description to determine participant level of care.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of level of care determinations are completed by the CMHSP, or by a qualified provider.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input checked="" type="checkbox"/> Other Specify: At the time of initial application, as the child's needs change, and at annual reevaluation.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:
100% of the level of care determinations are documented on the approved Waiver Certification form.

Data Source (Select one):
Record reviews, off-site
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Other Specify: At the time of initial application, as the child's needs change, and at annual reevaluation.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Other
Specify:

Performance Measure:

Assessments, data sheets, plans of service and budgets are reviewed by MDCH-CWP staff for 100% of requests for “exception hours” for individual consumers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

100% of each child's initial and annual budget is reviewed by MDCH-CWP staff to assure that waiver services are identified and that budgeted services are consistent with active treatment confirming ICF/MR LOC.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: An individualized budget is developed when a child is first approved for the CWP, and annually thereafter.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Children evaluated for the Children's Waiver Program (CWP) must meet the admission criteria for an ICF/MR and require a continuous active treatment program directed toward acquisition of behaviors and skills necessary to function with as much participant direction and independence as possible in the home and community setting.

The Community Mental Health Services Programs (CHMSPs) complete a CWP assessment, as described above, to provide a child with an individual Level of Care (LOC) evaluation to determine if the child meets admission criteria for an ICF/MR, and if so, is at risk of placement without home and community based waiver services. The evaluators then use a Category of Care Decision Guide (Section 3.2 of the Michigan Medicaid Provider Manual) which has seven categories of care (COC)/Intensity of Care (IOC) under the waiver.

In addition to reviewing all LOC determinations at the time of initial enrollment and annually thereafter, MDCH-CWP staff review LOC determinations quarterly for consumers with the highest category of care / intensity of care (indicating the highest level of need). This means that assessments, quarterly reports, data sheets, and plan of services are reviewed to determine appropriateness of care and confirm both level of care and category of care. When a Waiver Certification is submitted indicating a change in category of care of 2 or more levels, MDCH requests and reviews the child's assessments, data sheets, plan of service, and budget. Annual budgets are reviewed for all CWP consumers to assure that waiver services are identified and that budgeted services are consistent with active treatment confirming ICF/MR LOC. Additionally, all requests for "exception hours" involve a review of all assessments, data sheets, plan of service and budget to ensure that requested services are consistent with both level of care and category of care.

During on-site reviews, a sample of clinical records is reviewed, including all assessments and documentations that underpin the waiver certification, to determine that the identified level of care is supported by.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

A Disposition Transmittal (DT) is used MDCH-CWP staff to identify questions or issues that must be addressed by the CMHSP regarding individual LOC determinations that arise as the result of review of waiver certifications, quarterly reports, budgets, etc. The CMHSP must respond within 30 days of issuance of the DT. Their response is reviewed by the MDCH staff person (nurse or psychologist) who issued the DT to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDCH staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days.

During on-site reviews, a sample of clinical records is reviewed, including all assessments and documentation that underpins the waiver certification, to determine they support the identified level of care. Potential problems with level of care evaluation/re-evaluation may be identified during these annual site reviews, and are documented by MDCH staff using the Site Review Protocol. The CMHSP is required to respond to MDCH's site review report within 30 days of receipt of the report with a plan of correction. This plan of correction must be reviewed and approved by MDCH staff that completed the site review and by MDCH administration. The remediation process continues until all concerns have been appropriately addressed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Section 3 of the Waiver Certification form is used to document freedom of choice. This section is completed by the child's parent or legal guardian, and verifies that the case manager, or other qualified provider chosen by the consumer or consumer's representative, has informed the family of their right to choose between the community based services provided by the CWP and ICF/MR placement. This section also confirms that the family has been informed of their choice among qualified service providers. The Waiver Certification form is maintained in the child's clinical record at the CMHSP, and in the child's MDCH case file. Both aspects of choice are discussed with waiver participants at the time of initial certification. It is also typically discussed when the participant's plan of care is reviewed - which may be as frequent as monthly. During on-site reviews, the State monitors / confirms that choice is offered to consumers and their families.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

As stated above, Freedom of Choice is part of the Waiver Certification form and is maintained by the CMHSP in the consumer's clinical record and by MDCH in the consumer's record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The contract between MDCH and PIHPs/CMHSPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. Each PIHP/CMHSP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP/CMHSP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHP/CMHSPs access system.

Access system services must be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. The PIHP/CMHSP must arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines must be toll-free and accommodate Limited English Proficiency (LEP) and other linguistic needs, as well as be accessible for individuals with hearing impairments and must accommodate persons with diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Extended State Plan Service	Enhanced Transportation
Supports for Participant Direction	Fiscal Intermediary
Other Service	Community Living Supports
Other Service	Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies
Other Service	Family Support and Training
Other Service	Family Training
Other Service	Non-family Training
Other Service	Respite
Other Service	Specialty Service

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Enhanced Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Enhanced transportation is offered in order to enable the child served on the Children's Waiver Program (CWP) to gain access to waiver and other community services, activities and resources, specified by the child's individual plan of service (IPOS). This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. For purposes of this waiver, transportation is subject to what is reasonable and cost-effective, and limited to local destinations. "Local" is defined as destinations within the child's county of residence or a bordering county. Parents / guardians of a child on the CWP cannot be reimbursed or otherwise paid to provide this service for their child.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation is limited to local distances, where local is defined as within the child's county or a bordering county.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Individual	respite staff, clinical/professional service providers
Agency	Home care agency, staffing agency, CMHSP or other OHCDs network provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Enhanced Transportation

Provider Category:

Individual

Provider Type:

respite staff, clinical/professional service providers

Provider Qualifications

License (specify):

current Michigan's Driver's license

Certificate (specify):

NA

Other Standard (specify):

NA

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-participant's representative hires the individual directly through a Choice Voucher arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and periodically thereafter. (Michigan driver's licenses are issued for 5 years.)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Enhanced Transportation

Provider Category:

Agency

Provider Type:

Home care agency, staffing agency, CMHSP or other OHCDs network provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Individuals must hold a valid Michigan driver's license.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires staff directly through an Agency of Choice arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and intermittently thereafter. (Michigan Driver's licenses are issued for 5 years.)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction ▼

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services ▼

Alternate Service Title (if any):

Fiscal Intermediary

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

A fiscal intermediary is an independent legal entity that acts as the fiscal agent of the CMHSP for the purpose of assuring financial accountability for the funds authorized to purchase the services and supports identified in the participant's plan of service. The fiscal intermediary receives the funds; makes payments authorized by the participant's representative, to providers of services and supports; and acts as an employer agent when the participant's representative directly employs staff or other service providers.

Fiscal intermediary services include, but are not limited to:

- a) Facilitation of the employment of service workers by the child's parent or guardian, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- b) Assuring adherence to federal and state laws and regulations; and
- c) Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the participant and his/her representative to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the participant and his/her representative to understand billing and documentation requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Factor D was based on an estimated average usage of 5 hours per month, for consumers using this service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	financial management / services agency; accounting firms; advocacy and human services agencies
Individual	accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Fiscal Intermediary

Provider Category:Agency **Provider Type:**

financial management / services agency; accounting firms; advocacy and human services agencies

Provider Qualifications**License (specify):**

NA

Certificate (specify):

NA

Other Standard (specify):

The qualifications for a fiscal intermediary are:

1. Cannot be a provider of direct mental health services;
2. Cannot be a guardian or trust holder of any participant or have any other compensated fiduciary relationship with a participant (except representative payee);
3. Must be able to fulfill the functions (which may include Employee Verification, Employer Agent, and/or Information and Guidance Functions) required by CMHSP as identified in the Fiscal Intermediary Agreement;
4. Must have a positive track record of managing money and accounting;
5. Must be oriented to support and respond to each participant or family with an individualized response;
6. Must be able to work with participants to consider creative approaches both in payments and in arrangements (such as weekly payroll payments).

Verification of Provider Qualifications**Entity Responsible for Verification:**

The OHCD/CMHSP must verify provider qualifications.

Frequency of Verification:

At time of initial contract with the agency.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Fiscal Intermediary

Provider Category:Individual **Provider Type:**

accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below

Provider Qualifications**License (specify):**

NA

Certificate (specify):

NA

Other Standard (specify):

The qualifications for a fiscal intermediary are:

1. Cannot be a provider of direct mental health services;
2. Cannot be a guardian or trust holder of any participant or have any other compensated fiduciary relationship with a participant (except representative payee);
3. Must be able to fulfill the functions (which may include Employee Verification, Employer Agent, and/or Information and Guidance Functions) required by CMHSP as identified in the Fiscal Intermediary Agreement;
4. Must have a positive track record of managing money and accounting;
5. Must be oriented to support and respond to each participant or family with an individualized response;
6. Must be able to work with participants to consider creative approaches both in payments and in arrangements (such as weekly payroll payments).

Verification of Provider Qualifications**Entity Responsible for Verification:**

The OHCD/CMHSP must verify provider qualifications.

Frequency of Verification:

At the onset of service for an individual consumer, and at the time of initial and renewal contracts.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of Community Living Supports (CLS) services (i.e., the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the CLS Hourly Care Decision Guide, the following elements contribute to the overall assessment of need:

- * Type of behaviors identified;
- * Frequency, intensity, and duration of identified behaviors;
- * How recently serious behaviors occurred;
- * Actual specific effects of the behavior on persons in family and property;
- * Level of family intervention required to prevent behavioral episodes;
- * Extent to which family must alter normal routine to address behavioral needs of the child;
- * Prognosis for change in the child's behavior;
- * Whether or not child functions more effectively in any current setting than in other settings; and
- * Age, size, and mobility of child.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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Provider Category	Provider Type Title
Individual	CLS aide
Agency	Home care agency, staffing agency, CMHSP, or other OHCDs network provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Living Supports

Provider Category:

Individual

Provider Type:

CLS aide

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Individuals providing Community Living Supports (CLS) must be hired through Choice Voucher arrangements or be independent contractors of the OHCDs.

Individuals providing CLS must:

- * Be at least 18 years of age.
- * Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- * Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- * Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- * Be able to perform basic first aid and emergency procedures.
- * Be trained in recipient rights.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every 1 to 3 years thereafter, depending on the criterion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

Home care agency, staffing agency, CMHSP, or other OHCDs network provider agency

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Individuals employed by the agency to provide Community Living Supports (CLS) must:

- * Be at least 18 years of age.
- * Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves

to others in the environment where they are providing support.

- * Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- * Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- * Be able to perform basic first aid and emergency procedures.
- * Be trained in recipient rights.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires the agency directly through a Choice Voucher or Agency of Choice arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every 1 to 3 years thereafter, depending on the criterion.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance and Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified

equipment and are not intended to correct existing code violations in a child's home.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDCH are not obligated for any restoration costs. If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations.

The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased. Additional square footage may be prior authorized following a MDCH specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.

Specialized Medical Equipment & Supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. Generators may be covered for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator.

Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.

A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards.

All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Accessibility Adaptations that add to the total square footage of the home are limited to a lifetime maximum of \$25,000 and/or 250 square feet, with an exception process in place for extraordinary circumstances.

Specialized Medical Equipment & Supplies - The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Prior authorization for a van lift in a full size van will be considered no more frequently than once every five years, which is the minimum life expectancy of a lift.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	licensed builder or contractor
Agency	Durable Medical Equipment & Supplies Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

Provider Category:

Individual

Provider Type:

licensed builder or contractor

Provider Qualifications

License (specify):

Holds current Michigan license under MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)

Certificate (specify):

NA

Other Standard (specify):

NA

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDS/CMHSP

Frequency of Verification:

Prior to service execution

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment & Supplies Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Durable Medical Equipment & Supplies Provider must meet any requirements by private insurance or Medicaid as appropriate. All items provided under this service must meet applicable standards of manufacture, design and installation. The OHCDS/CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDS/CMHSP is responsible for verifying provider qualifications.

Frequency of Verification:

Prior to purchasing the item.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Support and Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

This service is provided by a peer-parent who has completed specialized training. It is a family-focused service provided to families (birth or adoptive parents, siblings, relatives, foster family, and other unpaid caregivers) of children with developmental disabilities (DD) for the purpose of assisting the family in relating to and caring for a child with DD. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in his ability to achieve goals of: performing activities of daily living, improving functioning across life domain areas, perceiving, controlling, or communicating with the environment in which he lives, or improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

Coverage includes: education and training, including instructions about treatment regimens to safely maintain the child at home as specified in the individual plan of service (POS), and peer support provided by a trained peer-parent, one-on-one or in a group, for assistance with identifying coping strategies for successfully caring for or living with a person with DD.

Parent-to-Parent Support is designed to support parents/families of children with DD as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained peer-parent support partner has had or currently has a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The peer-parent support partner provides these services to the enrolled child's parents and their family. These activities are provided in the home and in the community.

This service will not be a duplication of other services provided.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount, frequency and duration of the service must be identified in the child's Individual Plan of Service, along with the child's goal(s) that are being facilitated by this service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Advocacy agencies; family organizations and agencies; other OHCDs-contracted agency providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Support and Training**Provider Category:**Agency **Provider Type:**

Advocacy agencies; family organizations and agencies; other OHCDs-contracted agency providers

Provider Qualifications**License (specify):**

NA

Certificate (specify):

NA

Other Standard (specify):

The peer-parent support partner must complete specialized training and be provided regular supervision and team consultation by the treating professionals. Completion of the training curriculum is documented by a Certificate of Completion, which must be maintained in the parent support partner's personnel file.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OHCDs/CMHSPs are responsible for verifying that contracted service provider agencies meet all contractual requirements, including assuring that direct service providers meet all generalized training requirements established by MDCH (e.g., recipient rights training). The contracted agency is responsible for verifying that the peer-parent support partner has completed the required specialized training and supervision.

Frequency of Verification:

At time of initial and renewal contract with the agency, and at the onset of service for an individual consumer.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Family Training provides for training and counseling services for the families of children served on the Children's Waiver Program (CWP). For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home.

Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Up to 4 sessions per day but no more than 12 sessions per 90 day period.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	CMHSPs, home care agencies, clinical service agency providers, out-patient clinics

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Training

Provider Category:

Individual

Provider Type:

Clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License (specify):

Psychologists and social workers must hold current licenses under the Michigan Public Health Code, Public Act 368 of 1978, as amended.

Certificate (specify):

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard (specify):

Service providers for Family Home Care Training must be either a licensed psychologist, Master's level social worker, or other clinician (e.g., occupational therapist, physical therapist, speech therapist or nurse) who is a Qualified Mental Retardation Professional (QMRP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDS/CMHSP is responsible for credentialing providers of this service. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the OHCDS/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Training

Provider Category:

Agency

Provider Type:

CMHSPs, home care agencies, clinical service agency providers, out-patient clinics

Provider Qualifications

License (specify):

Psychologists and social workers must hold current licenses under the Michigan Public Health Code, Public Act 368 of 1978, as amended.

Certificate (specify):

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of

1978.

Other Standard (*specify*):

The hands-on service provider must be either a licensed psychologist, Master's level social worker, or other clinician (e.g., occupational therapist, physical therapist, speech therapist or nurse) who is a Qualified Mental Retardation Professional (QMRP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSPs, home care agencies, clinical service agency providers and out-patient clinics are responsible for assuring that staff meet all provider qualifications. The OHCDs that contracts with the agency to provide Family Training services must verify provider qualifications. If the agency is hired directly by an individual through a Choice Voucher or Agency of Choice arrangement, the OHCDs may delegate responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At initial and renewal of the contract. At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-family Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

This service provides coaching, supervision and monitoring of Community Living Support (CLS) staff by clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse, or QMRP). The professional staff work with CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Up to 4 sessions per day but no more than 12 sessions per 90 day period.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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Provider Category	Provider Type Title
Individual	Clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	CMHSPs, home care agencies, clinical service agency providers, out-patient clinics

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-family Training

Provider Category:

Individual

Provider Type:

Clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License (specify):

Psychologists and social workers must hold current licenses under the Michigan Public Health Code, Public Act 368 of 1978, as amended.

Certificate (specify):

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard (specify):

Service providers for Family Home Care Training must be either a licensed psychologist, Master's level social worker, or other clinician (e.g., occupational therapist, physical therapist, speech therapist or nurse) who is a Qualified Mental Retardation Professional (QMRP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-family Training

Provider Category:

Agency

Provider Type:

CMHSPs, home care agencies, clinical service agency providers, out-patient clinics

Provider Qualifications

License (specify):

Psychologists and social workers must hold current licenses under the Michigan Public Health Code, Public Act 368 of 1978, as amended.

Certificate (specify):

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard (specify):

Direct service providers for Family Home Care Training must be either a licensed psychologist, Master's level social worker, or other clinician (e.g., occupational therapist, physical therapist, speech therapist or nurse) who is a Qualified Mental Retardation Professional (QMRP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSPs, home care agencies, clinical service agency providers and out-patient clinics are responsible for

assuring that staff meets all provider qualifications. The OHCDs that contracts with the agency to provide Family Training services must verify provider qualifications. If the agency is hired directly by the consumer's family through a Choice Voucher or Agency of Choice arrangement, the OHCDs may delegate responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At initial and renewal of the contract. At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care can be provided in the following locations: child's home or place of residence; licensed family foster home; licensed children's group home; licensed camp; licensed respite care facility approved by the State that is not a private residence; home of a friend or relative.

Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State of Michigan that is not a private residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum monthly respite allocation is 96 hours. In addition to monthly respite, vacation respite can be used up to 14 days per year and must be billed in conformance with Medicaid requirements for per diem services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	aide-level respite provider
Agency	Home care agency, staffing agency, CMHSP, or other OHCDs network provider
Agency	Licensed camp; family foster home; licensed children's group home; licensed respite care facility
Individual	Independent Nurse (RN or LPN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

aide-level respite provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Individuals providing respite must be hired through Choice Voucher arrangements or be independent contractors of the OHCDs.

Individuals providing Respite must:

- * Be at least 18 years of age.
- * Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- * Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- * Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- * Be able to perform basic first aid and emergency procedures.
- * Be trained in recipient rights.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every 1 to 3 years thereafter, depending on the criterion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home care agency, staffing agency, CMHSP, or other OHCDs network provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Individuals employed by the agency to provide aide-level respite must:

- * Be at least 18 years of age.
- * Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- * Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- * Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- * Be able to perform basic first aid and emergency procedures.

- * Be trained in recipient rights.

Individuals employed by the agency to provide nursing-respite must be either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) working under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211.

Nurses may provide respite only in situations where the participant's medical needs are such that a trained respite aide cannot care for the participant during times where the unpaid caregiver is requesting respite.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency is responsible for assuring that all staff providing this service meet provider qualifications. The OHCDs/CMHSP also verifies provider qualifications before adding the agency to the provider network panel and during routine monitoring of providers. If the CWP-enrollee's representative hires the agency directly through a Choice Voucher arrangement or Agency of Choice, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and intermittently thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed camp; family foster home; licensed children's group home; licensed respite care facility

Provider Qualifications

License (*specify*):

Camps are licensed under: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11319.

Children's Foster Care is licensed under Public Act 116 of 1973, Act 218 of 197 as amended, Administrative Rules R400.4101-.9506 and R400.1401-.15411 and R400.1901-1906, MCL 722.115-118(a)

Certificate (*specify*):

NA

Other Standard (*specify*):

Individuals employed by the agency to provide respite must:

- * Be at least 18 years of age.
- * Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- * Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- * Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- * Be able to perform basic first aid and emergency procedures.
- * Be trained in recipient rights.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP must verify provider qualifications. If the CWP-enrollee's representative hires the agency directly through a Choice Voucher arrangement or Agency of Choice, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

The licensed camp provider is responsible for assuring that all employees providing this service meet the provider qualifications. DHS also verifies provider qualifications during regular and special investigation visits.

Frequency of Verification:

At the onset of service for an individual consumer, and every 1 to 3 years thereafter, depending on the criterion.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Nurse (RN or LPN)

Provider Qualifications

License (specify):

When respite is provided by a nurse, the nurse must be either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) working under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211.

Certificate (specify):

NA

Other Standard (specify):

Nurses may provide respite only in situations where the participant's medical needs are such that a trained respite aide cannot care for the participant during times where the unpaid caregiver is requesting respite.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP verifies provider qualifications. If the nurse is hired directly by a participant through a Choice Voucher or Agency of Choice, the OHCDs/CMHSP may delegate responsibility for verifying provider qualifications to the Fiscal Intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and intermittently thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialty Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Specialty Services include: Music Therapies; Recreation Therapies; Art Therapies; and Massage Therapies. Specialty services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy models covered under Medicaid State Plan. Services must be directly related to an identified goal in the individual plan of service and approved by the physician.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are limited to four sessions per therapy per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Massage Therapists, Therapeutic Recreation Specialist, Music Therapist, Art Therapist
Agency	CMHSPs, home care agencies, clinical service agency providers, out-patient clinics or other OHCDs network provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialty Service

Provider Category:

Individual

Provider Type:

Massage Therapists, Therapeutic Recreation Specialist, Music Therapist, Art Therapist

Provider Qualifications

License (specify):

Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008.

Certificate (specify):

Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The OHCDs/CMHSP is responsible for credentialing providers of this service. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the OHCDs/CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license or certification.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialty Service

Provider Category:

Agency

Provider Type:

CMHSPs, home care agencies, clinical service agency providers, out-patient clinics or other OHCDs network provider

Provider Qualifications

License (specify):

Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008.

Certificate (specify):

Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must

be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSPs, home care agencies, clinical service agency providers, out-patient clinics and other OHCDS network providers are responsible for assuring that staff meets all provider qualifications. The OHCDS that contracts with the agency to provide Specialty Services must verify provider qualifications. If the agency is hired directly by an individual through a Choice Voucher or Agency of Choice arrangement, the OHCDS may delegate responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At initial and renewal of the contract. At the onset of service for an individual consumer and intermittently thereafter, depending on the type of license or certification.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The CMHSPs are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver participants. Individuals performing case management functions must meet the requirements for a Qualified Mental Retardation Professional (QMRP) and have: A minimum of a Bachelor's degree in a human services field; and one year of experience working with people with developmental disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

- (a) Criminal background checks are required for all direct care aide-level staff, clinicians, and other CMHSP employees
- (b) the CMHSP or it's contracted provider agency is responsible for completing the criminal history/background investigation by

checking statewide databases and for providing documentation in the employee's personnel file. The Michigan Department of Community Health's QMP and CWP site reviews are the mechanisms for ensuring the background checks are completed.

(c) requirements, as set forth in the Michigan Medicaid Provider Manual, state that staff must "be in good standing with the law (ie., not a fugitive from justice, a convicted felon, or illegal alien)."

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

Michigan does not allow payment to legal guardians or to relatives who are legally responsible for providing services to the child. Subject to this qualification other relatives may be paid if they meet all provider qualifications. Services provided by relatives meeting these criteria are subject to the same claim processing edits (including quantity parameters) as services provided by non-relatives.

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The CMHSPs qualify as an Organized Health Care delivery System (OHCDs), requiring them to provide at least one service directly. They must meet certification requirements as specified in Section 232a of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto. They must also be able to provide either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.

In order to provide a comprehensive array of services each CMHSP establishes a procurement schedule for enrolling providers. In addition the CMHSP may open enrollment at any time that additional providers are needed.

Any provider may enroll directly with Medicaid if they meet the certification requirements specified in the Michigan Mental Health Code, as cited above.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and

assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of the CMHSPs are certified by MDCH as a qualified community mental health services provider, both initially and on an ongoing basis.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

100% of CMHSP contractual providers that are not subject to other governmental regulatory authority are certified by the responsible CMHSP.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Source (Select one):
Record reviews, on-site
 If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of non-licensed and non-certified service providers meet provider qualifications as identified in the Michigan Medicaid Provider Manual, both initially and on an ongoing basis.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The Michigan Department of Community Health reviews 100% of CMHSPs' documentation of waiver services' provider training.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Section 6.4 of the contract between the Michigan Department of Community Health (MDCH) and the PIHPs/CMHSPs specifies provider network requirements. Michigan’s Mental Health Code requires that each CMHSP be certified by the MDCH in order to receive funding by the MDCH. Certification can be granted for up to a three-year period. The MDCH ensures that the PIHPs/CMHSPs meet state certification standards using a combination of site review and certification activities. The MDCH grants deemed status to CMHSPs who have achieved a recognized accreditation. Certification application materials from each CMHSP are reviewed to ensure that recognized accreditation processes cover the CMHSP and its provider network. The CMHSPs are required to register all mental health service providers with the MDCH on an ongoing basis. To be certified by the MDCH, a CMHSP must be in compliance with the Recipient Rights Protection standards. Compliance with rights protection requirements is determined during an on-site visit conducted by the Office of Recipient Rights (ORR) within the MDCH.

The annual QMP site reviews verify that the PIHP/CMHSPs have documentation of training required by policy, as published in the Michigan Medicaid Provider Manual. These reviews include discussions with PIHP/CMHSP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

The Children’s Waiver Program (CWP) site review staff verify that the CMHSPs have documentation of training by reviewing both individual personnel records of staff providing waiver services for selected consumer, and a review of provider training data, aggregated by the CMHSP.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Any findings noted during the site review process are included in a formal report issued by the MDCH to the PIHP/CMHSP. The PIHP/CMHSP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Teams review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP/CMHSP’s implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Plan of Service (IPOS)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):
- Registered nurse, licensed to practice in the State**
 - Licensed practical or vocational nurse, acting within the scope of practice under State law**

- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Individuals performing case management functions must meet the requirements for a Qualified Mental Retardation Professional (QMRP) as specified in 42 CFR 483.430 and as required in the Michigan Medicaid Provider Manual, and have:

- 1) A minimum of a Bachelor's degree in a human services field, and
- 2) One year of experience working with people with developmental disabilities.

Case managers must demonstrate the capacity to assist CWP-enrolled families to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.

- Social Worker.**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

If the child's family does not wish to have a designated case manager who is responsible for all aspects of "targeted case management", they may choose from a list of QMRPs to carry out selected tasks - including developing and monitoring the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Michigan uses a Person-Centered Planning (PCP) process. "PCP means a process for planning and supporting the individual receiving services that builds upon the individuals capacity to engage in activities that promote community life and that honors the individuals preferences, choices, and abilities" MCL 330.1700(g). The PCP planning process: 1) focuses on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identifies outcomes based on the individual's life goals, interests, desires and preferences; 3) makes plans for the individual to work toward and achieve identified outcomes; 4) determines the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) develops an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

Meaningful PCP is at the heart of supporting consumer choice and control. PCP planning focuses on the goals, interests, desires and preferences of the individual, while still exploring and addressing an individual's needs within an array of established life domains (including, but not limited to those listed in the Michigan Mental Health Code: the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). PCP focuses on services and supports necessary for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.

For children, the concepts of person-centered planning are incorporated into a family driven, youth-guided approach. A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to

success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

While a case manager or other qualified provider chosen by the consumer/family may coordinate and facilitate development of the IPOS, the consumer/family has free choice of qualified providers to directly deliver services identified in the IPOS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Refer to description of the service planning process in b., above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Michigan uses a Person-Centered Planning (PCP) approach in the development of the individual plan of service (IPOS). For children, the concepts of person-centered planning are incorporated into a family driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The family is the constant throughout the life of their child, while fluctuations occur at the service system level due to personnel changes and turnover. The PCP process is an individualized, needs-driven, strengths based process for children and families with multiple needs. The planning process begins prior to the application for the Children's Waiver Program (CWP).

b) Assessments can include, but are not limited to, psychological, behavioral; psycho/social; speech, occupational, physical therapy; social/recreational, as well as medical evaluations. The IPOS is a dynamic document that is revised based on changing needs, newly identified or developed strengths and/or the result of an outcomes' review update. The child's team include those persons most familiar with the child and family, plus service providers. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the PCP team include: 1) focus on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identification of outcomes based on the individual's life goals, interests, desires and preferences; 3) making plans for the individual to work toward and achieve identified outcomes; 4) determining the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) developing an IPOS that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

c) Once the needs of a child are identified through assessments, the family is informed of available services and their choice of qualified providers to respond to the child's identified needs. This can be accomplished through several methods. The case manager, or other qualified service provider chosen by the family, can review the list of waiver services with the child, family and team. A copy of the CWP Technical Assistance Manual, which is available to the family, identifies and describes all of the CWP available services. CWP services are also identified in the Michigan Medicaid Provider Manual.

d) Each PCP Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including: emotional, psychological and behavioral health; health, education/vocational needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains, as determined by the consumer/family and the PCP Team.

- e) The IPOS must address the coordination and oversight of any identified medical care needs to ensure health and safety. This includes areas of concern such as drug / medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or coexisting general medical conditions requiring care.
- f) Life Domain planning is always a blend of formal and informal resources. It uses strategies based on strengths, focused on need, and which are individualized and community-based. The IPOS identifies each of the interventions/responsibilities to be implemented, and who is responsible to implement or monitor the service.
- g) The PCP Team develops the IPOS and provides on-going oversight, with the case manager or other qualified provider chosen by the participant taking the lead responsibility. The Plan of Service must be updated at least annually, or as needed as the child's needs change; revisions must be reflected in the IPOS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Although a child or youth participates in planning for services, as minors, they can not direct services or service providers. As noted above all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child's Team define the "crisis". The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include a safety plan that is intended to insure the safety of the children or family members in the home.

The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills.

The crisis plan is based on a careful review of the child's history to identify triggers of crisis. For example, is crisis brought on by new situations, a new route, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the child and family by community agencies, fears or worries expressed by the family, etc. For each identified crisis and safety concern both preventive and reactive strategies are identified and written into the IPOS. However, as with all aspects of the IPOS strategies are strength based and grounded in the family's strengths and culture.

All children enrolled in the CWP are minors living with their birth or adoptive parents who are ultimately responsible for the care and well being of their child. Waiver services provide active treatment, training, support and relief for parents. The CWP standards include requirements that staffing meets the child's identified needs as outlined in the child's plan of services. Crisis and safety plans must identify when a child's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; the written plan must identify provisions for alternate arrangements for staffing services that are critical to child's well being. While the OHCDs/CMHSP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the child's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the OHCDs (e.g., contractual staffing agencies, Agency with Choice).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Michigan assures that each individual found eligible for the Children's Waiver Program (CWP) will be given free choice of all qualified providers for each service included in his or her written Individual Plan of Service (IPOS.) At a practical level, once a child's / family's needs are identified and prioritized, an IPOS is created. The IPOS is grounded in the strength and culture discovery and is based on brainstorming options and strategies to meet the child's identified needs. Options and strategies include, but are not limited to, waiver services. Where waiver or Medicaid State plan services are the appropriate service response, the family can choose

among any qualified provider to directly deliver the service. The child and family choice drives the IPOS. The family choice of waiver services over institutional care is documented on the "Parent Choice Assurance" section of the Waiver Certification form by the parent's / guardian's signature.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The MDCH Division of Quality Management and Planning (QMP) currently conduct annual on-site visits to the PIHP/CMHSPs. Because the Children's Waiver Program (CWP) is a fee-for-service program, day to day operations are performed by the Community Mental Health Service Provider (CMHSP) and are not the responsibility of the PIHPs. The CMHSPs are certified as organized health care delivery systems (OHCDs). The MDCH CWP staff currently complete site reviews of the CMHSPs every three years at which time the Individual Plans of Service are reviewed. On alternate years the QMP completes on-site visits, which includes reviews of IPOSs. Note: beginning in 2011, CWP staff will no longer conduct a site review separate from that conducted by QMP staff. The QMP site review protocol will incorporate CWP review standards and measures. CWP staff will join QMP staff and will conduct a clinical review of records every 2 years (with QMP staff conducting the administrative review of CWP records); one site review report will be issued to each CMHSP. In alternate years, QMP staff will conduct the follow-up review of both administrative and clinical records.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager, or other qualified provider selected by the child/family, is responsible for monitoring the provision of services and supports, as identified in the child's Individual Plan of Service (IPOS), which address the child's health and welfare. The IPOS is reviewed as needed, but at least annually by the case manager, or other qualified provider selected by the child/family, and the child's Team, and revisions are reflected in the IPOS, and are part of the child's clinical records. Participant access to non-waiver services identified in the IPOS, including health care, are also monitored. Parents are the essential component of the Child's Team, are integral to every decision, and must approve the IPOS prior to implementation or changes to the IPOS, as evidenced by their signature on the IPOS.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

While the case manager and other clinical staff may provide direct services, the child's team, which includes parents, other family members, and family friends ensure that monitoring is conducted in the best interest of the waiver participant.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of all Individual Plans of Service (IPOS) address participant's assessed needs and identify strategies for meeting those needs.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All Individual Plan of Service are developed in accordance with Michigan Department of Community Health established policies and procedures.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of Individual Plans of Service are updated when the child's needs change or, if no changes have occurred, at least annually.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: minimum of 10% of the CMHSP's Children's Waiver Program enrolled consumer records.

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of Individual Plan of Service are reviewed by the Community Mental Health Service Programs to ensure that the identified services are provided in the amount, frequency and duration specified.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: minimum of 10% of the CMHSP Children's Waiver Program enrolled cl \\ minimum of 10% of the CMHSP Children's Waiver Program enrollments
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

100% of Children's Waiver Program (CWP)consumers' parents or legal guardians are offered the choice between CWP services and services in an Intermediate Care Facility for the Mentally Retarded.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other	

	Specify: at the time of initial application and annual	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

100% of Children's Waiver Program consumers are informed of their right to chose among enrolled qualified service providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: minimum of 10% of the CMHSP Children's Waiver Program enrollments
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. When the Michigan Department of Community Health Children's Waiver Program site review team reviews a consumer record they look for the following things specific to the Individual Plan of Service (IPOS): the IPOS addresses the consumer's assessed needs and identifies the services by type, amount, frequency and duration; the IPOS was developed in accordance with the Person-Centered Planning principals; and services were delivered in accordance with the IPOS.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Any findings noted during the site review process are included in a formal report issued by the MDCH to the PIHP/CMHSP. The PIHP/CMHSP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Teams review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP/CMHSP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In 1996, the Michigan legislature made person-centered planning (PCP) a requirement for all participants receiving services and supports under the Michigan Mental Health Code (MMHC). The MMHC provides for the right of all consumers of mental health services to develop services and supports through the PCP process. For minor children and their families, this planning process includes a family-driven/youth-guided practice that builds upon the child's capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the child and the family and involves the participation of the child, family and friends. This process results in an Individual Plan of Services (IPOS) for the child that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

Additionally, since 1997, when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, the Michigan Department of Community Health (MDCH) has continued to build the demand and capacity for arrangements that support participant direction.

(a) The Children's Waiver Program (CWP) offers a concrete set of methods that gives families of CWP-enrolled children meaningful authority to choose and directly hire providers of authorized services and supports.

There will be two options for the parent/guardian of minor children (here-after called the participant's representative): the Choice Voucher System and Agency with Choice. Elements of the CWP Choice Voucher System are outlined in contracts between the state and the Community Mental Health Services Programs (CMHSPs), and the Michigan Medicaid Manual. In the Choice Voucher System, which is currently approved under the CWP, the participant's representative is the common law employer and delegates

performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant's representative directly recruits, hires and manages employees. Detailed guidance to CMHSPs is provided in the Choice Voucher System Technical Advisory. In the Agency with Choice model (to be included with the approval of this renewal), the participant's representative may contract with an Agency with Choice provider and split the employer duties with the agency. The participant's representative is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the Agency with Choice is the common law employer, and handles the administrative and human resources functions and provides other services and supports needed by the participant's representative. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to CMHSPs will be provided in the Agency with Choice Technical Advisory. A participant's representative may select one or both options. For example, a participant's representative may want to use the Choice Voucher System to directly employ a person to provide Community Living Support services (CLS) during the week and Agency with Choice to provide CLS on the weekends.

(b) Information on the Choice Voucher System, and the Agency with Choice option (when approved) is/will be provided to all children (and their parent or guardian) who enroll or are currently enrolled in the CWP. A participant's representative interested in these arrangements starts the process by letting their case manager or other chosen qualified provider know of their interest. The participant's representative is given information regarding the responsibilities, liabilities and benefits of these options prior to the PCP process. An IPOS will be developed through this process with the child/parent, case manager (or other chosen qualified provider), and other family and friends chosen by the participant's representative. The IPOS will include the CWP mental health services needed by and appropriate for the child. A budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The participant's representative will choose among qualified service providers and have the ability to act as the employer or co-employer. In Michigan, CMHSPs provide many options for participant's representatives to obtain assistance and support in implementing their arrangements.

c) This information is provided throughout the child's involvement with the CMHSP. It starts from the time that the participant's representative approaches the CMHSP for services and is provided with information regarding options for the Choice Voucher System or Agency with Choice. Participant's representatives are to be provided with information about the principles of Choice Voucher System and Agency with Choice, the possibilities, models and arrangements involved. The PCP process is a critical time to address issues related to participant's representative direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Choice Voucher or Agency with Choice arrangements begin when the CMHSP and the participant's representative reach an agreement on the IPOS, the services authorized to accomplish the IPOS, and the arrangements through which the IPOS will be implemented. Each participant's representative signs a Choice Voucher or Agency with Choice Agreement with the CMHSP that clearly defines the duties and responsibilities of the parties.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*
- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
 - Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
 - The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Although all participants are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the participant's representative. While participants have the right to choose between / among qualified providers, the following waiver services are considered provider managed services: fiscal intermediary; enhanced transportation; environmental accessibility adaptations and specialized medical equipment and supplies.

The fiscal intermediary is the financial management service that requires a contract with the OHCDS/CMHSP. Michigan has chosen to keep this as a provider managed service, giving participants choice among/between qualified fiscal intermediaries. Participant's representatives cannot hire individuals whose sole responsibility is to transport their child. Instead, they may choose to hire respite staff and clinical service providers who, in the course of providing services, can provide transportation services when appropriate to the service. The participant's representative obtains a minimum of three qualified providers to submit itemized bids for environmental accessibility adaptations or for specialized medical equipment and supplies. The OHCDS/CMHSP reviews the bids and if appropriate, accepts the lowest bid, as required by policy.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The CMHSPs are responsible for providing information about participant direction opportunities. General information about arrangements that support the Choice Voucher System or Agency with Choice is made available to all waiver participants and participant's representatives - initially and on-going - by providing them with a general brochure and with directions how to obtain more detailed information. When a parent of a child receiving waiver services expresses interest in participating in Choice Voucher or Agency with Choice arrangements, the case manager (or other qualified provider selected by the participant's representative) will assist the participant's representative in gaining an understanding about the Choice Voucher System or Agency with Choice, and how those options might work for the participant.

Specific options and concerns such as the benefits of participant-direction, participant responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each participant develops an Individual Plan of Service (IPOS) through the person-centered planning (PCP) process, which involves his or her family and friends and a case manager (or other qualified provider) from the CMHSP. The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The PCP Policy and Practice Guideline require that health and safety concerns be addressed.

The MDCH-CWP staff provide support and technical guidance to CMHSPs with developing local capacity and with implementing options for participant direction. MDCH is currently developing booklets specifically targeted to CWP-enrollees and their families about incorporating participant direction into the person-centered / family-driven / youth-guided planning process. These booklets include information about the responsibilities, liabilities, and benefits of participant direction.

(b) The CMHSPs are responsible for disseminating this information to participants and their representatives. In addition, the program

staff from MDCH provide information and training to provider agencies, advocates and consumers.

(c) This information is provided throughout the participant's involvement with the CMHSP. It starts from the time that the child and his/her parent approaches the CMHSP for services and is provided with information regarding options for participant direction. Parents of minor children to be served by the CWP are to be provided with information about the Choice Voucher System and Agency with Choice options and arrangements involved. The PCP process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Choice Voucher and/or Agency with Choice arrangements begin when the CMHSP and the participant's representative reach an agreement on the IPOS, the services authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each participant's representative who chooses to direct services and supports on behalf of the CWP-enrollee signs a Choice Voucher Agreement with the CMHSP that clearly defines the duties and responsibilities of the parties.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Family Training	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community Living Supports	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family Support and Training	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Service	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-family Training	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

Fiscal Intermediary

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

A fiscal intermediary (FI) is an independent legal entity that acts as the fiscal agent of the CMHSP for the purpose of assuring financial accountability for the funds authorized to purchase the services and supports in the child's IPOS. The FI receives the funds; makes payments as authorized by the family to providers of services and supports; and acts as an employer agent when the family directly employs workers. FI entities include: accountants and accounting firms, financial advisors / managers, financial management firms, attorneys, and advocacy and human services agencies.

To procure FI services, the CMHSP offers the child and his/her parent or guardian (i.e, the participant's representative) a choice among available FI entities that meet the qualifications for this provider type and are included in the CMHSP provider panel. Additionally, if the participant's representative identifies a qualified FI who is not currently on the provider panel, that FI may apply to the CMHSP to be included on the provider panel. A contract between the CMHSP and the FI is developed and signed that outlines the roles, responsibilities, basis and process for payment.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The Contract between the CMHSP and the Fiscal Intermediary (FI) stipulates the conditions of the agreement including the role and responsibility of the FI and how the FI is compensated for the services it provides. The FI submits a claim to the CMHSP for services rendered. The CMHSP reimburses the FI for adjudicated claims, based on the amount agreed upon in the contract.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

The Role of the fiscal intermediary is fully described in the Choice Voucher Technical Advisory (www.michigan.gov/.../Choice_Voucher_System_Transmittal_9_30_08_251403_7.pdf).

The fiscal intermediary must designate a liaison person, who will be the primary contact person and have responsibility for monitoring and ensuring that the terms of the contract between the the Fiscal Intermediary and the OHCDs/CMHSP:

1. To receive, safeguard, manage and account for funds provided by the OHCDs/CMHSP on behalf of each participant and maintain complete and current financial records and supporting documentation verifying expenditures paid by the fiscal intermediary and a chart of accounts.
2. To assist participants or participant's representative to understand billing and documentation responsibilities.
3. To perform the financial administrative duties of employer and provide employer agent services to the participant or participant's representative directly employing workers. The fiscal intermediary must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the OHCDs/CMHSP and the participant or participant's representative must provide copies of all required employment documents including the Medicaid Provider Agreement to the fiscal intermediary.
4. To disburse funds to vendors and other providers of services and supports as directed by each participant or participant's representative for the services and supports selected by the participant or participant's representative and in accordance with the participant's individual plan of services and an individual budget, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the participant or participant's representative.
5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the fiscal intermediary on behalf of each participant. These records must be retained for seven years from the start of fiscal intermediary services.
6. To record and maintain a monthly spending report for each participant to keep each participant or participant's representative informed of budget expenditures and to keep the OHCDs/CMHSP informed of the expenditures in all participant's budgets.
7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by the participant or the participant's representative and/or OHCDs/CMHSP.
8. To flag for the OHCDs/CMHSP and the participant or participant's representative any deviation in an individual budget either under or over expenditures at any time.
9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.
10. To make records regarding participants available to the OHCDs/CMHSP as requested and to allow each participant or participant's representative access to his or her own records.
11. To commission a full financial audit of the fiscal intermediary's books and records as required by the OHCDs/CMHSP].

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget
- Tracks and reports participant funds, disbursements and the balance of participant funds
- Processes and pays invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

--

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) MDCH requires that OHCDs/CMHSPs develop and implement a plan for assessing and monitoring fiscal intermediary (FI) performance that involves participants, participants' representatives and their allies in the assessment and monitoring. The plan should include a periodic performance review process of FI performance at least annually. Elements of the plan for assessing and monitoring FI performance must minimally include:

- a. Fulfillment of FI Agreement requirements;
- b. Competency in safeguarding, managing and disbursing funds;
- c. Ability to indemnify the CMHSP pursuant to FI agreement requirements;
- d. Evaluation of participant feedback and experience with and satisfaction of FI performance data with alternate methods for collecting data from participants;
- e. Involvement of participants and their allies in the development and implementation of the FI arrangement; and
- f. Performing an audit of a sample of the budgets.

(b) The OHCDs/CMHSP is responsible for this monitoring. Compliance with the requirement is included in the Quality Management Program (QMP) site review process.

(c) The FI performance review must be conducted at least annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Specific options for participant-direction are addressed through the person-centered planning process (PCP), which is mandated in the Michigan Mental Health Code. Each participant develops an Individual Plan of Service (IPOS) through the PCP process, which involves his or her family and friends and a case manager or other qualified provider (such as an independent facilitator). For minor children and their families, this planning process includes a family-driven/youth-guided practice that builds upon the child's capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the child and the family and involves the participation of the child, family and friends. This process results in a IPOS for the child that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

When a parent of a child expresses interest in participating in Choice Voucher or Agency with Choice arrangements, the case manager (or other qualified provider selected by the participant's representative) will assist the participant's representative in gaining an understanding about the Choice Voucher system or Agency with Choice, and how those options might work for the participant. This includes providing information regarding the responsibilities, liabilities and benefits of these options prior to the PCP process. The IPOS will include the CWP mental health services needed by and appropriate for the child. A budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The participant's representative will be informed of qualified service providers from which to choose, including available fiscal intermediaries (FI).

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver
-------------------------------------	---

	Service Coverage
Enhanced Transportation	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Community Living Supports	<input type="checkbox"/>
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	<input type="checkbox"/>
Fiscal Intermediary	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Family Support and Training	<input type="checkbox"/>
Specialty Service	<input type="checkbox"/>
Non-family Training	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

A couple of options for independent advocacy are available. These are: utilizing a network of family and friends in the person-centered / family-driven / youth-guided planning process and using an Independent Facilitator to facilitate the planning process. In either case, the "independent advocate" is part of the person-centered planning process and assures that the consumer and his/her participant's representative have an ally in directing the planning process. The independent advocate can assist by: arranging the planning meeting; helping the consumer to identify his/her dreams and goals; keeping the meeting focused on the consumer's wishes and needs; making sure the consumer is heard and understood; and providing information on a variety of supports, services and qualified providers.

An Independent Facilitator should be someone trusted by the consumer or his/her representative. (For children, the Independent Facilitator cannot be the participant's representative, as Independent Facilitators do not decide what will be paid for in the plan, authorize services and supports, or benefit from the outcome of the plan.) If the consumer or his/her representative would like assistance in finding an Independent Facilitator, they can ask their case manager, other service provider or an advocacy agency to provide a list of names and resumes of facilitators.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates

participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The participant's representative has the freedom to modify or terminate the arrangements for Choice Voucher or Agency with Choice at any time. The most effective method for making changes is through the person-centered / family-driven / youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a consumer to terminate participant direction does not alter the services and supports identified in the IPOS. Upon termination of participant direction, the OHCDs/CMHSP has an obligation to assume responsibility for assuring the provision of those services through its network of qualified providers.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An OHCDs/CMHSP may involuntarily terminate participant direction when the health and welfare of the consumer is in jeopardy due to the failure of the participant's representative to direct services and supports; or when the participant's representative consistently fails to comply with contractual requirements.

The MDCH Self-Determination Policy and Practice Guideline will set forth the procedure for the PIHP/CMHSP to follow, and will provide direction as follows: "Prior to the [PIHP/CMHSP] terminating an agreement, and unless it is not feasible, the PIHP/CMHSP shall inform the participant of the issues that have led to the decision to consider altering or discontinuing the arrangement in writing, and provide an opportunity for problem resolution. Typically, the person-centered planning process will be used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found". In any instance of discontinuation or alteration of a self-determination arrangement, the local grievance procedure process may be used to address and resolve the issues. The decision of the PIHP/CMHSP to terminate participant direction does not alter the services and supports identified in the individual plan of service. Upon termination of participant direction, the OHCDs/CMHSP has an obligation to assume responsibility for assuring the provision of those services through its network of qualified providers.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	<input type="text" value="135"/>	<input type="text"/>
Year 2	<input type="text" value="135"/>	<input type="text"/>
Year 3	<input type="text" value="135"/>	<input type="text"/>
Year 4 (renewal only)	<input type="text" value="135"/>	<input type="text"/>
Year 5 (renewal only)	<input type="text" value="135"/>	<input type="text"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

In the Agency with Choice model, the participant's representative serves as the managing employer who has the sole responsibility for selecting, hiring, managing and firing workers. The Agency with Choice provider serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing worker's compensation insurance). In the Agency with Choice model, participant's representatives may get help with selecting workers (for example, from a pool of workers available for consideration by participants). The Agency with Choice provider may also provide back-up workers when the consumer's regular worker is not available. Like traditional staffing agencies, the Agency with Choice provider may be able to provide benefits to workers (such as paid vacation, sick time, and health insurance) that participants' representatives directly employing workers cannot provide. The Agency with Choice model is also an important option for participants' representatives who do not want to directly employ workers or who want to transition into direct employment.

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets
 Discharge staff (common law employer)
 Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*
- Reallocate funds among services included in the budget
 - Determine the amount paid for services within the State's established limits
 - Substitute service providers
 - Schedule the provision of services
 - Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
 - Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
 - Identify service providers and refer for provider enrollment
 - Authorize payment for waiver goods and services
 - Review and approve provider invoices for services rendered
 - Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

- b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

- b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service (s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When an individual presents themselves for intake at a Community Mental Health Services Program (CMHSP) they are provided basic information regarding available services, recipient rights, local dispute resolution and administrative hearings. At the time of Individual Plan of Service (IPOS) development, the consumer is again notified of these rights.

The MDCH Administrative Tribunal provides an hearing to appellants requesting a hearing who do not agree with a decision made by the Michigan Department of Community Health (MDCH) or CMHSP. The Administrative Tribunal issues timely and legally accurate hearing decisions and orders. Consumers can access the Administrative Tribunal Policy and Procedures manual on the MDCH website.

The parent or guardian must be sent a written notice of actions affecting eligibility or amounts of Medicaid benefits or Medicaid covered services for their child. This may include a termination, suspension or reduction of Medicaid eligibility or covered services. There are two types of written notice: 1) Adequate Action Notice, which is a written notice sent to the parent or guardian at the same time an action takes effect. Adequate notice is provided in the following circumstances: Denial of new services not currently being provided; Approval or denial of an application; Completion of an IPOS; Increase in service benefits. 2) Advance Action Notice is required when an action is being taken to reduce, suspend or terminate a benefit or service the child is currently receiving. The notice must be mailed at least 12 days before the intended action takes effect. The action is pending to provide the parent or guardian an opportunity to react to the proposed action. If the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the Administrative Law Judge (ALJ) or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

The Request for Hearing form (DCH-0092) or its equivalent is sent to the parent or guardian with all adequate or advance notices. It is the responsibility of the CMHSP to designate a hearings coordinator who will serve as the liaison between the agency and the Administrative Tribunal. The purpose of the hearings coordinator is to serve as the single contact point for the Administrative Tribunal in order to communicate procedural aspects of any case. The hearings coordinator may also represent the CMHSP at a hearing.

If a parent or guardian wants to appeal an action, the request for a hearing must be in writing and sent to the State Office of Administrative Hearings and Rules (often referred to as the Administrative Tribunal).

The parent/guardian or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The State Office of Administrative Hearings and Rules must receive the written hearing request within that 90-day period. If a Medicaid covered service is being reduced, suspended or terminated, a written notice must be mailed to the child or authorized representative at least 12 days before the intended action takes effect. The letter sent to the parent/guardian also indicates that if the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the ALJ, or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules assigns a docket number and faxes a copy of the Request for Hearing to the CMHSP that took the action being appealed. The hearings coordinator is responsible for receiving hearing requests, identifying the responsible staff and forwarding a completed Hearing Summary to the State Office of Administrative Hearings and Rules and the appellant within 14 days of receipt of the hearing request, but no later than seven (7) days prior to a scheduled hearing date.

The CMHSP staff prepares the DCH-0367 Hearing Summary form and presents the case at the hearing. The Hearing Summary must be completed in its entirety. The narrative must include all of the following: A clear statement of the action 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 appellant or authorized hearing representative; Copy of the documents the CMHSP intends to offer as exhibits at the hearing; Appellants and authorized hearing representatives (AHR) have the right to review the case record and obtain copies of all documents and materials to be used or relied upon at the hearing. (A copy of the hearing summary, and all supporting documents to be used at the hearing, is sent to the appellant and AHR. All parties should receive copies of the Hearing Summary and all documents at least seven days before the scheduled hearing.) A copy of the documents is also sent to the MDCH Children's Home and Community Based Waiver Director.

Hearings are routinely scheduled for telephone conference calls. The ALJ conducts the hearing from his/her office. The appellant or AHR is directed to the local CMHSP or other location as indicated on the notice. The appellant or AHR may request permission of the Administrative Tribunal to appear by phone from an alternative location. The request must be made to the State Office of Administrative Hearings and Rules at least one full business day before the hearing. The appellant or AHR may request the ALJ appear in person at the hearing. The ALJ will travel to the local office or facility.

The parties present their positions to the ALJ who determines whether the actions taken are correct according to fact, law, policy and procedure. Following opening statement(s), if any, the ALJ directs the CMHSP representative to explain the agency's position. The Hearing Summary, or highlights of it, may be read into the record. The Hearing Summary may be used as a guide in presenting evidence.

Both parties must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses and cross-examine the author of a document offered in evidence. The ALJ must ensure the record is complete and may take an active role in the questioning of witnesses and parties. The ALJ will assist either side to ensure all necessary information is presented on the record, or refuse to accept evidence the ALJ believes is unduly repetitious, immaterial, irrelevant or incompetent. Either party may state on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement and object to evidence the party believes should not be part of the hearing record. When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and the reason it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides.

An appellant or AHR may agree to withdraw their Request for Hearing at any time during the hearing process. The appellant or AHR should complete the DCH-0093 – Request for Withdrawal of Appeal or its equivalent and return it immediately in the postage paid envelope to the State Office of Administrative Hearings and Rules. The Request for Withdrawal of Appeal can be ordered via the Administrative Tribunal Forms Requisition.

When an issue is still in dispute, the appellant or AHR is not to be asked to withdraw their Request for Hearing or to be mailed a withdrawal form unless asked to do so by the appellant.

When all issues have been resolved, the appellant or AHR may wish to withdraw the Request for Hearing. A Request for Withdrawal of Appeal form can be submitted, or the appellant or AHR can submit a signed, written statement. The withdrawal must clearly state why the appellant or AHR has decided to withdraw the Request for Hearing. All identifying case information is entered on the withdrawal form, and the original copy is attached to the request and forwarded to the State Office of Administrative Hearings and Rules. A copy of the withdrawal is maintained in the child's record.

The ALJ's Decision and Order is the final determination of MDCH. Rehearing or reconsiderations may be requested within 30 days of the Decision and Order. The State Office of Administrative Hearings and Rules will send the Decision and Order to the appellant or the AHR for the CMHSP. The State Office of Administrative Hearings and Rules will send a DCH-0829 - Order Certification with the Decision and Order to the AHR if the Decision and Order requires implementation by CMHSP. Since the Order Certification confirms the status of the Decision and Order's implementation (e.g., when the Decision and Order has or will be acted upon), it must be completed in a timely manner and returned to the State Office of Administrative Hearings and Rules. It is the AHR's responsibility to ensure that the decision is implemented within 10 calendar days of the Decision and Order mailing date.

All documentation is maintained in the waiver participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In addition to the Fair Hearing Process described above the MDCH/PIHP contract requires each PIHP/CMHSP to develop and publish a local dispute resolution process. The MDCH/CMHSP Managed Mental Health Supports and Services Contract, FY 06-07 Attachment C6.3.2.1 details the CMHSP local Dispute Resolution process. "All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental health services may access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDCH/CMHSP contract. Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment P16131211 of the MDCH contracts with the Pre-paid Inpatient Health Plans (PIHPs). It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

Chapters 7, 7a, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. For the purposes of this requirement, the focus will be on those complaints related to the denial, reduction, suspension or termination of services and supports. Each CMHSP must have a written description of its local dispute resolution process available for review by MDCH. The description must reflect all of the requirements below and indicate if the CMHSP OFF system is to be used, and if so, any modification or additions to the CMHSP ORR system to be implemented..."

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
 - Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Michigan Mental Health Code establishes an Office of Recipient Rights (ORR) within the Michigan Department of Community Health (MDCH), each Community Mental Health Services Program (CMHSP) and licensed hospitals. Each CMHSP must complete a recipient rights data report at semi-annual and annual interval. Information from these reports are feed into a database which produces a rolled up report by waiver programs.

The following allegations are report: Abuse Class I, Abuse Class II, Abuse Class III, Abuse I-sexual abuse, Neglect Class I, Neglect Class II, Neglect Class III, Access to Rights System, Retaliation and Harassment, Complaint investigation process, Failure to Report, Denial of Services, Civil Rights, Religious Practice, Family Dignity and Respect, Visitation, Access to Telephone, Written/Posted Limitations, Uncensored Mail, Access to entertainment materials, Disclosure of Confidential Information, Withholding of Information (includes recipient access), Correction of Record, Safe Treatment Environment, Sanitary Treatment Environment, Humane Treatment Environment, Dignity and Respect, Nutrition, Restrictions/limitations, Restraint, Seclusion, Safeguarding Money, Facility Account, Easy Access to Account, Ability to Spend or Use as Desired, Delivery of Money Upon Release, Labor and Compensation, Property Possession and Use, Property Search/Seizure, Property Limitations, Protection of Person Property, Treatment suited to Condition, Treatment by Spiritual Means, Physical and Mental Exams, Choice of Mental Health Professional, Notice of Clinical Progress, Services of Mental Health Professional, Informed Consent, Psychotropic Drugs, Notice of Medication Side Effects, Person-Centered Process, PCP-Timely Development, Request for Review, Assessment of Needs, Prior Consent. The revised Department of Community Health Administrative Rules, effective 12/5/07 included Exploitation as a Abuse II offense.

It is required that anyone who witnesses or becomes aware of a critical event or incident must fill out an incident report. The person witnessing the incident must respond to the needs of the consumer immediately. The time frames for completing and submitting an incident report vary with the CMHSP. If the incident rises to the level of a sentinel evident (potential for loss of life, limb or function) then there is a 90 clock for investigation and reporting to MDCH.

In addition to the recipient rights reporting, aggregated sentinel event information is submitted by population and program to the MDCH four times a year. Sentinel events are defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or the risk thereof

includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998) Sentinel events include recipient death, injuries requiring emergency room visits or hospital admission, physical illness requiring hospital admission, arrest or conviction, serious challenging behaviors, and medication errors.

MDCH/MHSA has nearly completed its work with the Standards Group to design and implement a new critical incident reporting system that provides timelier information on critical incidents. Unlike the current aggregated sentinel event data collection system, the new critical incident reporting system will allow information on critical incidents to be linked to specific service recipients. It is expected that this critical incident reporting system will be operational and contractually required beginning October 1, 2010.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Michigan Department of Community Health (MDCH) Office of Recipient Rights assures that providers of mental health services maintain a rights system consistent with standards established in the Michigan Mental Health Code (PA 258 of 1974, as amended). Office of Recipients Rights (ORR) staff are housed at MDCH in Lansing. Each of the state hospitals and centers also house ORR staff. Finally, each CMHSP has an Office of Recipient Rights.

Each CMHSP is assessed yearly through review and follow-up on semi-annual and annual reports produced jointly by the CMHSP's Executive Director and their Rights Office. On-site assessments are conducted of approximately one-third of CMHSPs each year. This review includes interviews with the Executive Director, rights staff, consumers, and staff of contractual providers; compliance reviews of case files and logs; training requirements; and compliance with all 22 rights-related policies required by the Mental Health Code. Site visits are also made to LPH/Us under contract with the CMHSPs.

The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients' rights.

Chapter 7 of the Michigan Mental Health Code is dedicated to Recipient Rights , including, but not limited to:

330.1706 Notice of rights

Section 706:

Except as provided in section 707, applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients.

330.1706a Pamphlet; preparation; distribution; contents.

Section. 706a.

(1) The department shall prepare and distribute to each community mental health services program copies of a pamphlet containing information regarding resources available to individuals with serious mental illness and their families. The information shall include a description of advocacy and support groups, and other information of interest to recipients and their families. The pamphlet shall include the name, address, and telephone number of the organization designated by the governor under section 931 to provide protection and advocacy for individuals with developmental disability or mental illness.

(2) A community mental health services program shall distribute the pamphlet described in subsection (1) to each recipient receiving services through the community mental health services program and, if applicable, to the recipient's guardian or the parent of a minor recipient.

330.1722 Protection of recipient from abuse or neglect.

Sec. 722.

(1) A recipient of mental health services shall not be subjected to abuse or neglect.

(2) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, community mental health services program, or licensed hospital shall ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect.

(3) A recipient of mental health services who is abused or neglected has a right to pursue injunctive and other appropriate civil relief.

330.1755 Office of recipient rights; establishment by community mental health services program and hospital.

Sec. 755.

(5) Each office of recipient rights established under this section shall do all of the following:

(a) Provide or coordinate the protection of recipient rights for all directly operated or contracted services.

(b) Ensure that recipients, parents of minor recipients, and guardians or other legal representatives have access to summaries of the rights guaranteed by this chapter and chapter 7a and are notified of those rights in an understandable manner, both at the time services are initiated and periodically during the time services are provided to the recipient.

(c) Ensure that the telephone number and address of the office of recipient rights and the names of rights officers are conspicuously

posted in all service sites.

MDCH Rights offices at facilities are required to do consumer training per the ORR Field manager. At this point in time, the Code only requires staff training, however many CMHSP rights offices do consumer training on recipient rights. Additionally, The MDCH holds both an annual Recipient Rights Conference and an annual Consumer Conference, and an annual Home and Community Based Waiver Conference, all of which include participants and/or their families. Both conferences provided Recipient Rights training that describe the rights consumers have and the complaint resolution and appeal process.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP/CMHSP for the following persons: those receiving Targeted Case Management, enrolled in the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP) and the Waiver for children with serious emotional disturbance waiver (SEDW), those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services. A sentinel event (potential for loss of life, limb or function) must be investigated and reported to MDCH within 90 days. When sentinel events are reported, the MDCH reviews the CMHSP's process for conducting root cause analysis. Aggregated sentinel event information is submitted by population and program to the MDCH four times a year. The MDCH is now able to identify and analyze specific populations for which sentinel events occur and are reported, as well as the types and amounts of services those consumers are receiving. For waiver year 2008, there was a total of 4 (four) sentinel events: 2 (two) medication errors, 1 (one) physical illness requiring hospitalization, and 1 (one) serious challenging behavior for children enrolled in the CWP. There were 0 (zero) sentinel events reported for the last 3 (three) quarters of waiver year 2009.

Michigan law and rules require the mandatory reporting of recipient rights complaints within 48 hours to the CMHSPs' Office of Recipient Rights (ORR) for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to CMHSPs. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Recipient Rights: Semi-annually, local CMHSP ORRs report summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state ORR and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC, and waiver staff. The MDCH-ORR completes an assessment of the CMHSP Recipient Rights System on a tri-annual basis at each CMHSP. Beginning 10/1/2008, the State began data collection specifically identifying recipient rights data by each waiver population. For waiver year 2009, no recipient rights complaints were substantiated for waiver consumers.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Each Community Mental Health Services Provider (CMHSP) must complete a recipient rights data report to the Michigan Department of Community Health (MDCH) at semi-annual and annual interval. Information from these reports are feed into a database which produces a rolled up report by waiver programs. MDCH also requires each CMHSP serving Children Waiver Program (CWP) consumer to electronically report aggregated sentinel event data to MDCH every six months. Follow-up actions by MDCH include data confirmation, consultation, and on-site follow-up. Post CMHSP sentinel event data submission, MDCH staff contacts the CMHSPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required. On-site follow-up on reported sentinel events takes place during MDCH biennial site reviews. During these site reviews, MDCH staff review the CMHSP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of sentinel event would re-occur. Any noted shortcomings in the CMHSP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the CMHSP and additional follow-up by MDCH.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. Use of Restraints or Seclusion.** (*Select one*):

● The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

MDCH requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDCH Technical Requirement for Behavior Treatment Plan Review Committees. Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDCH-MHSA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any authorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.

The Department of Human Services Bureau of Child and Adult Licensing (BCAL) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of DHS-BCAL during announced or unannounced inspections and at the time of the biennial licensure process.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

● The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. (Select one):

● The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

● The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect

concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Attachments to the MDCH-MHSA contract with the CMHSPs define the Technical Requirement for a Behavior Treatment Plan Review Committee. The functions of the Committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
2. Expediently review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the Committee.
5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of service recipients.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The PIHP/CMHSP Behavior Treatment Committee must, on a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:

1. Dates and numbers of interventions used.
2. The settings (e.g., group home, day program) where behaviors and interventions occurred
3. Behaviors that initiated the techniques.
4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
5. Attempts to use positive behavioral supports.
6. Behaviors that resulted in termination of the interventions.
7. Length of time of each intervention.
8. Staff development and training and supervisory guidance to reduce the use of these interventions.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDCH review. The QMP Site Review Team also looks at the use of restrictive interventions.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Children's Waiver Program services to which this appendix applies are: Respite provided in a foster home, licensed camp, or licensed Respite facility. Licensing rules require that incident reports be completed when a medication error occurs. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs (wrong person, wrong medication, wrong dosage, wrong time, and wrong route). AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

At the local Community Mental Health Services Program level the child's case manager and the child's Team are responsible for monitoring the health and safety of the child (including Medication administration) as identified in the child's Individual plan of Service (IPOS), while in any community setting. Communication is therefore between the provider and the child's case manager, parents and other team members, not between the provider and the Medicaid State agency. Please see Appendix G-1: response to Critical Events or Incidents.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

- Not applicable.** (do not complete the remaining items)
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (complete the remaining items)

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Children's Waiver Program services to which this appendix applies are: Respite provided in a foster home, licensed respite homes, and licensed camps. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these setting the waiver service provider would administer medications as prescribed by the physician.

The following rule applies to licensed family foster homes and respite homes for children.

Rule 400.9411 Medical and dental care.

Rule 411. (1) A foster parent shall follow and carry out the health plan for a foster child as prescribed by a physician, health

authority, or the agency.

(2) A foster parent shall follow agency approved protocols for medical care of a foster child who is injured or ill.

(3) A foster parent shall ensure that medications are inaccessible to children unless medically necessary.

(4) A foster parent shall ensure that prescription medication is given or applied as directed by a licensed physician.

The following rule applies to licensed camps for children.

R 400.11119 Health service policy.

Rule 119. (1) A camp shall have and follow a written health service policy that is appropriate to the population served and the environment of the campsite.

(2) A camp shall establish the health service policy in consultation with, and reviewed annually by, a licensed physician. (3) A camp's health service policy shall cover all of the following subjects:.....(f) The storage and administration of prescription and nonprescription drugs and medications.

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reviewed, investigated and acted upon at the local level by each Community Mental Health Services Program and reported to the Michigan Department of Community Health (MDCH) directly when the error is considered a sentinel event. This information is reported in the aggregate to the MDCH semi-annually

- (b) Specify the types of medication errors that providers are required to *record*:

Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors a-d to the Department, but only when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs (wrong person, wrong medication, wrong dosage, wrong time, wrong route). AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider.

- (c) Specify the types of medication errors that providers must *report* to the State:

"Medication errors" mean: wrong medication; wrong dosage; double dosage; or missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDCH, when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

On-site follow-up on reported sentinel events regarding medication errors take place during the Michigan Department of Community Health (MDCH) biennial site reviews. During these site reviews, MDCH staff review the Community Mental Health Services Programs (CMHSP) sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that this type of sentinel event would re-occur. Any noted shortcomings in the CMHSP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the CMHSP and additional follow-up by MDCH. Post CMHSP sentinel event data submission, MDCH staff contacts the CMHSPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required. On-site follow-up on reported sentinel events takes place during MDCH biennial site reviews. During

these site reviews, MDCH staff review the CMHSP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of sentinel event would re-occur. Any noted shortcomings in the CMHSP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the CMHSP and additional follow-up by MDCH.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All Community Mental Health Services Programs review, investigate, and act upon all sentinel events and report to the Michigan Department of Community Health.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annually

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The Community Mental Health Services Program (CMHSPs) submit semiannually aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the 6-month period. The Michigan Department of Community Health (MDCH) analyzes the data and prepares a report on the number of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance indicators, MDCH reviews performance, with potential follow-up by contract managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

In the Final Report CMS requested information regarding effectiveness of the prevention policies and procedures for this waiver. As indicated elsewhere in this application each consumer has an individual Plan of Service (IPOS) developed based on the child's assessed needs and strengths. The IPOS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each consumer. Required staff training includes training in the IPOS, as well as in Recipient Rights. The IPOS is overseen by the child's case manager and the child's Team.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

All incidents should be reviewed to determine if the incidents meet the criteria and definitions for sentinel events and if they are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements." (JCAHO, 1998) A root cause analysis (JCAHO) or investigation (per CMS approval and Michigan Department of Community Health [MDCH] contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998) Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDCH contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annual

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work

plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Michigan's Quality Management Program (QMP), housed within the Michigan Department of Community Health (MDCH) incorporates all of the programs operated in the public mental health system, including all HCBS waivers. The PIHPs/CMHSPs adhere to the same standards of care for each individual served and the same data is collected for all consumers regardless of fund source. Each PIHP/CMHSP meets the standards for certification as specified in the Michigan Mental Health Code and Medicaid Provider Manual. The MDCH QMP staff is responsible for implementing the QMP at the 18 PIHPs (comprised of all CMHSPs), and sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews. During the alternate years, QMP staff visit PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy covers all consumers served by all of Michigan's waivers with rigorous standards for assuring consumers' health and welfare. The comprehensive reviews include the clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews.

Clinical record review are completed to determine that person-centered / family-driven / youth-guided planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meets program requirements that are published in the Michigan Medicaid Provider Manual. The MDCH QMP staff draws random samples of clinical records from encounter data in the MDCH warehouse. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs (including the CWP), all affiliates (if applicable), a sample of providers, and an sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:

- o PIHP/CMHSP Compliance with the Medicaid Provider Manual
- o Written agreements with providers, community agencies
- o The results of the PIHP/CMHSPs' annual monitoring of its provider network
- o Adherence to contractual practice guidelines
- o Sentinel event management

Consumer/Stakeholder meetings are completed during the biennial comprehensive review. The QMP staff meet with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered / family-driven / youth-guided planning, recipient rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the Quality Assessment and Performance Improvement Programs (QAPIP) and customer services; and the provider's responsiveness to the group's concerns and suggestions.

QMP staff conducts consumer interviews with a random sample of those individuals, whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted where consumers reside in group homes or living independently with intense and continuous in-home staff or in the homes of families served by the waivers. Interviews of other consumers may be conducted in the provider's office or over the telephone.

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDCH in 30 days. On-site follow-up will be conducted the following year or sooner if non-

compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC), and CWP staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QMP has been developed with the input of consumers and the Mental Health QIC that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Service Boards. Michigan's QMP reflects the activities, concerns, input or recommendations from the Michigan Mental Health Commission, MDCH's Encounter Data Integrity Team, MDCH's Administrative Simplification Process Improvement Team, the 2007 External Quality Review (EQR), and the terms and conditions from CMS' previous waiver approvals.

The existing infrastructure in Michigan includes 1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State plan through a managed care delivery system. The combined 1915(b) with the 1915(c) HSW enables Michigan to use typical Medicaid managed care program features such as quality improvement performance plans and external quality reviews to effectively monitor waiver programs. These same quality improvement performance plans and external quality reviews are used to monitor the CMHSPs in their provision of CWP services. Because the CWP is a fee-for-service program and is not covered under Michigan's managed care delivery system, the CMHSPs are the sub-state entity responsible for the day to day implementation of the CWP.

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the quality assessment and performance improvement programs. These elements are part of the MDCH/CMHSP contracts and are reviewed by MDCH staff and/or the external quality review process. While a review of the following three areas is not specific to the CWP, it assures overall quality services for all consumers.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. Very few clinical record reviews are completed as part of this process. One EQR component addresses PIHP compliance to BBA requirements. The other two EQR activities, performance improvement program validation and performance measures validation, have essentially no direct relationship to CWP service delivery or quality management.

The following minimum standards for customer services are covered by the MDCH QMP on-site visit or the External Quality Review (EQR):

- a. Customer services operation is clearly defined.
- b. Customer service staff is knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT).
- c. A range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network.
- d. Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP.
- e. The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice.
- f. Customer services is managed in a way that assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications.
- g. The relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews on-site the process, information to recipients and contractors, method for filing, provision of assistance to consumers, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify CMHSPs that have particularly high volumes of appeals.

Quality Assessment and Performance Improvement Programs: The MDCH contracts with PIHP/CMHSPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors, on-site, the PIHP/CMHSPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: sentinel Events and credentialing of providers. MDCH collects data for performance indicators and performance improvement projects as described in b.i. below.

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the External Quality Reviews (EQR). The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both. The scope of the review included: validation of performance improvement projects, validation of performance indicators, and compliance with Michigan's quality standards and BBA requirements.

In addition to the QMP strategies listed above that are implemented for all consumers, the CWP staff conduct both state level reviews of all applications and re-certifications, and on-site reviews of clinical and administrative records. The on-site reviews

use a CWP quality management protocol to ensure that federal requirements and assurances are met. The CWP staff includes a physician, two limited licensed psychologists, an individual with a master's degree in public health, a clinical nurse practitioner, and an occupational therapist. On-site reviews of the CMHSPs have been conducted every three years by the CWP staff with follow-up reviews in the alternate years by the QMP staff. Note: beginning in 2011, CWP staff will no longer conduct a site review separate from that conducted by QMP staff. The QMP site review protocol will incorporate CWP review standards and measures. CWP staff will join QMP staff and will conduct a clinical review of records every 2 years (with QMP staff conducting the administrative review of CWP records); one site review report will be issued to each CMHSP. In alternate years, QMP staff will conduct the follow-up review of both administrative and clinical records. A report of the findings is provided to the CMHSP, along with a copy to the MDCH Manager of the QMP. A plan of correction must be submitted to MDCH within 30 days if the review staff identifies areas of needed improvement or noncompliance. Information is used by MDCH to take contract action as needed for system improvements.

Trend patterns of effectiveness are evident and have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference, developing and identifying topics for technical assistance workshops at both state and local levels to address affective systems of care for this population.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input style="width: 150px; height: 15px;" type="text"/>	<input checked="" type="checkbox"/> Other Specify: The QI Committee meets bi-monthly. For the PIHPs/CMHSPs and MDCH, QI activities are on-going.

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

MDCH collects data for performance indicators and performance improvement projects for each of three areas: Medicaid performance indicators measure the performance of the PIHP/CMHSPs. The QIC performance indicators are categorized by the following domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP/CMHSP issues that need to be addressed immediately; to identify trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in MDCH’s data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDCH and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and CWP staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Participant level encounter data is reported electronically in HIPAA-compliant format each month for services provided in the previous month and for which claims have been adjudicated. Demographic data are also reported monthly for each individual. Aggregate data from the encounter data system are shared with the MDCH Mental Health and Substance Abuse Management Team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. The CWP staff review data for those individuals enrolled in the CWP and whose records will be reviewed as part of an on-site review. This review process is used

to ensure that services billed to and paid by the CWP were included in the approved IPOS. This review process is also used to assure the participant receives services in the amount and frequency, as identified in the IPOS. When CWP claims are processed through CHAMPS (the new Medicaid Management Information System) data is pulled from the data warehouse.

PHIPs are required by contract to submit Medicaid sub-element cost reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PHIP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PHIP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP for the following persons: those receiving Targeted Case Management, enrolled in the HSW, CWP and the SEDW, and those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDCH semi-annually. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and SEDW staff. Information is used by MDCH to take contract action as needed, becomes the focus of on-site reviews conducted by MDCH, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP ORRs report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state ORR and submitted to stakeholders and the Legislature. Data collection improvements distinguish Medicaid consumers from other individuals served. Information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC, and CWP staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years with interim updates as necessary (e.g., changes/additions of new providers: termination of contracts, change in accreditation status, change of address). This information is kept in a database and is used by the Mental Health and Substance Abuse Administration to verify the capacity of the service network.

The MDCH staff collaborates to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and stakeholder concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDCH; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDCH performance improvement project reports are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and CWP staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDCH staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team, with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

As described in a.i. above, trend patterns of effectiveness are evident and have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference and developing and identifying topics for technical assistance workshops at both state and local levels to address effective systems of care for this population.

The Quality Improvement Council(QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. To the extent that the MDCH-MHSA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract.

The MDCH-MHSA leadership meets regularly with the PIHP and CMHSP directors and quality improvement strategies may be discussed during the course of those meetings. Feedback from the group is used to help evaluate the QI process and identify opportunities for improvements to MDCH-MHSA management team and the QIC.

As a result of this periodic evaluation of Michigan's QI strategy, the QI Council recommended integration of the CWP and QMP on-site review process, which will be implemented in 2011. Beginning in 2011, CWP staff will no longer conduct a site review separate from that conducted by QMP staff. The QMP site review protocol will incorporate CWP review standards and measures. CWP staff will join QMP staff and will conduct a clinical review of records every 2 years (with QMP staff conducting the administrative review of CWP records); one site review report will be issued to each CMHSP. In alternate years, QMP staff will conduct the follow-up review of both administrative and clinical records. For both the "full" and "follow-up" site reviews, a "combined" QMP site review report will be issued to PIHPs/CMHSPs, and a "combined" plan of correction will be submitted to MDCH to address findings related to areas of needed improvement or noncompliance.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As required in the Michigan Department of Community Health/Community Mental Health Services Program (MDCH/CMHSP) contract, an annual Financial Status Report (FSR), certified by CMHSP Finance staff is submitted by each CMHSP. Children's Waiver Program (CWP) revenue and expenditures are uniquely identified on these FSRs, which also break out CWP expenses by federal, local, and state funding sources. During the contract reconciliation and cash settlement process, MDCH staff reconciles the CWP revenues reported by the CMHSP to the official MDCH records, including the CHAMPS CWP fee-for-service (FFS) payment totals. Documentation for the contract reconciliation and cash settlement analysis is maintained in the Bureau of Finance.

By contract between MDCH and the PIHPs/CMHSPs, the CMHSP is obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: whether services claimed were listed in the Michigan Medicaid Provider Manual; whether services were identified in the person-centered plan; and verification of documentation that services claimed were actually provided. Sampling methodologies are used to conduct the Medicaid services verification reviews, which cover all Medicaid-reimbursed services. A report, known as the "Medicaid Services Verification Report", is submitted to and reviewed by MDCH's Division of QMP annually.

The PIHP/CMHSP and other qualified/approved community-based mental health and developmental disability services providers monitor claims through the services verification review process described above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff follows up with the provider on actions taken to correct and monitor identified deficiencies. If an identified problem rises to a level of fraud and abuse, the PIHP/CMHSP is required to report the finding to the MDCH Medicaid Fraud Unit for investigation and follow-up. If it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

Beginning fiscal year 2007 PIHP/CMHSPs are required by contract to conduct a CMH Compliance Examination audit. The audit is to be conducted by an independent auditor to examine compliance examination issues related to contracts between PIHPs and CMHSPs. The Compliance Examination also applies to Medicaid Programs and contracts between CMHSPs and MDCH to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbance and developmental disabilities as described in MCL 330.1208 (Chapter 2, CMHSPs). The CMH Compliance Examination (CE) does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit. The test is for compliance, and is an examination of the Financial Status Report (an auditable financial statement). The CE places emphasis on internal control and compliance with laws, regulations (including GAAP and A-87) and the provisions of the contracts applicable to Medicaid, GF and other programs administered by the CMHSP. The Compliance Examination is required annually and submitted to the MDCH Office of Audit.

PIHPs and CMHSPs that expend \$500,000 (threshold) or more in federal awards during their fiscal year must submit to MDCH a Single

Audit prepared consistent with the Single Audit Act of 1996. OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" is issued pursuant to the Single Audit Act Amendment of 1996. This circular sets forth standards for obtaining consistency and uniformity among Federal agencies for the audit of States, Local Governments, and Non-Profit organizations expending federal awards.

PIHPs and CMHSPs who are exempt the Single Audit must submit to MDCH a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS). Financial Statement Audits are separate from the CMH Compliance Examination. This type of audit is for the assets, liabilities and results of operations for the PIHP or CMHSP. This may include disclosures or findings identifying areas for corrective action that may impact MDCH-funded programs. The Financial Statement Audit is required annually.

As an organized health care delivery system (OHCDS), CMHSPs bill MDCH-MSA for CWP services. In September, 2009, Michigan implemented the Community Health Automated Medicaid Processing System (CHAMPS). This web-based system is used to process and pay all Medicaid claims, including fee-for-service payments for services provided to CWP consumers. Systems' requirements to enable processing CWP claims through CHAMPS have been incorporated into all aspects of design for this system. Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services and a combination of service edits. CHAMPS produces either a paper or electronic Remittance Advice (RA) identifying the status of submitted claims (e.g., paid, pend, reject), amount approved for payment, and error codes (as applicable).

The CWP Site Review Team reviews service claims submitted to Medicaid for selected children, the child's individual budget and his/her IPOS. This review ensures that the services billed were identified in the IPOS as appropriate to identified needs, and that the IPOS was developed through a person-centered, family-driven / youth-guided planning approach.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

CWP claims are included in the annual Medicaid Services Verification audit completed by all participating CMHSPs and other qualified/approved community-based mental health and developmental disability services providers and reported to MDCH.

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Sampling methodologies are used to conduct the Medicaid Services Verification reviews, which cover all Medicaid-reimbursed services.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDCH review of the Medicaid Services Verification Audit Reports

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

All CWP claims are processed through CHAMPS and edited to ensure that, on the date-of-service, the: 1) provider Medicaid-enrolled; 2) child was eligible for the CWP; 3) child was Medicaid eligible; 4) service was one that can be billed; 5) billed quantity and frequency were within the established parameters; and 6) service was paid at the lesser of the charge or the Medicaid fee screen.

Data Source (Select one):

Other

If 'Other' is selected, specify:

electronic claims submitted by the OHCDS to Medicaid

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The PIHP/CMHSP and other qualified/approved community-based mental health and developmental disability services providers monitor claims through the services verification review process described in I-1 above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff follows up with the provider on actions taken to correct and monitor identified deficiencies. If an identified problem rises to a level of fraud and abuse, the PIHP/CMHSP is required to report the finding to the MDCH Medicaid Fraud Unit for investigation and follow-up. If it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

The CWP Site Review Team reviews service claims submitted to Medicaid for selected children, the child’s individual budget and his/her IPOS. This review ensures that the services billed were identified in the IPOS as appropriate to identified needs, and that the IPOS was developed through a person-centered, family-driven / youth-guided planning approach. If a problem is identified in the course of the site review, the CMHSP is required to address the problem in their plan of correction.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Establishing Costs/Charges for Services:

OHCDS/CMHSPs are bound by their Medicaid Provider Agreements and Master Contracts with MDCH to assure their service charges are determined consistent with Generally Accepted Accounting Principles (GAAP) and OMB Circular A-87 (here after referred to as A-87). Beginning in FY10, for FY09 expenditure reporting, new administrative cost reporting requirements were implemented for all 46 CMHSPs. These administrative costs distinguish OHCDS functions from service provider administrative costs. Compliance with the requirements of A-87 and with the new cost reporting requirements is audited by MDCH using a variety of strategies, as described in I-1, above.

Administrative Costs:

The new cost reporting requirements enable CMHSPs to distinguish administrative costs associated with being an Organized Health Care Delivery System (OHCDS) for the Children's Waiver Program (CWP) from administrative costs associated with directly delivering services to CWP-enrolled consumers as a service provider. As a basis, these requirements include compliance with A-87, an audited cost allocation methodology and isolation of those administrative costs that are associated with the OHCDS responsibilities of the CMHSP in administering the Children's Waiver Program (CWP). (Allowable CMHSP administrative costs are defined in the MDCH document "Establishing Administrative Costs Within and Across The CMHSP System" dated February, 2010 and provided to CMS in June, 2010.)

The administrative reimbursement for CMHSPs as OHCDS for the CWP fee-for-service program will be the total reported OHCDS administrative costs for CWP as confirmed by the CMHSP administrative cost report, the MDCH/CMHSP cost settlement process and the CMHSP audited financial reports. The amount reimbursed will be determined in compliance with A-87 principles. Beginning with FY09 expenditures, MDCH will use the logic from the new (460) PIHP/CMHSP administrative cost reporting requirements which distinguish CMHSP administrative costs distributed to their direct service operations from their OHCDS administrative costs associated with managing the CWP. MDCH will reimburse CMHSPs for actual OHCDS administrative expenditures attributed to the CWP, as reported on a financial report certified as accurate by the CMHSP and submitted to MDCH. An Intergovernmental Transfer (IGT) will be used to pay OHCDS administrative costs at the applicable federal (Medicaid) share. For services that they (the CMHSPs) directly deliver, the OHCDS will continue to establish their service rates based on A-87 principles. These service rates would include only provider specific service and administrative costs.

Setting Medicaid Payment for Services:

Maximum Medicaid payment for each billable service - in the form of a Medicaid fee screen - is established by the State Medicaid Agency, published on the Medicaid web site and available to providers, waiver participants and the general public. Services are paid uniformly at the lesser of billed charges or the established Medicaid fee screen. Because Medicaid fee screens have not kept pace with increasing costs, in many instances the OHCDS/CMHSP must use local, non-Medicaid resources to fund service costs that exceed Medicaid reimbursement. As additional state appropriations to the MDCH are not available to support an increase in Medicaid fee screens for CWP services, the MDCH developed a methodology for adjusting payments to CMHSPs for services provided to CWP consumers. CMS approved this methodology beginning in FY09, with the provision that MDCH work with CMS to clarify the policy regarding OHCDS rate setting. The first adjustor payment was made in September 2009, based on FY08 expenditure data.

For purposes of this discussion, the term "interim fee screen" refers to the established Medicaid fee screen used to pay claims submitted thru CHAMPS (detailed in I-2 b. below). The term "final fee screen" is used to denote the adjusted maximum amount payable for each service, determined via the methodology outlined below at year-end. Those OHCDS/CMHSP providers whose service costs / charges exceeded the interim fee screen will provide the non-federal share (i.e., 1-FMAP) for the Medicaid payment difference accruing from the final fee screens, and will do so in the form of an intergovernmental transfer. Payments to providers will be adjusted to final once a year. The final fee screens are set to the Medicare Physicians Fee Schedules where applicable, and to the 90 percentile of provider charges for those without a fee published within the Medicare Physicians Fee Schedule. Detail regarding the method for determining the final fee screen for each waiver and state plan service available to CWP enrollees is outlined under "Adjustor Payment Methodology" below. The adjustor payment does not result in any OHCDS/CMHSP being paid more than their cost of providing services.

Responsible Entity:

Within MDCH, Michigan's Single State Medicaid Agency, the Medical Services Administration (MSA) establishes the interim fee screens (i.e., service payment rates); the Mental Health and Substance Abuse Administration (MH/SA) in collaboration with MSA implements the methodology that results in the final fee screens. Oversight of the final fee screen (rate) determination methodology is

provided by the staff of MSA and MH/SA. Both the interim and final fee screens are reviewed by the Budget, Accounting and Audit Offices within MDCH.

Public Comment:

The interim and final fee screens are presented and comments solicited from attendees of the CWP track of the annual Home and Community-Based Waivers Conference. This conference is well publicized and well attended by waiver participants, their families and friends, providers, and a wide variety of key stakeholders.

Informing Waiver Participants About Service Rates:

As noted above, the rates are published on the MDCH web site. The interim and final fee screens are also available to participants as well as the general public in written form when requested.

Adjustor Payment Methodology:

The methodology outlined below combines the strengths of Medicare's RBRVS-based Physician's Fee Schedule, the 90th percentile of charges method used by third party payers throughout the health care industry, and pricing conventions from Michigan's current CWP fee screens [applicable to procedures provided to more than one beneficiary at a time and/or those eligible for a holiday premium rate]. The goal of the adjustor payment is to assure the federal reimbursement for these Medicaid covered services is calculated based on their full cost and reimbursed consistent with the applicable Federal Medical Assistance Percentages. The steps of the "adjust interim to final fee screens" methodology are the following:

- 1) For the prior Fiscal Year (FY), the OHCDs/CMHSP fee-for-service paid claim data is extracted from the MDCH Data Warehouse for all CWP enrollees. For each service for which there was one or more claim, the extracted data includes: a) the billing OHCDs/CMHSP, b) the unduplicated number of CWP enrollees that received the service, c) the total number of service units billed, d) the total amount of service charges submitted to Medicaid, and, e) the total Medicaid amount approved for payment. Because some services are paid at a premium rate when provided on a holiday, a parallel data extract is completed for those codes for the holiday dates-of-service. That data is subtracted from the base data to assure no duplication.
 - 2) Data for services for which a fee adjustment is not appropriate (e.g., prior authorized services for which the authorized amount sets the maximum amount payable), is removed from base data and no adjustor payment is made.
 - 3) The average charge per unit is calculated for each OHCDs billing for each service, and the average charge per unit is arrayed in descending order for each service.
 - 4) Each service is reviewed to determine if there is a corresponding "non-facility fee" within the Medicare Physicians Fee Schedule for Michigan. Where one exists, it is set as the final CWP fee screen. Where there is no corresponding fee within the Medicare Physicians Fee Schedule for Michigan, the 90th percentile of the arrayed average unit charge is calculated and set as the final CWP fee screen.
 - 5) Consistent with the existing CWP fee screen protocol, the screens for services that can be provided to more than one (1) beneficiary at a time (e.g., T1005 - respite), are set at 75% of the corresponding unmodified procedure's final fee screen. (E.g., the final fee screen for T1005TT is set at 75% of T1005's adjusted screen.)
 - 6) Also consistent with the existing CWP fee screen protocol, the screens for procedures eligible for a holiday premium and provided on holidays are set at 150% of the corresponding unmodified procedure's final fee screen. (E.g., the adjusted fee screen for H2015 - Community Living Services - provided on Christmas day is set at 150% of H2015's adjusted screen.)
 - 7) For those procedures billed by only one OHCDs and to which none of the above rules apply, the existing screen is used and no adjustor payment is made.
- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For services provided to CWP enrollees, OHCDs/CMHSPs bill Medicaid (through CHAMPS) in accordance with policies and procedures published in the "Billing and Reimbursement for Professionals" section of the Michigan Medicaid Provider Manual. That portion of the Manual also contains information about how claims are processed and how providers are notified of MDCH actions. OHCDs/CMHSPs can bill directly through CHAMPS, or they may choose to use a billing agent. CHAMPS issues payments directly to the OHCDs/CMHSP for all services at the lesser of the charge for the service or the Medicaid fee screen.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) Claims processed through CHAMPS in b. above are edited prior to payment for many parameters, including that the consumer was enrolled in the CWP and Medicaid eligible on the date of service, that the provider was eligible to be paid for services, that the service was one that could be billed on the date of service (procedure validity), and all other edits built into the system (e.g., claim duplication, frequency and quantity limitations).

(b) and (c) Post-payment validation that billed services are included in the consumer's approved service plan and that billed services were actually provided is done at the time of the CWP on-site review. It is also done as part of the annual Medicaid Services Verification audit (as described in Appendix I-1 above).

The CWP Site Review Team reviews billings to Medicaid, budgets, IPOSs, case notes, assessments and reports for selected children. The review ensures that the services billed were identified in the IPOS as appropriate to identified needs, were recommended by the child's team, and that the services were provided. When the site-review reveals a problem with a billing, the OHCDs must submit a claim adjustment so that Medicaid recoups the inappropriate payment.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Community Mental Health Service Providers (CMHSPs), certified as Organized Health Care Delivery Systems (OHCDs), provide all CWP services, directly and through contracts with qualified providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

private insurance or other-wise covered by Medicaid.

(d) MDCH certifies CMHSPs every three years. This process includes review that service providers – both employees and contracted – meet provider qualifications as detailed in the Mental Health/Substance Abuse section of the Medicaid Provider Manual. In addition, review of provider qualifications for individual consumers is part of site reviews conducted by the Quality Management Program (QMP) and by CWP staff.

(e) MDCH's master contract with CMHSPs specify requirements regarding contracts and subcontracts and include an assurance that service providers – both employees and contractual – meet provider qualifications as detailed in the Medicaid Provider Manual. Compliance with these requirements is part of the tri-annual certification process and the QMP / CWP site review process referenced in (d) above.

(f) The process for financial accountability, including cost reporting and audit requirements, is the same for an OHCDs as for a CMHSP and is detailed in F-1 above.

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

-
- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The source of the non-federal share to the MDCH Mental Health/Substance Abuse Administration is funded through an appropriation of tax revenue paid to the CMHSPs as General Fund-formula funds. Should the CMHSP not have adequate local funds to provide local match they may use their general fund dollars.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

(a) & (b) County Boards of Commission have the authority to levy taxes and allocate a portion of general county funds (including property tax revenue) to CMHSPs to be used as local match. Cities and townships also have authority to appropriate funds to CMHSPs.

(c) An Intergovernmental Transfer (IGT) will be used to execute the year- end adjustor payment detailed in I-2 above.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

(a) & (b) In addition to the funds raised through local (i.e., county/city/etc) taxing authority and appropriated to CMHSPs, the CMHSPs receive State non-Medicaid general fund / general purpose (GF/GP) funding to discharge their contractual obligations under the State's Mental Health Code. These State GF/GP non-Medicaid funds are the primary source of the nonfederal share (i.e., 1-FMAP) discussed throughout Appendix I.

(c) An Intergovernmental Transfer (IGT) will be used to execute the year end adjustor payment discussed in I-2.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

1.5. EXCLUSION OF MEDICAID PAYMENT FOR ROOM AND BOARD**a. Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As stated in the Michigan Medicaid Provider Manual, respite care services can be provided in the child's home, foster home, licensed respite care facility, licensed camp, or the home of a friend or relative who meet provider qualifications. Cost of room and board cannot be included as part of CWP respite care. The Department of Human Services (DHS), Michigan's child welfare organization, licenses and regulates these facilities. Room and Board rates are as follows:

- a.) Age birth - 12: \$14.24 a day
- b.) Age 13 - 18: \$17.59 a day

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
 - i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible

- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
 - ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
 - iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
 - iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*
 - No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
 - Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount

collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	28312.30	22525.00	50837.30	307110.00	2540.00	309650.00	258812.70
2	28903.68	22525.00	51428.68	345714.00	2508.00	348222.00	296793.32
3	28903.68	22525.00	51428.68	389171.00	2477.00	391648.00	340219.32
4	28903.68	22525.00	51428.68	438091.00	2446.00	440537.00	389108.32
5	28903.68	22525.00	51428.68	493160.00	2416.00	495576.00	444147.32

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/MR	
Year 1	464	464	
Year 2	464	464	
Year 3	464	464	
Year 4 (renewal only)	464	464	
Year 5 (renewal only)	464	464	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) for waiver years 1 through 5 (FY 2011 thru FY 2016) of the CWP Renewal Application is based on the ALOS as reported on the CMS 372 for FY08 (waiver year 3 of the approved CWP). That ALOS was 343.9 days. Although the unduplicated number of consumers for approved waiver year 3 was 441, and the unduplicated number of consumers for renewal years 1 through 5 is 464, there is no reason to believe that the ALOS for the renewal years will be any different than the experience under the currently approved waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Data from the CMS-approved annual 372 report for FY08 (i.e., the period 10/1/2007 through 9/30/2008) was used as the basis for calculation of the various elements of Factor D for all services included in the currently approved waiver. For these services, the unduplicated number of consumers using each service for renewal waiver year 1 (2011) is estimated from the 372 report for FY 2008. (The unduplicated number of consumers using each service in FY08 was used to calculate the percent of consumers estimated to use the service in FY11.) This number is carried through for renewal waiver years 2 through 5 (2012 through 2015), as factor C remains the same for all years. As the 372 report does not capture the average number of service units per user, that number was derived for renewal waiver year 1 by dividing the actual expenditure for each service for FY08 by the number of consumers using the service in FY08, divided by the average unit rate. This number is carried forward for renewal waiver years 2 through 5.

Please Note: When using actual 372 data for projections for renewal waiver year 1, it is not possible to exactly match the 372 data for both expenditures and the unduplicated number of consumers using a service, when one must also estimate the average usage of each service. Our approach was to prepare the demonstration of Factor D based on the actual number of consumers using each service as reported on the 372 and the actual Factor D value (average per capital expenditures for waiver services) as reported on the 372, while keeping the "demonstration of expenditures" for each service as close as possible to expenditures as reported on the 372. You will note that, because the average number of units per user is a derived number, total expenditures for each service for renewal waiver year 1 are not an exact match with expenditures as reported on the 372 report. Another aberration in using the 372 data is that some services (e.g., home modifications and specialized equipment and supplies) are prior authorized and paid at the lower of charge or the amount authorized. Although we can identify the unduplicated number of consumers using the various components of "environmental accessibility adaptations and specialized medical equipment & supplies" - we can only identify the "average cost per consumer" for each service - not the "average units per user".

Estimates for the 2 new services (Family Support and Training and Fiscal Intermediary services) could not be derived from the FY08 372. For both services, several CWP-participating CMHSPs were polled as to their experience with these services (as provided, but not billed to Medicaid), and utilization and expenditures were estimated from the "average" experience of those CMHSPs.

No projected growth rate was built into the average unit cost for any service, so this is static for renewal waiver years 1 through 5.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Data from the CMS-approved annual 372 report for FY08 (i.e., the period 10/1/2007 through 9/30/2008) was used as the basis for calculation of D'. D' for waiver renewal year 1 is the same as D' for FY08 as there was no increase in Medicaid fee screens for "all other Medicaid State plan services provided in addition to waiver services while the individual was on the CWP". Factor D' is carried forward for waiver renewal years 2 through 5, as no increase in Medicaid fee screens is anticipated for "other Medicaid State plan services" during this time period.

There is no adjustment in D', as there are no dually-eligible (Medicare / Medicaid) consumers served by the CWP. There was no Medicare Part D expenditures for CWP recipients in FY08, and none are anticipated for FY11 through FY16.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G are based on MMIS data equivalent to the information previously required for Cost Effectiveness formula Factor B on the 372 long form using fiscal years 2005-2008, i.e. total [nonwaiver] ICF/MR expenditures divided by the unduplicated count of [nonwaiver] ICF/MR beneficiaries, and trended forward.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G' are based on MMIS data equivalent to the information previously required for Cost Effectiveness formula Factor B' on the 372 long form using fiscal years 2005-2008, that is, the Medicaid expenditures for all services other than those included in Factor B (ICF/MR services) provided to [non-waiver] beneficiaries, divided by the unduplicated count of the [non-waiver] ICF/MR beneficiaries who used/received them, and trended forward.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (4 of 9)**

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Enhanced Transportation
Fiscal Intermediary
Community Living Supports
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies
Family Support and Training
Family Training
Non-family Training
Respite
Specialty Service

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Transportation Total:						3680.00
Enhanced Transportation	mile	46	250.00	0.32	3680.00	
Fiscal Intermediary Total:						170100.00
Fiscal Intermediary	15 minutes	135	240.00	5.25	170100.00	
Community Living Supports Total:						8175504.87
Community Living Supports	hour	419	1347.51	14.48	8175504.87	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:						141223.50
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	request	198	1.00	713.25	141223.50	
Family Support and Training Total:						90160.00
Family Support and Training	15 minutes	46	98.00	20.00	90160.00	
Family Training Total:						123275.37
Family Training	session	231	8.42	63.38	123275.37	

Non-family Training Total:						157559.58
Non-family Training	session	260	9.76	62.09	157559.58	
Respite Total:						4027455.73
Respite	hour	438	547.98	16.78	4027455.73	
Specialty Service Total:						247949.70
Massage Therapy	15 minutes	17	91.29	12.70	19709.51	
Activity Therapy - Art, Music, Recreation	session	116	29.57	66.54	228240.18	
GRAND TOTAL:						13136908.75
Total Estimated Unduplicated Participants:						464
Factor D (Divide total by number of participants):						28312.30
Average Length of Stay on the Waiver:						344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Transportation Total:						3680.00
Enhanced Transportation	mile	46	250.00	0.32	3680.00	
Fiscal Intermediary Total:						170100.00
Fiscal Intermediary	15 minutes	135	240.00	5.25	170100.00	
Community Living Supports Total:						8175504.87
Community Living Supports	hour	419	1347.51	14.48	8175504.87	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:						141223.50
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	request	198	1.00	713.25	141223.50	
Family Support and Training Total:						364560.00
Family Support and Training	15 minutes	93	196.00	20.00	364560.00	
Family Training Total:						123275.37
Family Training	session	231	8.42	63.38	123275.37	
Non-family Training Total:						157559.58

Non-family Training	session	260	9.76	62.09	157559.58	
Respite Total:						4027455.73
Respite	hour	438	547.98	16.78	4027455.73	
Specialty Service Total:						247949.70
Massage Therapy	15 minutes	17	91.29	12.70	19709.51	
Activity Therapy - Art, Music, Recreation	session	116	29.57	66.54	228240.18	
GRAND TOTAL:						13411308.75
Total Estimated Unduplicated Participants:						464
Factor D (Divide total by number of participants):						28903.68
Average Length of Stay on the Waiver:						344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Transportation Total:						3680.00
Enhanced Transportation	mile	46	250.00	0.32	3680.00	
Fiscal Intermediary Total:						170100.00
Fiscal Intermediary	15 minutes	135	240.00	5.25	170100.00	
Community Living Supports Total:						8175504.87
Community Living Supports	hour	419	1347.51	14.48	8175504.87	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:						141223.50
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	request	198	1.00	713.25	141223.50	
Family Support and Training Total:						364560.00
Family Support and Training	15 minutes	93	196.00	20.00	364560.00	
Family Training Total:						123275.37
Family Training	session	231	8.42	63.38	123275.37	
Non-family Training Total:						157559.58
Non-family Training	session	260	9.76	62.09	157559.58	

Respite Total:						4027455.73
Respite	hour	438	547.98	16.78	4027455.73	
Specialty Service Total:						247949.70
Massage Therapy	15 minutes	17	91.29	12.70	19709.51	
Activity Therapy - Art, Music, Recreation	session	116	29.57	66.54	228240.18	
GRAND TOTAL:						13411308.75
Total Estimated Unduplicated Participants:						464
Factor D (Divide total by number of participants):						28903.68
Average Length of Stay on the Waiver:						344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Transportation Total:						3680.00
Enhanced Transportation	mile	46	250.00	0.32	3680.00	
Fiscal Intermediary Total:						170100.00
Fiscal Intermediary	15 minutes	135	240.00	5.25	170100.00	
Community Living Supports Total:						8175504.87
Community Living Supports	hour	419	1347.51	14.48	8175504.87	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:						141223.50
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	request	198	1.00	713.25	141223.50	
Family Support and Training Total:						364560.00
Family Support and Training	15 minutes	93	196.00	20.00	364560.00	
Family Training Total:						123275.37
Family Training	session	231	8.42	63.38	123275.37	
Non-family Training Total:						157559.58
Non-family Training	session	260	9.76	62.09	157559.58	
Respite Total:						4027455.73

Respite	hour	438	547.98	16.78	4027455.73	
Specialty Service Total:						247949.70
Massage Therapy	15 minutes	17	91.29	12.70	19709.51	
Activity Therapy - Art, Music, Recreation	session	116	29.57	66.54	228240.18	
GRAND TOTAL:					13411308.75	
Total Estimated Unduplicated Participants:					464	
Factor D (Divide total by number of participants):					28903.68	
Average Length of Stay on the Waiver:						344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Transportation Total:						3680.00
Enhanced Transportation	mile	46	250.00	0.32	3680.00	
Fiscal Intermediary Total:						170100.00
Fiscal Intermediary	15 minutes	135	240.00	5.25	170100.00	
Community Living Supports Total:						8175504.87
Community Living Supports	hour	419	1347.51	14.48	8175504.87	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:						141223.50
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	request	198	1.00	713.25	141223.50	
Family Support and Training Total:						364560.00
Family Support and Training	15 minutes	93	196.00	20.00	364560.00	
Family Training Total:						123275.37
Family Training	session	231	8.42	63.38	123275.37	
Non-family Training Total:						157559.58
Non-family Training	session	260	9.76	62.09	157559.58	
Respite Total:						4027455.73
Respite	hour	438	547.98	16.78	4027455.73	

Specialty Service Total:						247949.70
Massage Therapy	15 minutes	17	91.29	12.70	19709.51	
Activity Therapy - Art, Music, Recreation	session	116	29.57	66.54	228240.18	
GRAND TOTAL:						13411308.75
Total Estimated Unduplicated Participants:						464
Factor D (Divide total by number of participants):						28903.68
Average Length of Stay on the Waiver:						344