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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Michigan** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
MI Choice

C. **Waiver Number: MI.0233**
Original Base Waiver Number: MI.0233.90.R1.03

D. **Amendment Number: MI.0233.R03.02**

E. **Proposed Effective Date:** *(mm/dd/yy)*
09/30/11
Approved Effective Date of Waiver being Amended: 10/01/07

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Michigan Department of Community Health wishes to amend the MI Choice waiver to comply with a request from CMS to bring the cost effectiveness projections into line with submitted CMS 372 reports.

The estimated number of unduplicated participants presented in Appendix B-3-a is revised for Waiver Years 4 and 5 to better approximate the anticipated MI Choice enrollment. Similarly, the cost estimates used in the Cost Effectiveness Demonstration in Appendix J are revised for Waiver Years 4 and 5 to reflect the methodology used by MDCH to prepare the CMS 372 reports.

Prior to the current amended waiver, the state had been straddling the approved cap of unduplicated participants due to increases in appropriation levels and a focus on rebalancing the state's long-term care environment by transitioning persons out of nursing facilities. In the current amended waiver, estimates of unduplicated participants were trended based on the growing levels of funding targeted for the waiver program. In reality, the number of persons enrolled in MI Choice has not kept pace with the growth in funding. This is due to factors such as increasing service costs, a rising population acuity, and a correction to appropriate service levels after years of restricted funding. The discrepency between the approved numbers in the waiver and the number being served makes it appear as though there is a significant unused capacity in the program and that is not the case. The central purpose of this amendment is to correct the estimates to alleviate that perception.

These are the only changes made to the waiver application in this amendment request.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	3.a
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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*):
MI Choice

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve*

individuals who are dually eligible for Medicaid and Medicare.)

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.0233
Waiver Number: MI.0233.R03.02
Draft ID: MI.03.03.02

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/07
Approved Effective Date of Waiver being Amended: 10/01/07

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 in42 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:

MI Choice is limited to serving the aged (65 and over) and disabled populations (age 18 and over).

○ **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:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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.
MI Choice is a 1915(c) waiver used to deliver home and community-based services to elderly and disabled individuals meeting Michigan's nursing facility level of care, who, but for the provision of such services, would require nursing facility services. The waiver is administered by the Michigan Department of Community Health (MDCH), Medical Services Administration (MSA), as the single state agency. MDCH exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations.

MDCH carries out its waiver obligations through a network of enrolled providers, including but not limited to Area Agencies on Aging (AAAs), that are operating as organized health care delivery systems (OHCDS) to provide services. These entities are referred to by the department as waiver agents.

Michigan is able to assure that an entity submitting claims for waiver services is either a directly enrolled provider of specific services or an OHCDS that is approved by the Medicaid agency as operating in compliance with the requirements as defined at 42 CFR 447.10(b) and (g)(4). Each waiver agent operating as an OHCDS must sign a provider agreement with the single state agency assuring that it meets all program requirements. In addition, each OHCDS must directly provide at least one waiver service.

Entities operating as OHCDS may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under subcontract with the OHCDS must meet provider standards elsewhere described in the waiver application. Subcontracts also assure that providers of services receive full reimbursement for services outlined in the waiver application. Providers meeting the waiver requirements for providers are permitted to participate.

Although MI Choice participants must have services approved by the OHCDS, participants are free to select any participating provider, thereby assuring freedom of choice. Through its Cash and Counseling grant, Michigan introduced the opportunity for participant direction in MI Choice via a 2006 amendment to the waiver.

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. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness 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 statewideness 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:
Michigan has complied with the requirement to seek public input in the development of the MI Choice waiver renewal. Beginning in February 2007, a series of bi-weekly stakeholder meetings were convened to solicit ideas and commentary on issues associated with the waiver renewal. The forum meetings were open to all interested stakeholders with a different topic identified for discussion in each meeting. Key stakeholders that were identified to participate initially included:
-The MI Choice Waiver Program Directors
-The Area Agencies on Aging Associaton of Michigan
-The Olmstead Coaltion (representing consumers of long term care services in Michigan)
-The Michigan Association of Assisted Living
-The Michigan Association of Homes & Services for the Aging
-Health Care Association of Michigan/Michigan Center for Assisted Living
-Michigan Home Health Association
-Michigan's Long Term Care Supports & Services Advisory Commission
-Michigan Hospice and Palliative Care Organization
-Representaives from Michigan's twelve federally recognized tribes
-Consumers of long term care services

The above list is not exhaustive of the stakeholders participating in the meetings, but represents a large cross section of regular attendees. Following the meetings, minutes of the discussions and materials from the meetings pertinent to MI Choice renewal were posted on a website accessible to interested parties.

In addition to the stakeholder forums designed to encourage stakeholder participation in the waiver renewal process, Michigan developed its quality strategy with meaningful contributions from consumers, advocates and caregivers who participated in monthly meetings with staff from DCH, MSA and OHCDS representatives. A leadership group composed of 7 consumer/advocates and 7 OHCDS representatives organized formally into the MI Choice Person-Focused Quality Management Collaboration. Collaboration activities were supported by a 2001 Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS) and are co-facilitated by DCH and the Michigan Disability Rights Coalition (MDRC).

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:	Coleman
First Name:	Jacqueline
Title:	Waiver Specialist
Agency:	Medical Services Administration, Actuarial Division
Address:	P.O. Box 30479
Address 2:	400 S. Pine, 7th Floor
City:	Lansing
State:	**Michigan**
Zip:	48909-7979
Phone:	(517) 241-7172 **Ext:** ☐ **TTY**
Fax:	(517) 241-5112
E-mail:	ColemanJ@Michigan.gov

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: Stephen Fitton

State Medicaid Director or Designee

Submission Date:	Jun 9, 2011

Last Name:	Fitton
First Name:	Stephen F.
Title:	Director
Agency:	Medical Services Administration, Michigan Department of Community Health
Address:	400 S. Pine Street
Address 2:	
City:	Lansing
State:	**Michigan**
Zip:	48933
Phone:	(517) 241-7882
Fax:	(517) 335-5007
E-mail:	Fitton S@Michigan.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

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:
   Michigan Department of Community Health, Medical Services Administration
   (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.

(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:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   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.:*

   ◉ **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:

MDCH contracts with 20 Organized Health Care Delivery Systems (OHCDS) to perform administrative and case management functions for the State of Michigan. They are responsible for disseminating information related to the waiver to potential enrollees, assisting individuals in waiver enrollment (which includes assisting applicants with completion of the Medicaid eligibility application-DHS 1171-to secure financial eligibility), managing waiver enrollment against approved limits, monitoring expenditures against approved limits, conducting assessments and level of care evaluations, reviewing participant service plans to ensure waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

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:
The Home and Community Based Services Section (HCBSS), organizationally situated in the Bureau of Medicaid Financial Management & Administrative Services, Medical Services Administration, Department of Community Health, is responsible for assessing the performance of each OHCDS.

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:
The HCBSS staff uses the MI Choice Site Review Protocol (MICSRP). MDCH structured the MICSRP according to the CMS Protocol, Interim Procedural Guidance, and the CMS Quality Framework. MDCH separates each MICSRP review area into two parts; Structure and Process, and includes requirements for person centered planning (PCP). The HCBSS staff biennially examines structural elements during the on-site Administrative Quality Assurance Reviews (AQAR). MDCH enters into independent contracts with qualified registered nurse reviewers (RNRs) who annually examine the procedural elements during the on-site Clinical Quality Assurance Reviews (CQARs).

The AQAR includes an examination of policy and procedures manuals, peer review reports, participant satisfaction survey results, provider monitoring reports, provider contract templates, and verification of required provider licenses to assure that each OHCDS meets all requirements. The AQAR also verifies the OHDCS meets administrative, program policy, and procedural requirements, including: program records maintained for six years; program records are locked and controlled access is maintained according to the HIPAA requirements; OHCDS employees can access program policies and procedures; and the OHCDS follows proper accounting procedures. HCBSS staff also review OHCDS agreements with sub-contracted providers, perform provider reviews, and may conduct interviews with both supports coordinators and MI Choice participants.

HCBSS staff also examines the OHCDS monitoring of providers during the AQAR. MDCH requires each OHCDS to conduct annual sub-contractor monitoring according to the OHCDS MI Choice Waiver Program Provider Monitoring Plan, Attachment J, of the MDCH contract. MDCH designed this methodology to ensure and verify that:
1) Direct service providers comply with minimum service standards and conditions of participation in the Medicaid program
2) Providers deliver services according to the participants' plan of care
3) Providers maintain an adequate number of trained staff through recruitment, on-going training, and staff supervision and support
4) Providers maintain participant case record documentation to support claims.

If required items are not evident, HCBSS staff discusses the missing elements with OHCDS staff prior to issuing the final report. The final report verifies one of three findings for each standard in the MICSRP: 1) there was evidence that the OHCDS met the standard as required, 2) HCBSS staff did not find evidence of compliance, or 3) HCBSS staff found incomplete evidence. Following a review, MDCH prepares an administrative report. The report identifies problem areas and instances where required documentation was not evident or not found. MDCH sends the report to the OHCDS and provides the OHCDS thirty days to respond in writing with a corrective action plan. After receiving the OHCDS response and engaging in any necessary clarifying discussion, MDCH accepts or amends the corrective action plan.

HCBSS staff also conducts on-site reviews biyearly to discuss progress with implementing the OHCDS quality management plans (QMPs). HCBSS staff compiles a progress report for each visit, noting exemplary practices and recommendations for strengthening plans.

During the CQARs, the RNRs examine records from each OHCDS. The number of records reviewed equals 5% of the OHCDS MI Choice participants, with a maximum of 20 and a minimum of 10 records per OHCDS. RNRs conduct CQARs on-site and include interviews with OHCDS staff. Additionally, the CQAR includes home visit interviews with at least 10 participants for each OHCDS. The overall purpose of the CQAR is to determine, based on case record documentation, home visits, and discussion with supports coordinators, whether or not the OHCDS protects each participant's health and welfare during the implementation and delivery of services and supports. When RNRs find significant issues, concerns, or questions in the first 5% of case records reviewed, they may opt to review additional records to verify initial findings.

RNRs compile CQAR data into reports submitted to MDCH. HCBSS staff sends a report to each OHCDS summarizing successes in practice and areas in need of improvement. The OHCDS has 30 days to submit a corrective action plan to MDCH in response to this report. MDCH either accepts the corrective action plan, or suggests other actions to bring each OHCDS into full compliance with this portion of the MICSRP.

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	Local Non-State Entity
Participant waiver enrollment	☐	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☐	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☐	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

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:
HCBSS staff conducts biennial AQAR for each OHCDS as specified in item #A-6 above. HCBSS staff compiles results of all AQARs conducted and presents information to the QM collaboration.

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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HCBSS staff oversees implementation of the CQAR process as specified in item #A-6 above. Yearly, HCBSS staff compiles results of all CQARs conducted and present information to the QM collaboration.

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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HCBSS staff reviews and approves QMPs for each OHCDS as specified in item #A-6 above. Yearly, HCBSS staff compiles results of all QMPs and data provided on quality indicators and presents information to the QM collaboration.

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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
OHCDS staff monitor sub-contracted providers/entities to assure each provider meets criteria for policies and procedures, record maintenance, service delivery, and financial accountability. When needed, the OHCDS requires corrective action of the provider.

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):*

☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☑ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

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):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

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.
HCBSS staff compiles results using algorithms within the MICSRP. HCBSS staff compares specific and overall data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to identify trends and formulate recommendations for improvement. Members of the QM Collaboration may also make recommendations for improvement.

HCBSS staff conducts the following monitoring processes in addition to the quality assurance reviews:

1. Routinely monitors expenditures and administrative data from the Medicaid data warehouse.
2. Verifies active licensure via a public website for each RN and SW employed at the OHCDS annually or

sooner if the OHCDS provides an updated personnel list.
3. Routinely reviews, analyzes, and compiles all MI Choice administrative hearings and appeals decisions and takes corrective action when an OHCDS is non-compliant with a decision and order resulting from an administrative hearing.
4. Reviews the content and requests for funds in the monthly OHCDS financial status reports.
5. Continually monitors nursing facility transition (NFT) requests and activity.
6. Monitors clinical records for Special Memos of Understanding contracts for participants with extraordinary care needs, upon admission and annually thereafter.
7. As needed, investigates and monitors through resolution complaints received regarding operations of the MI Choice Waiver Program. This process might involve discussion with OHCDS, participants or their representatives, the Michigan Department of Human Services (DHS), or any other entity that might be helpful in producing a resolution.
8. Produces a Summary Expenditure Report as needed and analyzes it by comparing individual waiver agent results with statewide waiver agent results. This report details total expenditures and total units for each service by number of participants receiving each service. This report also includes support coordination and administrative expenditures.
9. Conducts annual reimbursement reconciliations with each OHCDS to close out and settle final waiver expenditures.
10. Monitors, reviews, and evaluates the Critical Incidence Management Reporting System and OHCDS reports submitted semi-annually.
11. Implements new monitoring procedures for Self Determination in Long Term Care as described in Appendix H.
12. Reviews and analyzes OHCDS QMP Reports submitted annually. The reports provide detail regarding progress in quality assurance and quality improvement activities. The reports compile and compare individual OHCDS quality indicators to statewide averages. OHCDS staff, the QM Collaboration, local quality committees, and advisory committees for self determination review QMP summaries.

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 HCBSS staff compiles reports for each AQAR and CQAR upon completion of the review and sends the completed reports to the OHCDS. When the AQAR and CQAR reports indicate a need for corrective action, the OHCDS has 30 days to respond with a corrective action plan. HCBSS staff reviews the corrective action plan, including any revised policies and procedures, training materials, information from staff meetings, or case record documentation supporting the corrective action plan and either approve the plan or work with OHCDS staff to amend the plan to meet MDCH requirements. Once approved, HCBSS staff sends the OHCDS an approval letter. HCBSS staff monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. HCBSS staff retains all documents generated from this process on file.
When MDCH receives a specific complaint, it works with the parties involved to resolve the complaint. MDCH staff keeps records of conversations, electronic communications, and documents on file. Depending on the nature of the complaint, MDCH may keep these documents in a general complaint file, or file them according to the OHCDS involved. When addressing a specific complaint, MDCH will work with the most appropriate parties to resolve the issue. Most complaint investigations involve contact with participants, allies, OHCDS staff, advocates, or the Department of Human Services.

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):*
☑ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☑ **Continuously and Ongoing**

☐ **Other**
Specify:

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
◉ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

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:

Participants in the MI Choice program who are eligible due to a physical disability and reach age 65 are then deemed to have continued program eligibility by virtue of their age. No transition is necessary within the program.

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	9517
Year 2	12745
Year 3	14163
Year 4	11929
Year 5	12214

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	
Year 5	

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:

(a) Michigan operates its waiver through agencies operating as OHCDS.

(b) The initial allocation was determined by demand for services when the waiver began operation. Currently Michigan maintains a quarterly reporting system that analyzes excess demand by geographical area. Reallocation of excess resources above current legislative appropriation levels will be based on a statistical formula that weighs demographic variables (Medicaid LTC percentage, Medicaid Aged, Blind, Disabled Percentage, Elderly population Percentage, NF bed – compared to typical usage predicted by population demographics, and current resource allocation).

(c) There is currently no excess capacity in any of the OHCDS. In its 15 years of operating this waiver program, Michigan has never had unused capacity. This status in not expected to change over the course of the renewal period, which ends September 30, 2012. All waiver participants have access to identical waiver services across geographical area ensuring comparability.

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

All entrants to any of the state's long term care programs must undergo the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) and meet the nursing facility level of care requirements. Individuals must be given information on all programs for which they qualify. Individuals indicate their choice and document that they have been informed of their options via the Michigan Freedom of Choice form that is provided to an applicant at the end of the LOCD. This form must be placed in the participant chart and retained for three years. This function is performed by the LTCC in regions where these entities exist.

When the number of program participants receiving and applying for MI Choice Program services exceeds program capacity, a procedure is implemented giving priority in descending order to the following groups for enrollment in the program: Children Special Health Care Service participants who are no longer eligible because of age restrictions for state plan private duty nursing services and who continue to demonstrate a need for service; nursing facility transition participants who have resided in a facility for six consecutive months, excluding short-term hospital stays; nursing facility transition participants who have resided in a nursing facility for less than six consecutive months, excluding short-term hospital stays; qualified applicants diverted from an imminent nursing facility admission including any applicant with an active Adult Protective Services (APS) case, and finally, all other qualified applicants. All waiting list priority categories are established and further defined in state Medicaid policy.

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)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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)**
- [x] **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 (TWWIIA 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)**
- [x] **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: 1

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:

OHCDS utilize supports coordinators to conduct evaluations and reevaluations.

- ( ) **Other**

Specify:

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 Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health care professional: physician, registered nurse, licensed practical nurse, licensed social worker (BSW or MSW), or a physician assistant.

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.

Michigan evaluates applicants via the Michigan Medicaid Nursing Facility Level of Care Determination based on one of seven doors for nursing facility level of care. These doors are: Door 1: ADL dependency, Door 2: Cognitive Performance, Door 3: Physician Involvement, Door 4: Treatment and Conditions, Door 5: Skilled Rehabilitation Therapies, Door 6: Behavioral Challenges, Door 7: Service Dependency.

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.
(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:
Independent or Supervision = 1
Limited Assistance = 3
Extensive Assistance or Total Dependence = 4
Activity Did Not Occur = 8

(D) Eating:
Independent or Supervision = 1
Limited Assistance = 2
Extensive Assistance or Total Dependence = 3
Activity Did Not Occur = 8

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.
1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3. 1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR 2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories and have a continuing need to qualify under Door 4.

Scoring Door 5: The applicant must have required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.
1. A "Yes" for either delusions or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency to qualify under Door 7.

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:

A formal level of care determination (LOCD) is entered into the on-line database at the initial determination of functional eligibility. Annual re-evaluations are conducted by supports coordinators and it is required that either a licensed social worker or an RN be present, generally whichever professional is more appropriate to addressing the individual circumstances faced by the participant. The determination must be noted in the case record and signed by the individual conducting the reevaluation. The same guidelines (or doors) are used by the supports coordinators for reevaluation. If the re-evaluation determines that the participant no longer meets the functional LOCD criteria for participation, a second LOCD must be entered into the online database reflecting the status change.

Effective October 1, 2007, individuals seeking long term care services (including MI Choice) paid for by Medicaid in four regions of Michigan have the LOCD performed by single point of entry entities called Long Term Care Connections (LTCC). These four pilot entities were established in state law by Public Act 634 of 2006. The four pilot LTCCs include Detroit/Wayne (serving eight cities plus Detroit), Southwest (serving eight counties in southwest Michigan), West Michigan (serving twelve counties in western Michigan) and Upper Penninsula (serving all counties in Michigan's upper penninsula).

The standards for performance of the LOCD by the LTCC are the same as those established for the waiver agents. A copy of the LOCD performed by the LTCC is provided to the appropriate MI Choice waiver agent to be maintained in the participant's case record.

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:

A reevaluation is required every twelve months or with significant change in condition.

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 state requires supports coordinators to reevaluate each MI Choice participant's level of care at each in-person reassessment visit. The supports coordinators document that the participant continues to meet the nursing facility level of care within the case record, usually specifying the appropriate "door" through which the participant meets level of care criteria. Reassessments are conducted every 90 to 180 days, or upon a significant change in the participant's condition. Supports coordinators track reassessment dates within the OHCDS information systems. If a supports coordinator determines the participant no longer meets the nursing facility level of care, the supports coordinator initiates program discharge procedures and provides the participant with advanced notice informing them of their appeal rights.

The standards for performance of the LOCD by the LTCCs are the same as those established for the OHCDS. A copy of the LOCD performed by the LTCC along with supporting documantation is provided to the appropriate waiver agent to be maintained in the participant's case record.

The state monitors compliance to this requirement during the clinical quality assurance reviews.

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:

Copies of level of care determinations for participants are maintained by case managers employed by the OHCDS for a minimum period of six years. This information is also maintained in the MDCH LOCD database for six years.

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:
HCBSS staff oversees implementation of the CQAR process annually utilizing the MICSRP. Item #I.B.2.b of the MICSRP assesses compliance to this sub-assurance and states: "Waiver agent provided an individual evaluation to determine that applicant meets the NFLOC criteria using the process and instrument described in MDCH policy."

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff oversees implementation of the CQAR process annually utilizing the MICSRP. Item #I.B.2.g of the MICSRP assesses compliance to this sub-assurance and states: "Waiver agent minimally provides an annual reevaluation of the nursing facility level of care for the participant."

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff oversees implementation of the CQAR process annually utilizing the MICSRP. Item #I.B.2.h of the MICSRP assesses compliance to this sub-assurance and states: "The participant record appropriately reflects the participant's 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*

☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
HCBSS staff oversees implementation of the CQAR process annually utilizing the MICSRP. Item #VII.B.2.a of the MICSRP assesses compliance to this sub-assurance and states: "Waiver agent addresses inappropriate LOC determinations when it finds inappropriate determinations have been made."

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

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.

1) The HCBSS Staff contracts with RNRs to conduct an annual on-site POC and case record review on a sample of cases to compare LOC determinations with actual assessments. RNRs analyze findings and verify that enrolled participants are eligible, LOC items match comparable assessment responses, and supports coordinators reevaluate enrollees annually. HCBSS staff compiles results into the final written review report provided to the OHCDS. When the HCBSS staff identifies non-compliance, corrective action plans are required and pursued. Additionally, the RNRs may provide instructions for assuring compliance on-site and HCBSS staff provides training as needed. The HCBSS staff disseminates and discusses final review results with OHCDS at the QM Collaboration that meets quarterly, and at monthly Waiver Directors' meetings.

2) MDCH conducts a monthly LOC exceptions review to assure that individuals who are denied services have access to an exception review. MDCH Program Policy Section monitors exceptions using a summary report. The MDCH Program Policy Section also identifies outliers.

3) The MMIS edit process prohibits approval of claims that do not have an approved LOC determination. MDCH monitors the edit report monthly to identify outlier issues that indicate a specific agency needs training or clarifying remediation.

4) The HCBSS staff reviews LOC appeals and decisions summaries monthly, provides technical assistance and training, and initiates corrective actions as needed.

5) MDCH Program Policy reviews monthly utilization reports to ensure that the OHCDS and SPEs use the LOC process and instruments described in the waiver application to determine LOC.

6) MDCH policy requires each OHCDS to use the established LOC process and forms. OHCDS have first line responsibility for ensuring on a continual basis that supports coordinators determine participants eligible by using this process and MDCH requires them to monitor determinations for errors and omissions. MDCH requires the OHCDS to have written procedures that follow MDCH policy.

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 HCBSS staff compiles reports for each CQAR upon completion of the review and sends the completed reports to the OHCDS. When the CQAR reports indicate a need for corrective action, the OHCDS has 30 days to respond with a corrective action plan. HCBSS staff reviews the corrective action plan, including any

revised policies and procedures, training materials, information from staff meetings, or case record documentation supporting the corrective action plan and either approve the plan or work with OHCDS staff to amend the plan to meet MDCH requirements. Once approved, HCBSS staff sends the OHCDS an approval letter.
HCBSS staff monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. HCBSS staff retains all documents generated from this process on file. RNRs may provide technical assistance to the OHCDS staff when the reviewers note deficiencies to any of the sub-assurances during the CQAR data collection process. When HCBSS staff identifies deficiencies in the report sent to the OHCDS, corrective action is required. If HCBSS staff notes deficiencies upon aggregating individual data, HCBSS staff will provide training or other interventions as necessary to assist each OHCDS to assure compliance.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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).

Any individual applying for Medicaid services, nursing facility care, home and community based services, home help, or PACE must meet functional eligibility through the Michigan Medicaid Nursing Facility Level of

Care. Once an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect, in writing, to receive services in a specific program. This election must take place prior to initiating services under Medicaid.

The applicant, or legal representative, must be informed of the following services available to persons meeting the nursing facility level of care. Services available in a community setting include the MI Choice Program, PACE program, Home Health, Home Help, or nursing facility institutional care.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination." Applicants who prefer a community long-term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must indicate their choice of program in writing by signing the Freedom of Choice (FOC) form. A completed copy of this form must be retained for a period of three years. The completed form must be kept in the medical record if the resident chooses admission to a nursing facility. The Freedom of Choice form must also be witnessed by an applicant representative when available. MDCH ensures that nursing facilities are informing beneficiaries of choice through the restrospective review of LOCDs, which is performed by the Michigan Peer Review Organization (MPRO). MRPO checks to see that facilities have signed FOC forms in the residents' records indicating that choice has been offered and discussed.

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.

The FOC form will be maintained with the plan of care for a period of at least three years.

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):
OHCDS are required to provide language and culturally sensitive information to all applicants for the MI Choice Waiver program. Depending on the local community, brochures are printed in Spanish, French, Arabic, Polish, and Chinese. In meeting with individual waiver applicants or participants, OHCDS may employ bi-lingual staff, or use translation services.

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
Statutory Service	Adult Day Health
Statutory Service	Homemaker
Statutory Service	Personal Care
Statutory Service	Respite
Extended State Plan Service	Specialized Medical Equipment and Supplies
Supports for Participant Direction	Fiscal Intermediary
Supports for Participant Direction	Goods and Services
Other Service	Chore Services

Other Service	Community Living Supports
Other Service	Counseling
Other Service	Environmental Accessibility Adaptations
Other Service	Home Delivered Meals
Other Service	Non-Medical Transportation
Other Service	Nursing Facility Transition Services
Other Service	Personal Emergency Response System
Other Service	Private Duty Nursing
Other Service	Residential Services
Other Service	Training

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:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

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 furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies are furnished as component parts of this service. Transportation between the participant's place of residence and the Adult Day Health center are provided as a component part of this service.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Adult Day Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:
Adult Day Care Center
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten participants. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

2. The provider shall require staff to participate in orientation training as specified in the "General Operating Standards for Waiver Agents and Contracted Direct Service Providers." Additionally, program staff shall have basic first-aid training.

The provider shall require staff to attend in-service training at least twice each year. The provider shall design this training specifically to increase their knowledge and understanding of the program and participants, and to improve their skills at tasks performed in the provision of service. The provider shall maintain records that identify the dates of training, topics covered, and persons attending.

3. If the provider operates its own vehicles for transporting participants to and from the program site, the provider shall meet the following transportation minimum standards:

a. The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
b. All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
c. All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
d. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

4. Each provider shall have first-aid supplies available at the program site. The provider shall make a staff person knowledgeable in first-aid procedures, including CPR, present at all times when participants are at the program site.

5. Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.

6. Each day care center shall have the following furnishings:

a. At least one straight back or sturdy folding chair for each participant and staff person.
b. Lounge chairs and/or day beds as needed for naps and rest periods.
c. Storage space for participants' personal belongings.
d. Tables for both ambulatory and non-ambulatory participants.
e. A telephone accessible to all participants.
f. Special equipment as needed to assist persons with disabilities.

The provider shall maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition.

7. Each day care center shall document that it is in compliance with:

a. Barrier-free design specification of Michigan and local building codes.
b. Fire safety standards.
c. Applicable Michigan and local public health codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS

Frequency of Verification:
Prior to delivery of service and annually 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:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):

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 consisting of the performance of general household tasks, (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and upkeep for him or herself or others in the home. This service also includes observing and reporting any change in the participant's condition and the home environment to the supports coordinator.

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

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

- [x] **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	Individuals chosen by the participant who meet the minimum required qualifications
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:
Individuals chosen by the participant who meet the minimum required qualifications
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal background check.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
1. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and

recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

2. Required bi-annual in-service training topics shall include, but are not limited to sanitation, household management, nutrition, and meal preparation.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Annually

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:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

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 range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law. Personal care under the waiver differs in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care services in the State plan. The differences between the waiver coverage and the State Plan are that the provider qualification and training requirements are more stringent for personal care as provided under the waiver than the requirements for this service under the State plan. Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the service furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care may be furnished outside the participant's home. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	Home Care Agency
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications

License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
1. A registered nurse licensed to practice nursing in the State shall furnish supervision of personal care providers. At the State's discretion, other qualified individuals may supervise personal care providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing personal care services.

2. The OHCDS and/or provider agency must train each worker to properly perform each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker can competently and confidently perform every task assigned for each participant served. MDCH strongly recommends each worker delivering personal care services complete a certified nursing assistance training course.

3. Direct service providers must develop in-service training plans and assure all workers providing personal care services are confident and competent in the following areas before delivering personal care services to MI Choice participants: safety, body mechanics, and food preparation including safe and sanitary food handling procedures.

4. Personal care providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each participant who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Exceptions can be made for training in cardiopulmonary resuscitation when the waiver participant has a "Do Not Resuscitate" (DNR) order.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually 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:
Statutory Service
Service:
Respite
Alternate Service Title (if any):

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 participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant. Services include:

• Attendant care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation.
• Basic care (participant may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Services are provided in the participant's home, in the home of another, or in a Medicaid certified hospital or a

licensed Adult Foster Care home.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a 30 day per calendar limit on respite services provided outside the home. The costs of room and board are not included except when respite care is provided in a facility approved by the State that is not a private residence.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	
Agency	

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
1. When chore, homemaking or personal care services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

2. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

3. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.

4. Be in good standing with the law as validated by a criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Provider Qualifications

License *(specify):*
Respite services provided in licensed care settings must meet the standards set forth in MCL 333.21511.

Certificate *(specify):*
N/A

Other Standard *(specify):*
When providing care in the home of the participant:

1. When chore, homemaking or personal care services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

2. Each direct service provider shall establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:

a. The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant.

b. Verification of prescription medications and their dosages. The participant shall maintain all medications in their original, labeled containers.

c. Instructions for entering medication information in participant files.

d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self administration of medications.

3. Each direct service provider shall employ a professionally qualified supervisor that is available to staff while staff provide respite care.

When providing respite in a licensed setting:

1. Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged.

2. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.

3. Each direct service provider shall demonstrate a working relationship with a hospital or other health care facility for the provision of emergency health care services, as needed. With the assistance of the participant or participant's caregiver, the OHCDS or direct service provider shall determine an emergency notification plan for each participant, pursuant to each visit.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually 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:
Extended State Plan Service
Service Title:
Specialized Medical Equipment and 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):*
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State plan that are necessary to address participant functional limitations. All items shall meet applicable standards of manufacture, design and installation. Waiver funds are also used to cover the costs of maintenance and upkeep of equipment. The coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the participant.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Enrolled Medicaid or Medicare DME Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Enrolled Medicaid or Medicare DME Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually 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:
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):*
Service that assists the adult participant, or a representative identified in the participant's care plan, to prevent institutionalization by living independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The Fiscal Intermediary helps the individual to manage and distribute funds contained in the individual budget. The funds are used to purchase waiver goods and services authorized in the individual plan of services. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring participant-directed budget expenditures and identifying potential over and under expenditures; and assuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and background checks and assisting the participant to understand billing and documentation requirements.

Services that assist the participant to meet the need for services defined in the plan of care while controlling an individual budget and choosing staff authorized by the waiver agent. The fiscal intermediary helps the individual manage and distribute funds contained in the individual budget.

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

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

- [x] **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	Fiscal Intermediary 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:
Agency
Provider Type:
Fiscal Intermediary Agency
Provider Qualifications

License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
1. Provider must be bonded and insured.

2. Insured for an amount that meets or exceeds the total budgetary amount the Fiscal Intermediary is responsible for administering. Demonstrated ability to manage budgets and perform all functions of the fiscal intermediary including all activities related to employment taxation, worker's compensation and state, local and federal regulations. Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the participant, the family or guardians of the participant may provide fiscal intermediary services to the participant. Fiscal Intermediary service providers must pass a readiness review and meet all criteria sanctioned by the state. Fiscal Intermediaries will comply with all requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to execution and annual renewal of contract.

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:

Other Supports for Participant Direction

Alternate Service Title (if any):

Goods and Services

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)*:

Individual directed goods and services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual plan of services, (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service is only approved by CMS for self-direction participants. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the individual plan of services.

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

N/A

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

- [x] **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	Contract Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Goods and Services

Provider Category:

Individual

Provider Type:
Contract Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. The service or item must be designed to meet the participant's functional, medical or social needs and advances the desired outcomes in his/her individual plan of services.

2. The service or item is not prohibited by Federal or State Medicaid or other statutes and regulations, including the State's Procurement Requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to contract execution.

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:
Chore Services

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 needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress inside the home. This service also includes yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
Specify applicable (if any) limits on the amount, frequency, or duration of 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
Individual	Individuals chosen by the participant who meet the qualification standards
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:
Individuals chosen by the participant who meet the qualification standards
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

2. Previous relevant experience/training to meet MDCH operating standards.

3. Must be deemed capable of performing the required tasks by the OHCDS.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*

N/A
Certificate *(specify):*
N/a
Other Standard *(specify):*
1. Only properly licensed suppliers may provide pest control services.

2. Each OHCDS must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.

3. Ability to communicate effectively both verbally and in writing as well as to follow instructions.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Annually

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 facilitate an individual's independence and promote reasonable participation in the community. Community Living Supports can be provided in the participant's residence or in community settings as necessary in order to meet support and service needs sufficient to address nursing facility level of care needs.
Community Living Supports includes:
A. Assisting* [see note below], reminding, cueing, observing, guiding and/or training in the following activities:

• meal preparation
• laundry
• routine, seasonal, and heavy household care and maintenance
• activities of daily living such as bathing, eating, dressing, personal hygiene
• shopping for food and other necessities of daily living
B. Assistance, support and/or guidance with such activities as:
• money management
• non-medical care (not requiring nurse or physician intervention)
• social participation, relationship maintenance and building community connections to reduce personal isolation
• transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence
• participation in regular community activities incidental to meeting the individual's community living

preferences
• attendance at medical appointments
• acquiring or procuring goods and services necessary for home and community living
C. Reminding, cueing, observing and/or monitoring of medication administration
D. Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate waiver service for the beneficiary. Transportation to medical appointments is covered by Medicaid through the Department of Human Services (DHS).
Community Living Supports do not include the cost associated with room and board. This service is authorized when necessary to prevent the institutionalization of the person served.

*Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care services in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Living Support services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere available. The distinction must be apparent by unique hours and units in the approved care plan.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Individual chosen by the client who can perform duties.

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
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be

trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

2. A registered nurse licensed to practice nursing in the State shall furnish supervision of Community Living Support providers. At the State's discretion, other qualified individuals may supervise personal care providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing Community Living Support services.

3. The OHCDS and/or provider agency must train each worker to properly perform each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker can competently and confidently perform every task assigned for each participant served. MDCH strongly recommends each worker delivering Community Living Support services complete a certified nursing assistance training course.

4. Community Living Support providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each participant who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

5. Individuals providing Community Living Support services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of services and annually thereafter.

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:
Individual chosen by the client who can perform duties.

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
1. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be trained in universal precautions and blood-born pathogens and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Training in cardiopulmonary resuscitation can be waived if providing services for a participant who has a "Do Not Resuscitate" (DNR) order. If providing transportation incidental to this service, the provider must possess a valid Michigan driver's license.

2. Individuals providing Community Living Supports must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food

preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

3. Previous relevant experience/training to meet MDCH operating standards.

4. Must be deemed capable of performing the required tasks by the OHCDS.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of services and annually 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:
Counseling

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):*
Professional level counseling services seek to improve the individual's emotional and social well being through the resolution of personal problems and/or change in an individual's social situation.
Counseling services must be directed to waiver participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives may participate in the counseling session to address and/or resolve the problems experienced by the waiver participant and to prevent future issues from arising.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Counselor
Individual	Psychologist
Individual	Social Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Individual
Provider Type:
Counselor
Provider Qualifications
License *(specify):*
MCL 333.18101 ... 333.18117
Certificate *(specify):*
N/A
Other Standard *(specify):*
a. A master's degree in social work, psychology, psychiatric nursing, or counseling or

b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Individual
Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
MCL 333.18201 ... 333.18237
Certificate *(specify):*
N/A
Other Standard *(specify):*
a. A master's degree in social work, psychology, psychiatric nursing, or counseling or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify):*
MCL 333.1501 ... 333.18518
Certificate *(specify):*
N/A
Other Standard *(specify):*
a. A master's degree in social work, psychology, psychiatric nursing, or counseling or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually 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:
Environmental Accessibility Adaptations

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):*
Those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health and welfare of the participant or that enables the participant to function with greater independence in the home, without which the participant would require institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are not of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contracted provider
Individual	Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Contracted provider
Provider Qualifications
License *(specify):*
MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2404(3)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Each waiver agent shall develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to contract execution

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Contracted Provider
Provider Qualifications

License *(specify):*
MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Each waiver agent shall develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to service execution

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:
Home Delivered Meals

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):*
Home delivered meals (HDM) is the provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Counsel of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets, as indicated in the plan of care. A home delivered meal shall not constitute a full nutritional regimen.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Does not constitute a full nutritional regimen.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Home Delivered Meal Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Home Delivered Meal Provider
Provider Qualifications

License *(specify):*
Health Code Standards (PA 368 of 1978)
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available at least five days per week.

2. Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.

3. Each provider shall carry product liability insurance sufficient to cover its operation.

4. The provider shall deliver food at safe temperatures as defined in Home Delivered Meal service standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to the delivery of services and annually 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:
Non-Medical 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):*
Services offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, specified by the service plan. 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) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's individual plan of service. Whenever possible, family, neighbors, friends, or community agencies, that can provide this service without charge is utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
N/A

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	Individual
Agency	Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
Valid Michigan Driver's License
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must cover all vehicles used with no fault automobile insurance.

2. All paid drivers for transportation providers supported entirely or in part by MI Choice funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles.

3. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency

Provider Type:
Contracted provider

Provider Qualifications

License *(specify):*
Valid Michigan Driver's License

Certificate *(specify):*
N/A

Other Standard *(specify):*
1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must cover all vehicles used with liability insurance.

2. All paid drivers for transportation providers supported entirely or in part by MI Choice funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

3. The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of service and annually 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:
Nursing Facility Transition Services

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):*
Nursing Facility Transition services are non-reoccurring expenses for persons who are in the process of transitioning from a nursing facility to a less institutional community setting. Allowable transition costs include the following:

Housing Deposits: A one-time expense to secure housing or obtain a lease.

Utility hook-ups and deposits: A one time expense to initiate and secure utilities (cable is not included).

Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (TVs and VCRs are not included).

Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.

Coordination and support services to facilitate transitioning of individuals to a community setting.

Other services deemed necessary and documented within the plan of care to accomplish the transition into a community setting.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing Facility Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	OHCDS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Facility Transition Services

Provider Category:
Agency
Provider Type:
OHCDS
Provider Qualifications
License *(specify):*
MCL 133.18501 ... 333.18518 (Social Work), MCL 133.17201 ... 333.17242 (Registerd Nurse)

Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Service must be provided by a registered nurse, a clinical social worker (BSW or MSW), or otherwise qualified supports coordinator.

2. The OHCDS or contracted providers must minimally comply with the following: Have written policies and procedures compatible with the "General Operating Standards for Waiver Agents and Their Contracted Service Providers." Waiver agents furnishing services defined under HCPCS code T1023, T1028 or coordination and support through HCPCS code T2038 must also minimally comply with Section A of the "General Operating Standards for MI Choice Waiver Service Providers." Waiver agents furnishing services defined under HCPCS code T2038 with the exception of coordination and support must minimally comply with Section B of the "General Operating Standards for MI Choice Wavier Service Providers.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually 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:
Personal Emergency Response System

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):*
PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices/systems are also provided.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
PERS does not cover monthly telephone charges associated with phone service.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	PERS Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
PERS Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

2. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.

3. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.

4. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually 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:
Private Duty Nursing

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):*
Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home. PDN for waiver participants 18-21 years old is provided through the Medicaid State Plan. PDN services for participants older than 21 years are not available through the Medicaid State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nurse
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Individual
Provider Type:
Nurse
Provider Qualifications
License *(specify):*
Nursing MCL 333.17201 ... 333.17242
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Services paid for with MI Choice funds shall not duplicate nor replace services available through the Michigan Medicaid state plan. OHCDSs and direct service providers can find state plan coverage online in the Medicaid Provider Manual at www.michigan.gov/mdch.

3. This service may include medication administration as defined under the referenced statutes.
Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Nursing MCL 333.17201 ... 333.17242
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Services paid for with MI Choice funds shall not duplicate nor replace services available through the Michigan Medicaid state plan. OHCDSs and direct service providers can find state plan coverage online in the Medicaid Provider Manual at www.michigan.gov/mdch.

3. This service may include medication administration as defined under the referenced statutes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually 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:
Residential Services

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):*
MI Choice participants who receive residential services must reside in a homelike, non-institutional setting licensed by the State Of Michigan. As a stipulation of the licensure standards, such settings provide continuous on-site response capability to meet scheduled or unpredicted resident needs and provide supervision, safety, and security. Residential services include enhanced assistance with activities of daily living and supportive services that rise above the level of service mandated by licensing requirements. It is intended to supplement the existing level of services provided in these settings, particularly labor intensive activities, which are above the scope of service normally provided. This service is authorized when necessary to prevent the institutionalization of the person served.

Such additional assistance might include:

Assisting, reminding, cueing, observing, guiding and/or training in activities of daily living such as bathing, eating, dressing, or personal hygiene. Assistance, support and/or guidance with such activities as non-medical care (not requiring nurse or physician intervention), special homemaking needs, social participation, relationship maintenance and building community connections to reduce personal isolation, participation in regular community activities incidental to meeting the individual's community living preferences, attendance at medical appointments, and staff assistance with preserving the health and safety of the individual in order that they may reside and be supported in the most integrated independent community setting.

Third parties may only provide residential services with the approval of the participant, licensee, and OHCDS. Payment for residential services excludes room and board, items of comfort and convenience, costs of facility maintenance, upkeep, and improvement, or other costs that are required as a term of licensure.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Residential services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere available. The distinction must be apparent by unique hours and units in the approved care plan.

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	
Agency	Adult Foster Care
Agency	Home for the Aged

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:
Individual

Provider Type:

Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.

2. Be in good standing with the law as validated by a criminal background check.

3. Family members who provide residential services must meet the same standards as providers who are unrelated to the individual. Authorization must not be given for the payment of services provided by the participant's spouse, guardian, or responsible adult.

4. The OHCDS, provider agency, or licensee must train each worker to properly perform each task required for each participant the worker serves before delivering services to the participant. A supervisor must ensure that each worker can perform every assigned task competently and confidently for each participant served.

5. Residential Services does not include nursing and skilled therapy services.

6. Direct service providers must be trained in cardio-pulmonary resuscitation. This requirement may be waived when the provider is furnishing services to a participant with a standing "Do Not Resuscitate" order.

7. MDCH Strongly recommends that each worker delivering Residential Services complete a certified nursing assistance training course.

Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:
Agency
Provider Type:
Adult Foster Care
Provider Qualifications
License *(specify):*
Services must be provided in an Adult Foster Care Home that is licensed under the provisions of Act No. 218 of the Public Acts of 1978 as amended.
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.

2. Be in good standing with the law as validated by a criminal background check.

3. Family members who provide residential services must meet the same standards as providers who are unrelated to the individual. Authorization must not be given for the payment of services provided by the participant's spouse, guardian, or responsible adult.

4. The OHCDS, provider agency, or licensee must train each worker to properly perform each task required for each participant the worker serves before delivering services to the participant. A supervisor must ensure that each worker can perform every assigned task competently and confidently for each participant served.

5. Residential Services does not include nursing and skilled therapy services.

6. Direct service providers must be trained in cardio-pulmonary resuscitation. This requirement may be waived when the provider is furnishing services to a participant with a standing "Do Not Resuscitate" order.

7. MDCH Strongly recommends that each worker delivering Residential Services complete a certified nursing assistance training course.

8. Direct service providers must be supervised by a registered nurse licensed to practice nursing in the State Of Michigan. At the state's discretion, other qualified individuals may supervise care providers.

9. Agency providers must develop in-service training plans and assure that all workers providing care services are confident and competent in safety and body mechanics before delivering services to MI Choice participants.

10. Agency providers must provide a registered nurse to train and supervise residential services workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for participants who require such care. The supervising RN must assure each worker's competence and confidence to perform each task required.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:
Agency

Provider Type:
Home for the Aged

Provider Qualifications

License *(specify):*
Services must be provided in a Home For the Aged that is licensed under the provisions of Act No. 368 of the Public Acts of 1978 as amended.

Certificate *(specify):*
N/A

Other Standard *(specify):*
1. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.

2. Be in good standing with the law as validated by a criminal background check.

3. Family members who provide residential services must meet the same standards as providers who are unrelated to the individual. Authorization must not be given for the payment of services

provided by the participant's spouse, guardian, or responsible adult.

4. The OHCDS, provider agency, or licensee must train each worker to properly perform each task required for each participant the worker serves before delivering services to the participant. A supervisor must ensure that each worker can perform every assigned task competently and confidently for each participant served.

5. Residential Services does not include nursing and skilled therapy services.

6. Direct service providers must be trained in cardio-pulmonary resuscitation. This requirement may be waived when the provider is furnishing services to a participant with a standing "Do Not Resuscitate" order.

7. MDCH Strongly recommends that each worker delivering Residential Services complete a certified nursing assistance training course.

8. Direct service providers must be supervised by a registered nurse licensed to practice nursing in the State Of Michigan. At the state's discretion, other qualified individuals may supervise care providers.

9. Agency providers must develop in-service training plans and assure that all workers providing care services are confident and competent in safety and body mechanics before delivering services to MI Choice participants.

10. Agency providers must provide a registered nurse to train and supervise residential services workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for participants who require such care. The supervising RN must assure each worker's competence and confidence to perform each task required.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of services and annually 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:
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):*
Training services are instruction provided to a waiver participant or caregiver in either a one-to-one situation or

a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a home or community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the plan of care as a required service. Training in the following areas is covered: activities of daily living; adjustment to home or community living; adjustment to mobility impairment; adjustment to serious impairment; management of personal care needs; the development of skills to deal with service providers and attendants; effective use of adaptive equipment. For participants self-directing services, training may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision or other areas related to self-direction.

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

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	Physical Therapist
Individual	Registered Nurse
Agency	Home Care Agency
Individual	Occupational Therapist
Individual	Social Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify)*:
MCL 333.17801 ... 333.17831

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.17801 ... 333.17831 (Physical Therapist).

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracting OHCDS.

Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
MCL 333.17201 ... 333.17242
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 133.17201 ... 333.17242 (registered nurse).
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
MCL 333.17201 ... MCL 333.17242 (Nursing),MCL 133.17801 ... MCL 333.17831 (Physical Therapy), MCL 1333.18301 ... MCL 333.18311 (Occupational Therapy), MCL 333.18501 ... MCL 333.18518 (Social Work)
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS
Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
MCL 333.18301 ... 333.18311
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18301 ... 333.18311 (Occupational Therapist).
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify):*
MCL 333.18501 ... 333.18518
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18501 ... 333.18518 (social worker).
Verification of Provider Qualifications
Entity Responsible for Verification:
The contracting OHCDS.
Frequency of Verification:
Prior to delivery of service and annually thereafter.

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:

OHCDS Supports Coordinators and Individual Support Brokers

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):

Each OHCDS and direct provider of home-based services must conduct a criminal background review through the Michigan State Police for each paid or volunteer staff person who will be entering participant homes. The OHCDS and direct provider shall conduct the reference and background checks before authorizing the employee to furnish services in a participant's home.

The scope of the investigation is statewide, conducted by the Michigan State Police.

Both OHCDS and MDCH conduct administrative monitoring reviews of providers annually to verify that mandatory criminal background checks have been conducted in compliance with operating standards.

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).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Home For the Aged	
Adult Foster Care Home	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The State of Michigan licenses five types of Adult Foster Care (AFC) homes that are used in the MI Choice Waiver. Capacity limit for Family Homes are 1 - 6; Small Group Homes are 1-12; Medium Group Homes are 7-12; Large Group Homes are 13-20; and Congregate Homes are larger than 21 residents. Michigan is phasing out the licensing of Congregate Homes, but existing homes continue to operate. Homes For The Aged (HFA)are supervised personal care facilities (other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility) that provide room, board, and supervised personal care to 21 or more unrelated, nontransient, individuals 60 years of age or older. An HFA may include a supervised personal care facility for 20 or fewer individuals 60 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home.

A home care character is maintained in these settings supported by the licensing criteria that have been established for this purpose. These criteria for AFC Homes are found at Section 9 of Act No. 380 of the Public Acts of 1965, as amended, and section 10 and 13 of Act No. 218 of the Public Acts of 1979, as amended. Family Home rules are referenced under MCL rules 400.1401 - 400.1442 and 400.2201 - 400.2261; Small and Medium Group Homes are under MCL 400.1401 - 400.1442 and 400.14101 - 14601; Large Group Homes are under MCL 400.15101 - 400.15411; and Congregate Homes are under MCL 400.2101 - 400.2122, 400.2401 - 400.2475, and 400.2501 - 400.2567. HFA's are established under Act No. 368 of 1978 as amended, sections MCL 333.21301 - 333.21335.

These rules address licensee responsibilities to residents' rights, physical environmental specifications and maintenance.

The licensing criteria reflect an attempt to make staying in an AFC much like it would be in a home. The rules address such issues as opportunities for the growth and development of a resident; participation in everyday living activities (including participation in shopping and cooking, as desired); involvement in education, employment; developing social skills; contact with friends and relatives; participation in community based activities; privacy and leisure time; religious education and attendance at religious services; availability of transportation; the right to exercise constitutional rights; the right to send and receive uncensored and unopened mail; reasonable access to telephone usage for private communication; the right to have private communications; participation in activities and community groups at the individual's own discretion; the right to refuse treatment services; the right to relocate to another living situation; the right to be treated with consideration and respect; recognition of personal dignity, individuality; the need for privacy; right to access own room at own discretion; protections from mistreatment; access to health care; opportunity for daily bathing; three regular nutritious meals daily; the right to be as independent as the individual may so choose; right to a clean and sanitary environment; adequate personal living space exclusive of common areas; adequate bathroom and facilities for the number of occupants; standard home-like furnishings; and the right to make own decisions.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home For the Aged

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Counseling	☑
Training	☑
Personal Emergency Response System	☐
Homemaker	☐
Home Delivered Meals	☐
Specialized Medical Equipment and Supplies	☑
Residential Services	☑
Chore Services	☐
Community Living Supports	☐
Environmental Accessibility Adaptations	☐
Adult Day Health	☑
Personal Care	☐
Goods and Services	☑
Fiscal Intermediary	☑
Non-Medical Transportation	☑
Private Duty Nursing	☑
Respite	☑
Nursing Facility Transition Services	☑

Facility Capacity Limit:

100+

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑

Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Foster Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Counseling	☑
Training	☑
Personal Emergency Response System	☐
Homemaker	☐
Home Delivered Meals	☐
Specialized Medical Equipment and Supplies	☑
Residential Services	☑
Chore Services	☐
Community Living Supports	☐
Environmental Accessibility Adaptations	☐
Adult Day Health	☑
Personal Care	☐
Goods and Services	☑
Fiscal Intermediary	☑

Non-Medical Transportation	☑
Private Duty Nursing	☑
Respite	☑
Nursing Facility Transition Services	☑

Facility Capacity Limit:

20

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

Michigan may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his or her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished are included in the plan of care and authorized by the supports coordinator. The supports coordinator periodically evaluates the effectiveness of the relative in rendering the needed services. If after evaluation, the supports coordinator finds the relative fails to meet participant-specified goals and outcomes, or fails to render services as specified in the plan of care, the supports coordinator may rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative failed to render services, payments are not authorized.

The supports coordinator does not authorize respite care to relieve a caregiver already providing waiver services to that participant. Rather, the supports coordinator decreases that caregiver's authorized waiver service hours and assists the participant in finding another caregiver to provide the needed services and supports to the participant. Likewise, the supports coordinator does not authorize waiver funds to pay for respite care provided by the participant's usual caregiver (i.e. a relative is not authorized to provide respite to him or her self).

When a relative is authorized to provide waiver services to a participant, the authorization is based on the participant's medical need for the service, and not the relative's need for a specified level of income.

○ **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:

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:

OHCDSs are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit, or for-profit organizations that provide services meeting established service standards, certifications and/or licensure requirements.

The OHCDS mails service provider application packages to potential service providers as requested. Provider applicants complete and submit agreement and assurance forms to the OHCDS. The OHCDS reviews all applicant requests to determine that providers are qualified to provide requested MI Choice service(s) prior to the provision of services and supports. There are no limits on the number of qualified service providers with which an OHCDS may contract, if all the standards, certifications and/or licensure requirements have been met.

After service provider qualifications are reviewed and verified by the OHCDS, the OHCDS enrolls the provider as a Medicaid provider using a contractual agreement and the Medicaid Provider Enrollment agreement. The Medicaid agency delegates the OHCDS to maintain signed and executed contractual agreements on file.

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:
HCBSS staff conducts a biennial AQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section III of the MICSRP addresses provider qualifications. HCBSS staff compares data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to formulate recommendations for improvement. The QM Collaboration also makes recommendations for improvement.

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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
MDCH requires each OHCDS to provide a list of personnel working with MI Choice participants annually or within 30 days of a change in personnel. HCBSS staff verifies licensure using a State of Michigan database. If the list includes personnel not licensed in the State Of Michigan as either an RN or SW, HCBSS contacts the OHCDS and prohibits the person from working with MI Choice participants.

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):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

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):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
In addition to the initial evaluation, OHCDS staff annually monitors a 10%

sample of enrolled sub-contracted entities to assure that each meets criteria for policies and procedures, record maintenance, etc. If the provider fails to implement acceptable corrective actions, the OHCDS terminates its contract with the provider. OHCDS staff sends each monitoring report to HCBSS staff annually.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**

☐ **Other**
Specify:

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:
In addition to the initial evaluation, OHCDS staff annually monitors a 10% sample of enrolled sub-contracted entities to assure that each meets criteria for policies and procedures, record maintenance, etc. If the provider fails to implement acceptable corrective actions, the OHCDS terminates its contract with the provider. OHCDS staff sends each monitoring report to HCBSS staff annually.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff conducts a biennial AQAR for each OHCDS as specified in item #A-6 above. Section III of the MICSRP addresses provider qualifications. HCBSS staff compares specific and overall data from each OHCDS with aggregated statewide data and uses aggregated data to identify trends and formulate recommendations for improvement. The QM Collaboration may also make recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
In addition to the initial evaluation, OHCDS staff annually monitors a 10% sample of enrolled sub-contracted entities to assure that each meets criteria for policies and procedures, record maintenance, etc. If the provider fails to implement acceptable corrective actions, the OHCDS terminates its contract with the provider. OHCDS staff sends each monitoring report to HCBSS staff annually.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.
MDCH operational criteria require that the POC 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. MDCH monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in POC development. SCs update and revise the POC at least annually or when warranted by changes in the participant's needs. Providers deliver services in accordance with the POC, including the type, scope, amount, duration, and frequency specified in the POC. The OHCDS affords participants choice between waiver services and institutional care; and among waiver services and providers.

Strategies
1. OHCDS conducts monthly supervisory record reviews of POC development and updates to ensure that the POC addresses the participants' assessed needs, including risk management (RM) planning. The OHCDS conducts this review to ensure that SCs include changes noted during participant assessments into the POC. MDCH requires that SCs conduct reassessments formally at least every 180 days, and more frequently whenever the participant experiences a significant status change. When participants experience a significant status change, the SCs may reassess them every 90 days or sooner depending on the nature and severity of the status changes. The SCs must update the POC following an assessment or upon a change in the participants' supports and services. OHCDS supervisory review is one method that validates that the SCs updated the POC with amended supports and services changes as they occur. Supervisory reviews result in written directives to individual SCs requesting correction and update to the POC as needed.

2. OHCDS conduct peer reviews among SCs twice annually per their QMP. This results in written peer feedback recommendations, sharing information resources, and improved care planning.

3. MDCH requires a person centered planning (PCP) process for the development of the POC. MDCH provides training to OHCDS staff, and each OCHDS trains staff and participants. MDCH and the OHCDS maintain training records on attendance by date and total number of attendees, topics, and training evaluations. The OHCDS reviews PCPs monthly and MDCH reviews PCPs on a quarterly basis during implementation. MDCH validates that the OHCDS uses the PCP process according to the PCP guidelines. MDCH and the QMC review evaluations of trainings. MDCH implements corrective actions to the training plan as needed per evaluations.

4. SCs assist participants to identify risks during PCP and assure that the POC includes RM planning. The POC addresses identified participant risks with strategies and plans to reduce or ameliorate risk as approved by participants. SCs monitor RM strategies on an on-going basis and evaluate their effectiveness. The OHCDS submits quarterly reports to MDCH on PCP development, including RM. MDCH clearly describes RM procedures in contract requirements. OHCDS have required RM procedures to follow in agency policies.

5. The OHCDS surveys participants semi-annually to ensure participants receive needed services and supports, successfully implement back up plans, are satisfied with equipment, are satisfied with treatment by workers and other service providers, and have choice and control through the PCP process. OHCDS use the participant surveys as one method to determine that participants actually receive services as planned. OHCDS follow up with participants to correct any problems with service delivery.

6. During the CQAR process, RNRs perform annual on-site POC and case record reviews on a random sample of participants to ensure that the SCs conduct POC development according to MDCH contract requirements, as well as policy, procedures, and review protocols. The CQAR process ensures that the OHCDS authorizes and approves services in the POC. The home visits confirm that providers furnish services according to the POC and participant preferences. Additionally, the OHDCS also confirms service delivery by monitoring direct service providers according to the required MDCH OHCDS monitoring plan, which is Attachment J of the MDCH contract.

As a function of supports coordination, SCs validate that providers render services as planned during initial implementation and on a monthly basis with participants. MDCH requires OHCDS staff to follow up with participants within two weeks of arranging a new service or support to ensure and document that providers implemented the service as planned. MDCH also requires OHCDS staff to contact participants at least monthly to ensure delivery of services as planned and participant satisfaction with services. RNRs review these activities as part of the CQAR process. This includes verification (evidence) that the OHCDS honored the participants' choices of service setting (Freedom of Choice form signed), the type of services rendered, and the service providers. RNRs analyze findings to ensure that participants receive services and support consistent with identified needs and preferences. RNRs forward CQAR results and findings to HCBSS staff

who then compile the data into written corrective action and quality indicator outcome reports. The OHCDS implements corrective action plans and training as necessary to correct deficiencies. MDCH, OHCDS, and QMC members review summary reports. MDCH provides corrective interventions and follow-up with individual OHCDS as needed.

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.
HCBSS staff review Hearing and Appeal Decisions related to service plans on a continual basis. MDCH analyzes hearing decisions to determine when it needs to implement corrective action or provide technical assistance. HCBSS staff issue technical assistance advisories to all OHCDS as needed to correct or clarify policy interpretations, non-compliant procedures used by one or more OHCDS, procedures to meet requirements, or to issue cease directives for non-compliant procedures.

MDCH and the OHCDS maintain complaint logs that describe the nature of the complaint and resulting interventions, remediation, and follow-up. MDCH analyzes complaints received by the department on a monthly basis and reviews the OHCDS logs during the biennial AQAR. Remediation for complaints include ad-hoc and written technical assistance, policy clarifications, identification of non-compliant procedures used by one or more OHCDS, clarification of correct procedures, and cease directives for non-compliant procedures. MDCH also uses training as a remediation technique to bring OHCDS' with deficiencies into compliance. MDCH and each OHCDS maintain written training records. MDCH and the QMC review a summary of training reports and MDCH submits this summary annually to CMS in the 372 Report.

Each OHCDS holds quarterly participant focus groups, or participant and OHCDS staff quality management committee meetings to allow participants a venue to provide feedback on PCP and SD implementation and to review QM activities. The OHCDS maintains written agendas, minutes of meetings, and attendance logs by date. Currently, seven local advisory committees are active along with the state QM Collaboration.

OHCDS finance staff and SCs use monthly Variance Reports that compare planned and actual expenditures to confirm delivery of service before submitting Medicaid claims. The variance report compares the amount, duration, type of service, and total expenditure in the approved POC to the submitted provider bills so that the SCs can confirm whether providers render services as planned. The report provides detail on the amount of under or over billing so that the SCs can investigate discrepancies. SCs enter comment notes on the computerized care plan whenever participants temporarily enter a hospital, visit relatives, or otherwise suspend services. The variance report includes these comments so that the OHCDS and SCs can review them during the monthly billing cycle.
Other Quality Improvement projects implemented in MDCH and OHCDS QM plans include: decrease provider no show rates, decrease average number of days between participant enrollment and first day of service delivery, and decrease the number of participants enrolled for longer than 30 days who received no service. Each OHCDS reports performance indicators to MDCH annually. MDCH analyzes them and distributes the reports and analysis publicly at the QMC and Waiver Directors' meetings.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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:

Registered Nurse and licensed Social Worker

☐ **Social Worker.**

Specify qualifications:

☑ **Other**

Specify the individuals and their qualifications:

An independent supports broker – possession of a high school diploma, at least one year experience with the elderly or disabled, works under the direction and oversight of a supports coordinator. An independent supports broker works under the control, employment and direction of the participant in self-determined arrangements and may perform some of the functions otherwise delegated to the supports coordinator.

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:*

An OHCDS supports coordinator and the participant are responsible for service plan development, depending on participant choice. An independent supports broker may also have a role in the service plan development, based on the participant's choice. The OHCDS has no conflict in its roles in service plan development and waiver service provision. Participants are ensured free choice of providers by being able to choose any qualified provider to furnish services as authorized in the service plan. A supports coordinator or independent supports

broker assists, supports, and provides training to the participant in recruiting, hiring, and training providers to perform tasks based on the participant's needs, preferences and goals. Participants are given information on all providers and informed if there is only one provider of the required service. Participants have freedom of choice to select a supports coordinator, an independent supports broker and a fiscal intermediary.

The system does include safeguards, such as independent plan facilitation, independent supports brokerage and involvement of a fiscal intermediary to provide participants with a greater level of support and choice. In addition, use of a fiscal intermediary ensures that a participant's individual budget is portable and that the function of selecting and managing providers of services and supports is separated from the function of service plan development.

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.

(a) Supports and information made available to the participant: The participant and their allies and their family or legal representatives are provided with written information about the right to participate in the person-centered planning process and the self determination option at assessment or following enrollment into the waiver, at reassessment, or upon request. The supports coordinator provides additional information and support and directly addresses issues and concerns that the participant may have either over the phone or in a face-to-face meeting. Continued assistance from a supports coordinator is available throughout the service planning process.

(b) Participant's authority to determine who is included: The participant has authority to determine who will be involved in the person-centered planning process. The participant may choose from among his or her allies including family members, friends, community advocates, service providers and independent advocates. The process encourages natural supports. A pre-planning conference occurs prior to a person-centered planning meeting. In this pre-planning conference, the participant and his or her supports coordinator determine who the participant wants to involve in his or her planning process, the goals and dreams that will be addressed, topics that will be discussed at the meeting and topics that won't be addressed. The time and location for the planning meeting is also determined at the pre-planning session.

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) Who develops the plan, who participates in the process, and the timing of the plan:
The initial individual plan of service is developed after the eligibility determination has been made and an assessment has been conducted by the waiver agent supports coordinator. The plan is based on the expressed needs and desires of the participant. An interim plan of service may be developed by the OHCDS supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the person is not ready to fully participate in person centered planning. Interim service plans are authorized for no more than 30 days without a follow-up re-assessment to determine the participant's status. The first person-centered planning meeting is

conducted when a participant is not in crisis and at a time of the participant's choice. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with identifying and planning for his or her dreams, goals and desires. A newly enrolled participant directs the planning process as soon as reasonable after eligibility determination and assessment. The participant chooses the people who will be involved in the planning process as well as a time and location that meets the needs of all individuals involved in the process. A pre-planning session occurs prior to the first person-centered planning meeting. During pre-planning, the participant chooses dreams, goals and any topics to be discussed, who to invite, who will facilitate and who will record the meeting. The participant and selected allies design the agenda for the person-centered planning meeting. The individual plan of service is updated upon the request of the participant, when the need for services or participant circumstances changes or at least annually.

(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: The OHCDS supports coordinator conducts a standardized assessment or reassessment evaluating health status information, functional status, the participant's strengths, capacities, needs, preferences, risk factors and goals. Health care needs are discussed and addressed in the individual plan of service as approved by the participant. Information is provided directly from the participant as well as from the participant's network of support. A comprehensive assessment system based in the Minimum Data Set for Home Care (MDS-HC) with a person-centered planning focus is used to evaluate participant needs, preferences, and goals and assists the participant in making choices regarding the types of services needed and preferred.

(c) How the participant is informed of the services that are available under the waiver: The participant is informed of services available by the OHCDS supports coordinator. This occurs through direct communication with the supports coordinator as well as written information provided to the participant regarding waiver services and other available community services and supports. The participant is offered information on all possible service providers. The individual plan of service includes both authorized waiver services as well as other services required by the participants to meet their individualized goals. How the participant chooses to receive services is specified and written into the service plan. An independent supports broker may be used to access the identified needed services, locate providers and ensure implementation of services.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences: Michigan has developed "Person Centered Planning for Community-Based Long Term Care, A Guideline for Policy Development" that is used in the MI Choice Waiver program. This document has been revised from guidelines used in the MDCH mental health system to meet the needs of the elderly and disabled population served in the MI Choice Waiver. They are included as a FY 2008 attachment to the OHCDS contracts. The principles and values of person centered planning remain the same. The individual plan of service clearly identifies the participant's needs, goals and preferences with the services specified to meet them. Where possible, providers of services are identified. The unique requirements and skills needed to support, assist and train the participant to manage their services and supports are incorporated into the plan.

(e) How waiver and other services are coordinated and by whom: The individual plan of service clearly identifies the types of services needed from both paid and non-paid providers of services and supports. The amount (units), frequency, and duration of each waiver service to be provided is also included in the plan. The service plan defines the extent the participant chooses to direct services and identifies which support services are self-directed. When a participant chooses to participate in self-determination, information, support and training are provided by the OHCDS supports coordinator and others identified in the service plan. When a participant chooses not to participate in self determination, the OHCDS supports coordinator ensures that services and supports are implemented as planned. The participant chooses the services that best meet their needs and decides whether to self-direct each service with supports or rely on a supports coordinator to ensure that the service is implemented. Supports coordinators oversee the coordination of state plan and waiver services included in the service plans. This oversight ensures that waiver services in the service plans are not duplicative of similar state plan services.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan: The providers of services, as well as the frequency, scope and duration of services are included in the written individual plan of service. The assignment of responsibilities to implement the plan are determined through person centered planning and may be delegated to the participant, a supports coordinator, an independent supports broker, and/or relevant others designated by the participant. The waiver agent supports coordinator and the participant, to the extent they choose, are responsible for monitoring the plan. This occurs through periodic case reviews, monthly contacts, participant request, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the participant. OHCDS are required to contact participants monthly. Currently face-to-face reassessments

occur on a quarterly basis.

(g)How and when the plan is updated: The plan is updated at least annually, or when the needs or circumstances of the participant change, or when the participant requests that the plan be updated.

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.

Potential risks to the participant, which are identified during the assessment and reassessments by the OHCDS supports coordinator are fully discussed with the participant and their allies as soon as they have been identified. The planning process specifies risks and methods of monitoring their potential impact in conjunction with the participant. Some participants may be considered to be in at risk situations that are created by the absence of scheduled services, placing the participant in a vulnerable state and compromising their health and welfare. Other risk situations include (but are not limited to) a structurally damaged or unsanitary environment or non-compliance with medical care. Some participant risks are automatically triggered in the MDS-HC MI Choice Assessment System Caps and Triggers Reports. Strategies to mitigate risks are fully discussed with the participant and his or her allies, the family, and relevant others by the supports coordinator during person centered planning. Participant-approved risk strategies are documented and written into the service plan. Participants may be required to acknowledge situations in which their choices pose risks for their health and welfare. The OHCDS is not obligated to authorize services believed to be harmful to the participant. Negotiations of such issues are initiated in the person centered planning process. Supports coordinators assess participant risk and inform the participants of their identified potential risk(s) to make informed choices with regard to these risks. Service providers are informed of a participant's risk status when services are ordered in the traditional waiver program and by supports coordinators and participants when the participant is participating in self- determination options. Agency providers, including OHCDS, are required to have contingency plans in place in the event of emergencies that pose a serious threat to the participant's health and welfare (i.e., inclement weather, natural disasters, and unavailable personal caregiver).

Each service plan describes back-up plans that are to be implemented when selected service providers are unable to furnish services as planned. This may involve the following: developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the OHCDS supports coordinator when planned services are not available. Additionally, emergency plans are developed for each participant that clearly describe a course of action when an emergency situation occurs with the participant. Plans for emergencies are discussed and incorporated into the individual plan of service as a result of the person centered planning process.

MDCH staff review a random sample of back-up and emergency plans during the RN case record and care plan monitoring reviews. This is to assure the plans meet participant needs and that there is proper documentation for emergency and back up planning, as well as risk management procedures.

In addition, the MI Choice Quality Improvement Strategy requires OHCDS to monitor and track situations in which back-up plans are activated, as well as when they are successful or not, in an effort to make improvements in the way back-up plans are developed with participants.

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.

The OHCDS Supports Coordinator provides participants with information and training on selecting qualified providers of services. In addition, information can be shared by the participant's support circle of trusted allies.

Service providers must meet the minimum standards established by MDCH for service providers for each service. Participants choose among qualified providers or employ providers that they identify who meet the minimum standards. Participants may receive assistance as needed to identify and select qualified providers at any time from OHCDS supports coordinators or relevant others. A brochure on how to find and hire workers has been developed by MDCH and is distributed to participants via the OHCDS.

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):

MDCH contracts with 20 local OHCDS. OHCDS-qualified supports coordinators are responsible for: conducting, securing and verifying Level of Care (LOC) eligibility, conducting participant assessments and reassessments, initiating interim service planning and the person-centered planning process with participants, and specifying approval of these plans of service. On an annual basis, MDCH/Medical Services Administration (MSA) staff and their contracted auditors review and evaluate a random sample of participant care plans and case records for plan approval and service authorization concurrence. The RN care plan and case record reviews are conducted on-site at the 20 waiver agent locations. At each site, a random sample of 5% of participants, with a maximum of 20 and a minimum of 10 cases, that were open during the review period are evaluated and analyzed against requirements and operating standards to perform this concurrence.

An additional sampling component is part of the care plan approval and authorization review protocols for cases involving individual budgeting. This has been included to assure compliance with policies and guidelines associated with self-determination (SD) in long term care. MDCH developed these review protocols by working closely with the four pioneer self determination sites in Michigan and the OHCDS contractors with the RWJF Cash & Counseling grant to design the individual budget and plan review arrangements (care plan approval and authorizations). Every self-determination budget is reviewed by at least three entities: the waiver agents, the fiscal intermediaries and MDCH. Fiscal intermediaries submit monthly reports for each participant directed budget.

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:

Michigan uses a case status classification system to determine the reassessment and service plan review and update schedule for program participants. Supports coordinators designate a case status for each participant at the time of care plan development or reassessment using professional judgment in determining participant needs.

Participants classified with Active status are those cases with the most difficult, unstable, or complex needs that require more intensive involvement. Supports coordinators classify cases as active when it is determined that the participant requires a reassessment every 90 days or more frequently when necessary.

Participants classified with Maintenance status are more physically stable and less complex than active cases. Monitoring is required less frequently. Supports coordinators may designate maintenance case status

when the participant's situation is currently stable. The participant's level of frailty, risk, or illness determines that the participant requires a reassessment only every 180 days or more frequently when necessary.

Supports coordinators may change the case status classification of participants as indicated upon reassessment. Regardless of a defined case status classification, participants may refuse reassessment. The supports coordinators must note this refusal in the case record. However, to maintain program eligibility, the supports coordinator must assess all program participants at least every 180 days.

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:

The OHCDS.

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.

a) MDCH contracts with OHCDS to monitor the implementation of the service plans and participant health and welfare. MDCH then conducts retrospective monitoring reviews to ensure that this is being done according to plan.

b) Within two weeks of service implementation, OHCDS are required to contact each participant to ensure that services are implemented as planned. When services are not implemented as planned, OHCDS implement corrective actions to resolve problems and issues. OHCDS are also required to contact each participant in person or by telephone at least monthly (more frequently as needed) to ensure that services are continuing to be delivered as planned, that the participant is satisfied with service delivery and to determine if new needs have emerged since the previous contact. Participants and their families are provided with telephone numbers to contact OHCDS and support coordinators at any time when new needs emerge that require support coordination interventions and additional services support.

c) In-person reassessments are conducted upon participant request, annually or whenever the participant experiences a status change.

The individual plan of service clearly states how the participant accesses services, documents that the participant exercises free choice of providers and describes the use of non-waiver services. Entities responsible for implementation and monitoring are the OHCDS, independent support broker where applicable, the participant to the extent chosen by them and their support network as appropriate. Monitoring and follow-up methods of the individual plan of service include monitoring service budget utilization, time sheets of providers and authorization for services to ensure that services designated in the individual plan of services have been accessed and provided in accordance with the plan. Support coordinators make contact with participants at least monthly by telephone or through other methods determined through the planning process. The individual plan of service is reviewed at least quarterly by the OHCDS in conjunction with the participant. The OHCDS supports coordinator evaluates the effectiveness of back-up plans and the health and welfare of the participant at reassessment and more frequently as deemed necessary by participant request, change in participant status or participant conditions.

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:*

An OHCDS supports coordinator or the independent supports broker, along with the participant, are responsible for monitoring service plan implementation depending on participant choice. OHCDS do provide direct waiver services. However, these services are limited to those for which self-determination is not available and for which there are no other providers available. Therefore, the OHCDS has no conflict in its role monitoring service plan implementation and participant health and welfare. Participants may choose to monitor their own service plan implementation and alert/contact their supports coordinator or independent supports broker when they need assistance. A supports coordinator assists, supports and provides training to the participant in evaluating provider performance of tasks based on the participant's needs, preferences and goals as stipulated in the individual plan of service. Participants are encouraged to monitor their own service plan implementation, but are also provided with a supports coordinator or an independent supports broker and fiscal intermediary supports as safeguards in doing so. In addition, use of a fiscal intermediary ensures that a participant's individual budget is portable and that the function of selecting and managing providers of services and supports is separated from the function of service plan implementation.

OHCDS are responsible for on-going monitoring of service plan implementation and of direct providers of services in the traditional program. OHCDS conduct a formal administrative review annually according to the MDCH monitoring plan of direct service providers. MDCH reviews OHCDS monitoring activities and reports during its review of OHCDS to ensure that the monitoring activities are being conducted, that service issues and problems are being resolved appropriately and timely and to identify any patterns of irregularities or concerns regarding a specific provider. Additionally, OHCDS and MDCH maintain a written complaint log of all participant and non-participant complaints received regarding the waiver program. These logs document the complaint by date, actions taken to resolve each complaint and date complaint is resolved. All OHCDS complaint logs are reviewed by MDCH during on-site monitoring reviews.

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:
HCBSS staff oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section II.A of the MICSRP addresses service planning. HCBSS staff compares specific and overall data from each OHCDS with aggregated statewide data.

HCBSS staff uses aggregated data to identify trends and formulate recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff conducts a biennial AQAR, and oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section II.A of the MICSRP addresses POC development. HCBSS staff compares data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to formulate recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff conducts a biennial AQAR, and oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section II.B of the MICSRP addresses POC updates and revisions. HCBSS staff compares data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to formulate recommendations for improvement.

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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section II.B of the MICSRP addresses service delivery. HCBSS staff compares specific and overall data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to identify trends and formulate recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HCBSS staff conducts a biennial AQAR, and oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Sections I, II, IV, and V of the MICSRP address participant choice. HCBSS staff compares data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to formulate recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

In addition to the methods specified above, the MDCH Quality Management Plan also includes an annual examination of twenty Quality Indicators. Each OHCDS can run a Quality Indicators report as needed to determine its performance compared to aggregated state data. The Quality Indicator report analyzes specific assessment data that supports coordinators can use for service planning to assure each participant's POC includes interventions for need identified on the assessment. The OHDCS can examine records for participants scoring into a specific quality indicator to assure that the participant's POC contains interventions for the indicator. Please refer to Appendix H for additional information on the Quality Improvement elements for the MI Choice Waiver.

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 HCBSS staff compiles reports for each AQAR and CQAR upon completion of the review and sends the completed reports to the OHCDS. When the AQAR and CQAR reports indicate a need for corrective action, the OHCDS has 30 days to respond with a corrective action plan. HCBSS staff reviews the corrective action plan, including any revised policies and procedures, training materials, information from staff meetings, or case record documentation supporting the corrective action plan and either approve the plan or work with

OHCDS staff to amend the plan to meet MDCH requirements. Once approved, HCBSS staff sends the OHCDS an approval letter. HCBSS staff monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. HCBSS staff retains all documents generated from this process on file.
The OHCDS periodically examines Quality Indicator reports. For each quality indicator, OHCDS staff obtains a list of participants who scored into that indicator. OHCDS staff can then drill down to determine the reason that each participant scored into the specific indicator and whether or not supports coordinators included appropriate interventions for the identified issue on the POC. OHCDS staff initiates corrective actions as needed after the thorough examination of the data. When the OHCDS scores higher than MDCH set benchmarks on a specific Quality Indicator, its Quality Management Plan must include methods the OHCDS will take to decrease the number of participants scoring into the quality indicator. HCBSS staff examines each OHCDS's quality management plan and recommends improvements when staff determines the OHCDS methods are inadequate to make improvements.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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.

Through its Robert Wood Johnson Cash and Counseling grant, the Michigan Department of Community Health (MDCH) introduced the opportunity for participant direction into the MI Choice waiver in four pioneer sites with its 2006 waiver amendment. This option, called Self-Determination in Long-Term Care, provides participants with the option to direct and control their own waiver services through an individual budget. Participants are supported in directing the use of the funds comprising their respective individual budgets to hire personal care assistants, homemaker and chore service providers, community living support assistants, private duty nurses, and to pay for environmental accessibility adaptations, non-medical transportation, and respite inside the home or in the home of another. Supports coordinators work with participants to develop and revise individual budgets. Participants have the option of appointing a representative to assist them with directing their services and supports and obtaining additional assistance through participation in a peer support group. The opportunity for participant self-direction will be available to all waiver participants upon renewal of this waiver.

Each OHCDS directly provide supports coordination and hold contracts with providers of services that conform to federal regulations. As individuals exercise employer authority, each provider furnishing services is required to execute a Medicaid Provider Agreement with the waiver agent that conforms to the requirements of 42 CFR 431.107. The Self-Determination in Long Term Care program has four pioneer sites that began implementation of participant direction with approval of the 2006 waiver amendment to include participant direction as an option. These sites are the Tri-County Office on Aging, Burnham Brook, UPCAP Services and the Detroit Area Agency on Aging. The state is currently providing training to all other OHCDS so that particpant direction can be expanded to all individuals receiving services and supports from the MI Choice Waiver effective October 1, 2007. Guidance for self direction is provided through the MDCH's contracts with each MI Choice OHCDS, training and technical assitance, technical advisories and prototype documents, and the Self-Determination Leadership Implementation Seminars.

(a) The nature of the opportunities afforded to participants:
Waiver participants have opportunities for both employer and budget authority. Participants may elect either budget authority or both authorities, and can direct a single service or all of their services for which participant direction is an option. The participant may also allocate savings from services and supports in the plan to purchase appropriate goods and services. The participant may direct the budget and directly contract with chosen providers. The individual budget is transferred to a fiscal intermediary (this is the Michigan term for an agency that provides financial management services), which administers the funds and makes payment upon participant authorization.

There are two options for participants choosing to directly employ workers: the Choice Voucher System and Agency with Choice. Through the first option, the Choice Voucher System, the participant 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 directly recruits, hires and manages employees. Detailed guidance to OHCDS entities is provided in the Choice Voucher System Technical Advisory. In the Agency with Choice model, participants may contract with an Agency with Choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human

resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to OHCDS entities is provided in the Agency with Choice Technical Advisory. A participant may select one or both options. For example, a participant may want to use the Choice Voucher System to directly employ a good friend to provide personal care during the week and Agency with Choice to provide personal care on the weekends.

(b) How participants may take advantage of these opportunities:
Information on the Self-Determination in Long Term Care program is provided to all participants who enroll or are currently enrolled in the MI Choice Waiver. Participants interested in arrangements that support self-determination start the process by informing their supports coordinator of their interest. The participants are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the person centered planning process. A service plan is developed through this process with the participant, supports coordinator, and allies chosen by the participant. The plan includes the MI Choice waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the plan and must be sufficient to implement the plan. The participant selects service providers and has the ability to act as the employer of personal assistants. In Michigan, OHCDS provide many options for participants to obtain assistance and support in implementing their arrangements.

(c) The entities that support individuals who direct their services and the supports that they provide:
The OHCDS are the primary entities that support individuals who direct their own services. The supports coordination function is provided by supports coordinators employed by the OHCDS. Supports coordinators are responsible for providing support to individuals in arrangements that support self-determination by working with them through the person centered planning process to develop a service plan and an individual budget. The supports coordinators are responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and arrangements. The supports coordinator is responsible for assuring that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. The waiver provides many options for Independent Advocacy, through involvement of a network of participant allies and independent supports brokerage, which are described in Section E-1k below.

Through its contract with MDCH, each OHCDS is required to offer information and education on participant direction to participants. Each OHCDS also offers support to participants in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each OHCDS is required to contract with fiscal intermediaries to provide financial management services. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements.
The fiscal intermediary has four basic areas of performance:

1) Function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements;

2) Ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services;

3) Facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to participant and agency; and

4) Offer supportive services to enable participants to self-determine and direct the services and supports they need.

(d) Other relevant information about the waiver's approach to participant direction:
The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct certain waiver services. Contract language with OHCDS was used to introduce this option first in the four pioneer sites. The pioneer sites are assisting in the clarification and refinment of the final guidance that is provided to all OHCDS.

Michigan supports a variety of methods for participant direction so that arrangements can be specifically tailored to meet the participant's needs and wants. Participants may use an independent supports broker to assist with the development and implementation of the service plan and budget. Independent supports brokers, who are freely chosen by participants, work with participants in conjunction with the supports coordinator.

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

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 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:

General information about arrangements that support self-determination is provided to waiver participants by each local OHCDS with a multi-layered approach that meets each participant's level of need for information. Every waiver participant receives an information brochure with follow-up from his or her supports coordinator. A prototype brochure—"Everything You Need To Know About Self-Determination in Long-Term Care"—has been developed for and adapted by the pioneer sites.

When a person receiving waiver services expresses interest in participating in Self-Determination in Long-Term Care, the OHCDS supports coordinator provides ongoing information and assistance to the participant on the benefits of arrangements that support self-determination (participant direction), participant responsibilities, and potential liabilities.

Specific options and concerns regarding the benefits of self-determination, participant responsibilities and potential liabilities are addressed in the person centered planning process. Each participant develops an individual plan of service through the person centered planning process, which involves his or her allies and support coordinator from the OHCDS. The individual plan of service developed through this process addresses potential liabilities and ensures that concerns and issues are planned for and resolved.

The Michigan Department of Community Health provides support, training and technical guidance to the OHCDS on developing local capacity and implementing options for participant direction.

Comprehensive training on person-centered planning was offered to all OHCDS in three different sites in June 2007 with similar sessions planned for the future. Over 300 supports coordinators and other OHCDS staff have participated in this training to date. In addition, follow-up statewide telephone conference calls are planned for the months following the trainings. Self-determination coordinators from the pioneer sites are assisting in the trainings and providing on-going assistance and support to neighboring OHCDS.

MDCH also developed technical advisories and guidelines on all aspects of self-determination to provide resources both to OHCDS staff and to waiver participants. These materials include:
• The Choice Voucher System Technical Advisory provides guidance to local OHCDS in constructing and managing options for employer authority where the participant (or their representative) is the sole employer of personal assistance providers. This document includes both technical assistance and prototype agreements. It has been used by the pioneer sites for nearly a year and was adapted from a document that has been successfully used in the Michigan mental health system since 2000.
• Tools for the participants, including a Self-Assessment Tool, enables them to assess their individual comfort level and/or need for specific supports in order to direct their own care; a FAQ (Frequently Asked Questions) which provides clear and succinct answers to the most commonly asked questions; and a one page description of the self-determination option.
• "Person-Centered Planning for Community-Based Long Term Care," developed by MDCH staff in collaboration with a workgroup of supports coordinators, participants, and family members (currently in the final public comment period).
• The Risk Management in Self-Determination Guideline, developed by MDCH in collaboration with the Quality Management Collaborative, is currently under review by Collaborative members.
• A draft Technical Advisory on Agency with Choice, which offers another option for participants to select and manage support workers, is currently being reviewed by the pioneer sites.
• A Fiscal Intermediary Readiness Review was developed and used by the pioneer sites to evaluate fiscal intermediaries and select qualified providers for fiscal intermediary services.
• Draft booklets on person-centered planning, self-determination, and hiring personal assistants targeted toward participants in the Self-Determination in Long-Care program.
• A Self-Determination Policy and Practice Guideline currently is being adapted from a similar guideline successfully implemented in the Michigan mental health system and an Operations Manual is being put together that includes all prototype documents developed to date as well as guidance on their use.

• An additional Department-level document will provide overall guidance for participants who are interested in pursuing arrangements that support self-determination in the MI Choice Waiver Program. Michigan is also finalizing a technical guidance publication preliminarily titled, "Developing Individual Budgets in the MI Choice Waiver Program."

MDCH develops all of its materials with assistance of and review by workgroups that include consumers and their allies, advocates, and representatives from OHCDS.

(b)The entity or entities responsible for furnishing this information:

The OHCDS are responsible for disseminating this information to participants, and primarily the supports coordinators carry out this function. In addition, the MDCH program staff provides information and training to provider agencies, advocates and participants on new materials and self-determination materials.

(c) How and when this information is provided on a timely basis:

This information is provided throughout the participant's involvement with the OHCDS. It starts from the time that the participant approaches the OHCDS for services and is provided with information regarding options for participant direction. Participants are to be provided with information about the principles of self-determination and the possibilities, models and arrangements involved. The person centered planning 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. Self-determination arrangements begin when the OHCDS and the participant reach agreement on a service plan, the funding authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each participant (or his or her legal representative) who chooses to direct his or her services and supports signs a Self-Determination Agreement with the OHCDS 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:

Informal supports, such as non-legal representatives freely chosen by adult participants, can be an important resource for the participant. These individuals can include agents designated under a power of attorney or other identified persons participating in the person centered-planning process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the participant. Moreover, the waiver service definition of the Fiscal Intermediary includes the following safeguard: Fiscal Intermediary Services may not be authorized for use by a participant's representative where that representative is not conducting tasks in ways that fit the participant's preferences and/or do not promote achievement of the goals contained in the person's plan of services so as to promote independence and inclusive community for the participant or when they are acting in a manner that is in conflict with the interests of a participant." In the event the representative is working

counter to the participant's interests, the supports coordinator is authorized to address the issue and work with the participant to find an appropriate resolution.

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
Homemaker	☑	☑
Residential Services	☑	☑
Chore Services	☑	☑
Community Living Supports	☑	☑
Environmental Accessibility Adaptations	☑	☑
Personal Care	☑	☑
Goods and Services	☑	☑
Fiscal Intermediary	☑	☑
Non-Medical Transportation	☑	☑
Private Duty Nursing	☑	☑
Respite	☑	☑

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 Services

○ **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:

N/A

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

N/A

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:

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.

N/A

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:

☐ **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
Counseling	☐
Training	☐
Personal Emergency Response System	☐
Homemaker	☐
Home Delivered Meals	☐
Specialized Medical Equipment and Supplies	☐
Residential Services	☐
Chore Services	☐
Community Living Supports	☐
Environmental Accessibility Adaptations	☐
Adult Day Health	☐
Personal Care	☐
Goods and Services	☐
Fiscal Intermediary	☐
Non-Medical Transportation	☐

Private Duty Nursing	☐
Respite	☐
Nursing Facility Transition Services	☐

☑ **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:

a) OHCDS employ supports coordinators who carry out the OHCDS's responsibility to work with participants through the person-centered planning process. Supports coordinators work with participants to develop a service plan and an individual budget, to obtain authorization of the budget and the plan, and to monitor the plan, budget and arrangements made as part of the plan. The supports coordinators make sure that participants get the services to which they are entitled and the arrangements are implemented smoothly.

The participant can also obtain an independent supports broker to assist him or her with arranging services and supports, and implementing the arrangements. The independent supports broker works under the guidance of the supports coordinator to assist the participant in developing and implementing the individual plan.

(b) OHCDS is funded to provide supports coordination for each enrolled participant. Similarly, independent supports brokers may be paid from administrative funding.

(c) A variety of supports are furnished for each participant. They are described in (a) above and in E-1(a)-(c).

(d) The entity that furnishes I&A is the OHCDS Supports Coordination staff. I&A is furnished as part of the Person Centered Planning process to determine the needs and strengths of the individual. I&A is provided based those identified needs as part of initial assessment, reassessment and any other time the individual requests or their needs change. Secondarily, I&A could be provided by Fiscal Intermediaries and the allies participating in the Person Centered Planning process. I&A is assessed as part of the case audit process and evaluating participant satisfaction surveys for effectiveness.

(e) MDCH assesses the performance of OHCDS on an annual basis using a survey audit and a reporting process.

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 variety of options for independent advocacy are available in the Self-Determination in Long Term Care Program. These options include: utilizing a network of allies in the person centered planning process, and retaining an independent supports broker for assistance throughout the planning and implementing the service plan and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what works best for him/her, are consistent with his/her needs, and reflect the individual's circumstances. The independent supports broker may assist the participant to explore the

availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports. Supports brokerage services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting /hiring/managing workers, effective communication and problem solving. When a participant uses an independent supports broker, the supports coordinator has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the role of the supports coordinator in authorizing the individual plan and individual budget on behalf of the OHCDS cannot be delegated to an individual advocate.

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 has the freedom at any time to modify or terminate his or her arrangements that support self-determination. The most effective method for making changes is the person centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of an arrangement. The decision of a participant to terminate participant direction does not alter the services and supports identified in the individual plan of service. In that event, the OHCDS has an obligation to assume responsibility for assuring the provision of those services through its network of contracted provider agencies.

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 may involuntarily terminate participant direction by a person when the health and welfare of the participant is in jeopardy or other serious problems are resulting from the participant's failure in directing services and supports. Prior to the OHCDS terminating an agreement, and unless it is not feasible, the OHCDS informs the participant in writing of the issues that have led to the decision to consider altering or discontinuing the arrangement, and provides an opportunity for problem resolution. Typically, the person centered planning process is 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, offered by the MI Choice OHCDS, is available to address and resolve the issues. The decision of the OHCDS to terminate participant direction does not alter the services and supports identified in the individual plan of service. In that event, the OHCDS has an obligation to take over responsibility for providing those services through its network of contracted provider agencies.

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

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		97
Year 2		127
Year 3		157
Year 4		187
Year 5		217

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:

A technical advisory on Agency with Choice has been developed. The technical requirements include criteria for Agencies with Choice that the waiver agents can use in procuring agencies. OHCDS designate Agencies with Choice and make information on their availability known to participants in writing.

☑ **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:

The fiscal intermediary is responsible for conducting criminal background checks for directly employed

personal assistance providers. The cost is built into their monthly fee.

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **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:*

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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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

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.

The individual budget is based on the individual plan of service developed through the person centered planning process. The budget is created by the participant, the supports coordinator and the independent supports broker, if one is used. Funding must be sufficient to purchase the services and supports identified in that plan.

A simple methodology using reliable cost estimating information is used to develop the budget. Each budget is the sum of the units of services multiplied by the time period covered, multiplied by the rate for the service as authorized by the OHCDS. Due to the variations in economic conditions in this geographically diverse state, the state does not set a uniform rate for each service. This formula allows each participant and OHCDS to negotiate rates for providers. Typically, when an existing service plan is transitioned to a participant-directed set of service arrangements, the overall budget is not more than the costs of delivering the services under the previous provider-driven set of service arrangements.

An OHCDS may use a pre-determined amount based on the local usual and customary waiver costs for the identified services as a starting point for budget development. This amount is based on historic utilization of funds by that participant. If the participant is new to the system, then the pre-determined amount is based upon the average cost of services for individuals who have comparable needs and circumstances in the OHCDS's service system. Where rates for services are negotiated, the rates must be sufficient for the participant to access a sufficient array of qualified providers. If rates are determined by the participant to be insufficient, the OHCDS reviews the budget with the participant using a person centered planning process.

On behalf of the OHCDS, the supports coordinator authorizes the funds in an individual budget. The supports coordinator must share the cost estimating information with the participant and his or her allies. The target may be exceeded for any individual, but the supports coordinator typically obtains approval from a higher level of supervision within the OHCDS for those higher increments of cost. The OHCDS is responsible for monitoring the implementation of the budget and making adjustments as necessary to ensure that the budget is sufficient to accomplish the plan and maintain the health and welfare of the participant. To this end, the fiscal intermediary provides monthly reports on budget utilization to the participant and the OHCDS. The OHCDS supports coordinator is expected to review the status of each assigned participant's individual monthly budget utilization report and confers with the participant as necessary to support success with implementing the budget and obtaining needed services. An independent supports broker may share this task as determined during the planning process and outlined in the service plan.

Budget development occurs during the person centered planning process and is intended to involve the participant's chosen family members and allies. Planning for services and supports precedes the development of the individual budget so that needs and preferences can be accounted for in plan development without arbitrarily restricting options and preferences due to cost considerations. An individual budget is not authorized until both the participant and the OHCDS have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized individual budget, he or she may reconvene the person centered planning process. If the person centered planning process is not acceptable, the participant may utilize the internal grievance procedure of the OHCDS or file for a Medicaid Fair Hearing.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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.

Materials provided by the OHCDS include written information on the development of the individual budget ("Everything You Need to Know About Self-Determination" includes a selection on individual budgets). During the planning process, a participant is provided clear information and an explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the participant during individual budget implementation.

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the service plan, using the person centered planning process. If a participant has an existing service plan that meets his or her needs, an individual budget to implement the existing plan can be developed through the person-centered planning process. Budget authorization is contingent upon the participant and the OHCDS reaching agreement on the amount of the budget and on the methods to be applied by the participant to implement the service plan and the individual budget. The budget is provided to the participant in written form, as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the participant and the OHCDS. The participant's plan and individual budget is also attached to the agreement.

The participant's supports coordinator provides assistance to the participant in understanding the budget and how to utilize it. In situations where the participant has an independent supports broker, the broker assists the participant in understanding and applying the budget. The participant may seek an adjustment to the individual budget by requesting this from their supports coordinator. The supports coordinator assists the individual in convening a meeting that includes the participant's chosen family members and allies, and assures facilitation of a person centered planning process to review and reconsider the budget. A change in the budget is not effective unless the participant and the OHCDS authorizes the changes.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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:

Guidance provided to participants outlines the options for flexible application of the individual budget, with the expectation that the use of budgeted funds are to acquire and direct the provision of services and supports authorized in the plan of service. These options include:

a. Service authorizations allow flexibility across time periods (e.g. month, quarter, etc.) so that participants may schedule providers to meet their needs according to their preferences and individual circumstances. In situations where actual utilization is not exactly the same as initially planned utilization, no notification is necessary on the part of the participant; however, parameters are contained in OHCDS contracts with providers of Fiscal Intermediary Services that define ranges of monthly variation outside of which the Fiscal Intermediary is required to flag for attention and review by the participant and the participant's supports coordinator. The participant must be able to shift funds between line items as long as the funding pays for the services and supports identified in the individual service plan. Participants may negotiate rates with providers that are different from the rates that the budget is based upon, so long as they remain within the overall framework of their respective budgets. These utilization patterns and actual cost differences appear in monthly budget reports provided by the Fiscal Intermediary. The supports coordinator is expected to review monthly budget reports and in general interact with the participant as necessary to assure that implementation is

occurring successfully. When a participant is intending to significantly modify the relative amount of services in comparison to their plan, they are expected to inform the fiscal intermediary and the OHCDS's supports coordinator.

b. When a participant wants to significantly alter the goals and objectives in the service plan or obtain authorization of a new service that effects allocation of funds within the budget, the adjustment must be considered through the person centered planning process and mutually agreed upon by the OHCDS and participant, even if the overall budget amount does not change. The changes are reflected in the service plan and individual budget and appended to the participant's Self-Determination Agreement.

c. When the participant is not satisfied with the service plan and individual budget that result from the person centered planning process, he or she may reconvene the person centered planning process, file a fair hearing request, or utilize an informal grievance procedure offered by the OHCDS.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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:

The Fiscal Intermediary provides monthly reports to both the participant and OHCDS. In those reports, the Fiscal Intermediary flags over or under expenditures of ten percent in any line item in the budget. This procedure helps ensure that the parties have sufficient notice to take action to manage an over expenditure before the budget is depleted and to avoid any threats to the participant's health and welfare that may be indicated by an under expenditure. The supports coordinator is responsible for monitoring the reports and the arrangements to ensure that the participant is obtaining the services and supports identified in the individual plan. Any party can use the report to convene a person centered planning meeting to address an issue related to expenditures.

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.

The Michigan Department of Community Health has an established administrative appeals process that conforms to the requirements of the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E. Thus, the MI Choice program has established notice and appeals requirements for OHCDS to follow when programmatic action has been taken for program applicants and participants.

MI Choice OHCDS must send an Adequate Notice letter informing applicants/participants of OHCDS actions/determinations under the following circumstances: when new applicants are determined ineligible for MI Choice services based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool; when OHCDS are unable to accept new MI Choice applicants who request a Level of Care Determination when they are at operating capacity;

when a participant requests additional services or additional amounts of services and the request is denied; and when an existing benefit is reduced, suspended or terminated, but is an exception to the advance notice requirement. This notice informs the applicant of the right to an immediate review via the Michigan Peer Review Organization (MPRO) or their right to file a formal appeal via the Medicaid Fair Hearing procedure.

An Advance Action Notice letter must be sent to MI Choice participants when action is being taken to reduce, suspend or terminate service(s) a participant is currently receiving. This notice must be provided at least 12 days in advance of the intended negative action. For example, an Adequate Action Notice letter is sent when a MI Choice participant is determined to no longer be functionally eligible for services based on the Nursing Facility Level of Care Determination process. This type of notice would also be sent if it is determined, based on the participant's current needs assessment, that there should be a reduction in level/number of services being provided. The notice must inform the participant that services will not be reduced until a formal decision has been rendered through the Medicaid fair hearing process. The Adequate Action notice informs the applicant of their right to an immediate review via the MPRO, as well as their right to file a formal appeal via the Medicaid Fair Hearing procedure. The Advanced Action and Adequate Action notices are posted on the MDCH web site at the following location:

http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-103102--,00.html.

The provider must supply a copy of the DCH-0092, Request for Hearing form, to an individual when the participant or applicant believes a determination/decision by MDCH or the provider has a negative impact or is inappropriate. Providers are required to assist individuals requesting help in filing an exception review through MPRO or a formal appeal through the Medicaid fair hearings process. Likewise, an individual is within their right to request both a review and appeal simultaneously if they so desire.

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.

The following guidelines describe the second level review criteria for those applicants who did not meet the Michigan Medicaid Nursing Facility Level of Care Determination through the electronic web-based form. These criteria are used by the Michigan Department of Community Health (MDCH) and its designee, the Michigan Peer Review Organization (MPRO), on a provider's request to evaluate long term care program needs and appropriateness for Medicaid-reimbursed nursing facility care, the MI Choice Program, or the Program of All Inclusive Care for the Elderly (PACE).

Applicants who exhibit the following characteristics and behaviors may be admitted to programs requiring the Nursing Facility Level of Care definition. An applicant need trigger only one element to be considered for an exception.

Frailty

The applicant has a significant level of frailty as demonstrated by at least one of the following categories:
• Applicant performs late loss ADLs (bed mobility, toileting, transferring, and eating) independently but requires an unreasonable amount of time.
• Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.

• Applicant has experienced at least two falls in the home in the past month.
• Applicant continues to have difficulties managing medications despite the receipt of medication set-up services
• Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services
• Applicant meets criteria for Door 3 when emergency room visits for clearly unstable conditions are considered

Behaviors
The applicant has at least a one month history of any of the following behaviors, and has exhibited two or more of any these behaviors in the last seven days, either singly or in combination:
• Wandering
• Verbal or physical abuse
• Socially inappropriate behavior
• Resists care

Treatments
The applicant has demonstrated a need for complex treatments or nursing care.

The use of this review process in no way impacts the applicant's ability to access the Michigan Medicaid Fair Hearing process. If a review results in a negative finding, the applicant must be given an adequate access notice and informed of their right to an administrative hearing.

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).

Types of Critical Incidents and Serious Events that are reported to DCH:
Exploitation; Illegal activity in the home with potential to cause a serious or major negative event; Neglect; Physical abuse; Provider no shows, particularly when participant is bed bound all day or there is a critical need; Sexual abuse; Theft; Verbal abuse; Worker consuming drugs/alcohol on the job; and/or Suspicious or Unexpected Death that is also reported to law enforcement and is related to providing services, supports or caregiving.

OHCDS are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Management Report form. OHCDS are required to report the number of critical incidents recorded, the responses to those incidents, and the outcome and resolution of each event. It is required that OHCDS submit individual incident reports and a summary report that is due to MDCH staff on January 15 and July 15 of each year.

OHCDS have first line responsibility for identifying, investigating, evaluating and follow up of the critical incidents that occur with participants as listed above. All suspected incidents of abuse, neglect and exploitation require reporting to the Department of Human Services, Adult Protective Services (DHS-APS) for investigation and follow-up. All critical incident reports must include: a description of each incident, investigations, and strategies implemented to reduce, ameliorate and prevent future incidents from recurring and follow-up activities conducted through the resolution of each incident. Critical incident reports are submitted to MDCH, MSA, HCBSS on the critical incidence reporting forms. OHCDS should begin to investigate and evaluate critical incidents with the participant within 48 working hours of identification that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDCH HCBSS staff, as soon as reasonably possible, i.e., within 48 working hours.

By contract, OHCDS are required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect and/or exploitation. The policies and procedures must include procedures for follow up activities with DHS-APS to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect and/or exploitation, as well as the referral to DHS-APS, must be maintained in the participant's case record.

MDCH, MSA, HCBSS section reviews, evaluates, and trends the incident reports submitted by the OHCDS. Analysis of the strategies employed by OHCDS in an attempt to reduce or ameliorate incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. MDHS, APS receives notification of all suspected abuse, neglect and exploitation, and investigates these reported incidents as prescribed by Michigan law (Public Act 519 of 1982). Training is provided to OHCDS as necessary to educate staff on abuse and to strengthen preventive interventions and strategies.

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.

OHCDS train participants and their allies how to identify and report suspected abuse, neglect and exploitation, including the reporting of incidents to Adult Protective Services (APS) and/or local law enforcement agencies. The training takes place during face to face interviews with participants either during person centered planning (PCP) meetings, assessment visits or follow-up meetings. This training is conducted initially during enrollment and initial PCP or assessment, and annually thereafter. Training is provided more frequently when there is indication that it may be needed. Participants and their allies are informed that supports coordinators are mandated to report suspected incidents of abuse to the Michigan Department of Human Services (MDHS), APS and to the Michigan Department of Community Health through incident management reports.

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.

MDCH HCBSS staff must receive notification from OHCDS of suspicious deaths within 48 working hours of the event. In addition, OHCDS must submit critical incident reports on a semi-annual basis. These reports are reviewed and compared to the remainder of the state. The contract management staff then discusses any concerns over this process with the OHCDS within 60 days of their reciept. The DCH Quality Management Strategy, as outlined in Appendix H of this waiver application, provides detailed information regarding the expectations and requirements in critical incident reporting and response.

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.

MDCH HCBSS staff is responsible for oversight of reporting and response to critical incidents. It is required that OHCDS report suspicious deaths to HCBSS staff within 48 hours. Details of this process are outlined in the Quality Management Strategy contained in Appendix H.

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:

Michigan prohibits paid providers from using restraints.

MDCH contracts with individual registered nurse reviewers (RNRs) to conduct CQARs andhome visits. Part of this process is a discovery process to examine the use of restraints by family and informal care givers.

The supports coordinator also discusses the waiver program and services with consumers during their monthly contact. Any displeasure communicated at that time is thoroughly vetted and instances of restraint usage are discussed with unpaid care givers and informal support providers.

○ **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:

Michigan prohibits paid providers from using restrictive interventions.

Michigan has a contract with the University of Michigan School of Nursing that conducts both clinical quality assurance reviews and in home visits of participants. Part of this process is a discovery process to examine the use of restraints by family and informal care givers.

The supports coordinator also discusses the waiver program and services with consumers during their monthly contact. Any displeasure communicated at that time is throughly vetted and instances of restrictive interventions is investigated.

○ **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.

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:

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ○ **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.

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:
HCBSS staff conducts a biennial AQAR, and oversees contracted RNRs who conduct an annual CQAR for each OHCDS. HCBSS staff compiles results using algorithms within the MICSRP. Section IV of the MICSRP addresses participant health and welfare. HCBSS staff compares data from each OHCDS with aggregated statewide data. HCBSS staff uses aggregated data to formulate recommendations for improvement.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 OHCDS continuously monitors the health and welfare of participants and initiate remedial actions when appropriate. The state identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation on an on going basis.

Strategies

1) Critical Incident Management:

OHCDS staff manages critical incidents at the local level. To accomplish this they identify and evaluate each incident, initiate prevention strategies and interventions approved by participants to reduce and or ameliorate further incidents, and follow up, track, and compile mandatory critical incident reports. The OHCDS submit critical incident reports to MDCH semi-annually. Upon receipt of the reports, MDCH: monitors and reviews CIM report submissions; evaluates individual and summary CIM reports; evaluates prevention strategies/interventions; provides technical assistance and training as necessary to improve reports; identifies incidents and interventions; verifies that OHCDS report incidents of abuse, neglect and exploitation to the Department of Human Services (DHS) Adult Protective Services (APS) as required; and verifies that OHCDS use appropriate related planned services and supportive interventions to prevent future incidents. MDCH compiles a summary report of incident reports every 180 days, trends and analyzes report submissions for review by MDCH, OHCDS, and the QM Collaboration following submissions.

2) OHCDS conduct risk management (RM) planning with participants during PCP. RM planning includes strategies and methods for addressing health and welfare issues. Supports coordinators (SCs) negotiate RM with the participant through the PCP process. SCs and participants monitor and evaluate the effectiveness of RM plans, i.e., which strategies work and which do not work effectively with that given participant. RM planning and updates occur at reassessment (quarterly or semi annually) or more frequently as needed. SCs document RM planning in the POC.

3) MDCH verifies that RM planning is occurring during the CQARs conducted annually, and more frequently with the PCP audits currently under development. MDCH includes findings in written monitoring reports, with corrective actions and training as needed. MCDH, OHCDS, and the QM Collaboration review reports.

4) OHCDS train participants, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic and content, and training evaluations.

5) OHCDS use Quality Indicators (QI) extracted via a report from their assessment data base to measure 20 Participant Health Status Outcomes. Two Quality Indicators address abuse and neglect. The first is Prevalence of neglect/abuse. The numerator for this indicator is the number of clients who have unexplained injuries or have been abused or neglected. The denominator is all clients. The second is the Prevalence of any injuries. The numerator for this indicator is the number of clients with fractures or unexplained injuries. The denominator is all clients. The OHDCS can examine records for participants scoring into either of these quality indicators to assure that the participant's POC contains interventions for the indicator, including methods to prevent future occurrences. OHCDS staff runs and monitors the reports quarterly, and submits them annually to MDCH. MDCH is currently studying how these QIs work with the University of Michigan, Institute of Gerontology, which compiles QI results annually for review by MDCH, UoM, OHCDS, and the QM Collaboration. OHCDS QM plans include strategies for improving results of participant outcomes.

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 HCBSS staff compiles reports for each AQAR and CQAR upon completion of the review and sends the completed reports to the OHCDS. When the AQAR and CQAR reports indicate a need for corrective action, the OHCDS has 30 days to respond with a corrective action plan. HCBSS staff reviews the corrective action plan, including any revised policies and procedures, training materials, information from staff meetings, or case record documentation supporting the corrective action plan and either approve the plan or work with OHCDS staff to amend the plan to meet MDCH requirements. Once approved, HCBSS staff sends the OHCDS an approval letter. HCBSS staff monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. HCBSS staff retains all documents generated from this process on file.

The OHCDS periodically examines Quality Indicator reports. For each quality indicator, OHCDS staff obtains a list of participants who scored into that indicator. OHCDS staff can then drill down to determine the reason that each participant scored into the specific indicator and whether or not supports coordinators included appropriate interventions for the identified issue on the POC. OHCDS staff initiates corrective actions as needed after the thorough examination of the data. When the OHCDS scores higher than MDCH set benchmarks on a specific Quality Indicator, its Quality Management Plan must include methods the OHCDS will take to decrease the number of participants scoring into the quality indicator. HCBSS staff examines each OHCDS' quality management plan and recommends improvements when staff determines the OHCDS methods are inadequate to make improvements.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

MDCH designed the following strategy to assess and improve the quality of services and supports managed by the twenty one OHCDS entities that administer the MI Choice Waiver. The state agency responsible for establishing the components of the quality management plan listed here is the Michigan Department of Community Health's (MDCH), Medical Services Administration (MSA), Home and Community Based Services Section (HCBSS). The quality improvement strategy (QIS) includes using several tools to gather data and measure individual and system performance. Tools utilized in this plan include the MDCH Quality Management Plan (QMP), OHCDS-specific QMPs, MI Choice Site Review Protocol (MICSRP), and Critical Incident Management (CIM) system.

Michigan developed its QIS with meaningful contributions from consumers, advocates, and caregivers in collaboration with MDCH and the OHCDS. A leadership group composed of 7 consumers/advocates and 7 OHCDS staff organized formally into the MI Choice Person Focused Quality Management Collaboration (QMC). A 2001 Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS) originally supported the QMC activities. MDCH and the Michigan Disability Rights Coalition (MDRC) co-facilitate this group. A MI Choice participant currently serves as the QMC chairperson and leads each meeting.

The purpose of the QMC is to include consumers and advocates in the development and review of MI Choice quality management activities. The QMC provides a venue where providers, consumers, and advocates can review a variety of quality outcomes, identify areas that need improvement, develop strategies for remediation of service delivery, and recommend improvements to the Michigan Medicaid service delivery system. The QMC allows the provision of meaningful input by consumers and advocates during the implementation of person centered planning and self-directed care options that increase participant satisfaction with services and supports. The Self Determination Advisory Committee merged with the QMC in mid 2006.

Quality Management Plans

MDCH establishes a QMP biennially, which includes statewide goals and strategies identified in part by the QMC. The QMP focuses on meeting CMS assurances and requirements for protecting the health and welfare of waiver participants, MDCH contract requirements, and targeted participant outcome improvement goals. MDCH requires each OHCDS to have its own QMP and reviews them biennially. MDCH guides, prompts, and assists each OHCDS in preparing and updating its QMP based on individual agency and provider network results from compliance reviews, participant outcomes, consumer survey results, complaint history, and other performance based outcomes.

MDCH requires each OHCDS to update its QMP formally at least biennially. However, the OHCDS may update its QMP as frequently it deems necessary, to accomplish its goals. The QMP addresses how the OHCDS intends to meet State and Federal assurances and requirements stipulated in MDCH contracts, the CMS approved waiver plan, selected CMS protocols, and Medicaid requirements for assuring the health and welfare of the participants in the waiver program. Each OHCDS includes the MDCH required goals in its QMP and add its own unique quality improvement goals, or self-targeted quality improvement strategies, including service provider performance requirements and administrative improvements.

MICSRP

MDCH developed the MICSRP with input from the QMC, advocates, Area Agency on Aging Association, the MDRC, and other stakeholders. MDCH updates the MICSRP biennially or more frequently if needed to incorporate general improvements, policy changes, CMS initiatives, and MDCH priorities. The MICSRP has two parts, the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR) that also includes a participant home visit protocol (HVP). In 2007, MDCH contracted with the Muskie School of Public Service, University of Southern Maine to evaluate and comment upon the MICSRP. The 2008/2009 MISCRP incorporates many of these recommendations. Additionally, in response to comments, HCBSS staff developed a scoring system and algorithms to weight each standard in the MICSRP. This system allows HCBSS staff to calculate compliance equitably for each OHCDS, based on data obtained from the AQAR and CQAR, regardless of sample size.

The AQAR focuses on assuring that each OHCDS has policies and procedures consistent with waiver requirements. HCBSS staff completes the AQAR biennially for each OHCDS. During the on-site AQAR, HCBSS staff examines OHCDS policies and procedures, contract templates, financial systems, claims accuracy, and QMP in detail seeking evidence of compliance to the AQAR standards.

HCBSS contracts with qualified registered nurse reviewers (RNRs) to complete the CQAR. RNRs evaluate the OHCDS' enrollment, assessment, level of care evaluations, care planning, and reassessment activities annually seeking evident of compliance to the CQAR standards. The RNRs collect and review both qualitative and objective data, and evaluate the assessment and SCs actions, to assure that the POC includes every participant need identified in the assessment. The RNRs determine the OHCDS' level of compliance to the standards included in the MICSRP. The RNRs then compile the data from each CQAR and forward reports to HCBSS staff.

Once AQAR and CQAR data are complete, the HCBSS staff compiles reports to send to the OHCDS. Each report includes a summary of successes in practice and deficiencies in practice. HCBSS staff divides the deficiencies into citations and recommendations based upon algorithms for each standard. The OHCDS has 30 days to respond to the citations with a corrective action plan. The corrective action plan may also include actions to address recommendations, but MDCH does not mandate this. HCBSS staff works with the OHCDS to assure the corrective action plan will produce quality improvements. Once the OHCDS and HCBSS staff agrees on the final corrective action plan, the HCBSS staff sends written documentation detailing the plan and MDCH approval to the OHCDS. HCBSS staff applies algorithms to final AQAR and CQAR data to determine an overall quality score for each OHCDS, and statewide.

CIM System

MDCH developed the CIM system with assistance from the QMC and other stakeholders. MDCH requires each OHCDS to report all critical incidents to the HCBSS biannually. The HCBSS defined procedures for reporting critical incidents in the Supports Coordination Service Performance Standards and Waiver Operating Criteria, which is an attachment to the OHCDS contract with MDCH. OHCDS manage critical incidents at the local level by identifying and evaluating each incident. SCs then initiate strategies and interventions approved by participants to prevent further incidents and follow up, track, and compile mandatory critical incident reports.

Once the OHCDS submits reports to MDCH, HCBSS staff monitors and reviews them. This includes an evaluation of individual and summary CIM reports, the prevention strategies and interventions used, and verification that OHCDS staff reports incidents of abuse, neglect, and exploitation to the Department of Human Services Adult Protective Services as required. HCBSS staff provides technical assistance and training as necessary to improve reports and quality outcomes for the participants involved and that the OHCDS used appropriate related planned services and supportive interventions to reduce or ameliorate further incidents. MDCH compiles a CIM summary report every 180 days, and trends and analyzes report submissions for review by MDCH, OHCDS, and the QMC.

Additional QIS Activities

1) OHCDS conduct risk management (RM) planning with participants during PCP. RM planning includes strategies and methods for addressing health and welfare issues negotiated with the participant through the PCP process. SCs and participants monitor and evaluate effectiveness of RM plans, noting successful strategies and modifying unsuccessful strategies with the participant. RM planning and updates occur during reassessment or more frequently if needed. SCs document RM planning the PCP or POC.

2) OHCDS train participants, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic, content, and training evaluations.

3) OHCDS use Quality Indicators (QI) reported from their assessment database to measure 20 Participant Health Status Outcomes. The OHCDS runs and monitors the reports quarterly then submit them annually to MDCH. MDCH is currently studying how these QIs work with the University of Michigan (UoM), Institute of Gerontology, which compiles QI results annually for review by MDCH, UoM, OHCDS, and the QMC. OHCDS QMPs include strategies for improving results of participant outcomes.

4) OHCDS monitor service providers annually according to the MDCH provider monitoring plan. OHCDS compile provider monitoring reports of provider performance, corrective actions, trainings, and follow up activities conducted, as necessary. OHCDS submit provider monitoring schedules to MDCH annually and all provider monitoring reports to MDCH upon completion. HCBSS staff reviews the OCHDS provider monitoring schedules and administrative monitoring reviews, results, and findings as submitted on an on going basis. MDCH also requires the OHCDS to conduct in home participant visits to gauge the effectiveness of service delivery. The OHCDS reviewer is required to conduct two home visits with waiver participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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.

OHCDS QMPs and QI data
HCBSS staff compiles data from OHCDS quality management and QI reports and disseminates the information to MDCH, QMC members, OHCDS staff, and other stakeholders annually. This information includes statewide averages for each QI in the MDCH QMP, individual OHCDS QI data, and progress in meeting established benchmarks. MDCH presents this information at QMC meetings, Long Term Care forums, and as requested by other audiences.

AQAR
HCBSS staff shares individual OHCDS quality scores and aggregated data with MDCH, QMC members, OHCDS staff, and other interested parties biennially. The aggregated report includes the percentage of compliance found for each standard in the AQAR, summarized compliance for each section of the AQAR, and an overall compliance score. HCBSS staff usually presents this data at QMC and OHCDS staff meetings. The presentation includes a summary of successes in practice, noted deficiencies, and improvements from previous data. HCBSS staff may also discuss methods utilized to improve compliance and common reasons for deficiencies.

CQAR/Home Visits
HCBSS staff shares individual OHCDS quality scores and aggregated data with MDCH, QMC members,

OHCDS staff, and other interested parties annually. The aggregated report includes the percentage of compliance found for each standard in the CQAR, including the home visits, summarized compliance for each section of the CQAR, and an overall compliance score. HCBSS staff usually presents this data at QMC and OHCDS staff meetings. The presentation includes a summary of successes in practice, noted deficiencies, and improvements from previous data. HCBSS staff may also discuss methods utilized to improve compliance and common reasons for deficiencies.

CIM Reports
Twice each year, HCBSS staff compiles critical incident reports received from each OHCDS. HCBSS staff summarizes the number of incidents in each category, changes from previous summaries, methods of remediation, and whether or not the OHCDS resolved the incident. HCBSS staff monitors reported incidents that did not include a resolution until the OHCDS finalizes interventions to the satisfaction of the participant involved. HCBSS staff presents the CIM report to the QMC semi-annually.

Quality Website (under development)
MDCH is in the process of developing a website for disseminating QIS data. The website would include each of the reports mentioned above. The website will also include each OHCDS's QMP, QI reports, AQAR results and quality scores, CQAR results and quality scores, and general information on the MI Choice program. The Department of Information Technology is assisting HCBSS staff, and Office of Long Term Care Supports and Services staff with the development of this website. MDCH plans to have the website operational by October 1, 2009. Currently, staff is reviewing documents to assure that they present clear, concise, and easily understandable information to the public. This website will be accessible to anyone interested in the MI Choice QIS.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QMC reviews the QMP and which QIs to include in it biennially. During the review, QMC members discuss current methods, QIs, and benchmarks. Members reach consensus regarding which QIs to include in the revised QMP and whether MDCH should raise or lower benchmarks based on previous results. MDCH incorporates this advice into the revised QMP. In turn, each OHCDS incorporates the revised MDCH QMP requirements into its own QMP.

MDCH updates service standards and contract requirements routinely as needed to assure the health and welfare of MI Choice participants and maintain compliance to State and Federal requirements. Contract requirements include the PCP guidelines, Supports Coordination Service Performance Standards and Waiver Program Operating Criteria, reporting requirements, OHCDS MI Choice Waiver Program Provider Monitoring Plan, and billing procedures and coding systems.

MDCH convenes a workgroup to revise the MISCRP biennially or more frequently, if needed. The workgroup incorporates new standards, deletes ineffective and/or duplicative standards, and revises wording to clarify standard requirements. The HCBSS staff distributes draft copies to all interested stakeholders for review and comment before finalizing the revision.

HCBSS staff compiles AQAR and CQAR data to identify common deficiencies on an ongoing basis. When warranted, HCBSS staff or other appropriate experts, provide training to OHCDS staff to clarify issues and improve compliance to the MICSRP. HCBSS staff works closely with each OHCDS to target training sessions to meet the needs of its staff. Training may consist of formal presentations provided to staff of all OHCDS, targeted on site sessions for a few OHCDS' with similar problems, teleconferences, clarifying memos, or informal discussions to clarify policy interpretations, improve procedures, or otherwise remove barriers to compliance.

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).

a) Independent Audit Requirements:

MI Choice OHCDS are contractually obligated to comply with and assure compliance by their subcontractors with all of the requirements of the Single Audit Act and any amendments to this act. Contractors must submit to the Michigan Department of Community Health (MDCH) a Single Audit, Financial Statement Audit, or Audit Status Notification Letter as described below. If submitting a Single Audit or Financial Statement Audit, contractors must also submit a Corrective Action Plan for any audit findings that impact MDCH funded programs and a management letter (if issued) with a response.

Contractors that expend $500,000 or more in federal awards during the contractor's fiscal year must submit to MDCH a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" (as revised).

Contractors exempt from the Single Audit requirements that receive $500,000 or more in total funding from MDCH in state and federal grant funding must submit to MDCH a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS). Contractors exempt from the Single Audit requirements that receive less than $500,000 of total MDCH grant funding must submit to MDCH a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that might negatively impact MDCH funded programs including, but not limited to fraud, going concern uncertainties, financial statement misstatements, and violations of contract and grant provisions.

Contractors exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template Audit Status Notification Letter and further instructions are available at http://www.michigan.gov/mdch by selecting Inside Community Health – MDCH Audit.

The required audit and any other required submissions (i.e. Corrective Action Plan and management letter with a response) or audit Status Notification Letter must be submitted to MDCH within nine months following the end of the contractor's fiscal year to: Michigan Department of Community Health, Office of Audit, Quality Assurance and Review Section.

b) Financial Audit program to insure provider billing integrity:

All providers of waiver services contracting with an OHCDS must submit bills to the OHCDS detailing the date of service, type of service, unit cost, and the number of units provided for each waiver participant served. Provider bills are then matched and verified against the participant's approved care plan by the OHCDS prior to submitting claims to the Medicaid Management Information System (MMIS) utilizing the MI Choice Information System (MICIS).

The OHCDS processes payments for all verified claims by the waiver service providers. The right to payment is voluntarily reassigned to the OHCDS by the providers as indicated via agreement among MDCH, the OHCDS, and each direct care provider. Those providers not wishing to have payment voluntarily reassigned must submit their bills directly to the single state agency. The single state agency verifies such bills with the OHCDS using the MMIS before processing payment. The OHCDS must submit electronic invoices to MDCH detailing claims paid by type of service, date of service, and the amount of service for each waiver participant. This information is then processed into MMIS.

The MMIS verifies the eligibility of all waiver participants for whom waiver service payments are requested before approving a claim for payment. Each OHCDS utilizes eligibility edits for all claims to ensure that payments are made only for authorized services from enrolled providers for eligible clients.

Providers operating as an OHCDS are required to maintain all participants' records, including assessments, plans of care, service logs, reassessments, and quality assurance records for a period of not less than six years to support an audit trail. MDCH, providers, and the OHCDS all maintain records for a period of six years to allow for full auditing of payments for waiver services.

MI Choice reimbursement is annually reconciled to data contained in Michigan's MMIS system. The MMIS system suppresses payment for MI Choice claims. Claims approved in Michigan's MMIS system are compared to monthly prospective payments that are distributed to the OHCDS. The annual reconciliation process ensures MDCH deducts any rejected claims from the total payments provided to the OHCDS. This process assures that only claims that have been approved by the Michigan MMIS system and are subjected to system edits are paid.

c) Agencies responsible for financial integrity audit:

Standard contract language between MDCH and the OHCDS states that, "allowable and reimbursable expenditures are those expenditures considered proper, necessary, and reasonable for the provision of services to the waiver participants. All funds that the contractor receives from MDCH for services or operations/care management must be used directly or indirectly for the provision of services to its MI Choice HCBSED Waiver participants." Every OHCDS is contractually obligated to oversee their network of providers to assure that only claims that the state's Medicaid program is legally obligated to pay are submitted for reimbursement. MDCH waiver operations staff review this requirement through an annual reconciliation process (described in (b) above) that compares all approved claims within the MMIS system to total payments provided to each OHCDS. MDCH presents any claims in dispute to the OHCDS for additional information to clarify and resolve differences between the MMIS system and submitted claims.

In addition to this process, MDCH has an independent audit office that has oversight of the integrity of all Medicaid payments. It establishes its own priorities and develops an auditing plan based on an annual risk assessment. OHCDS are required to comply fully with any request by either the department's operational staff or the independently operated audit office.

A final entity, Michigan's Office of the Auditor General, has the authority to oversee state expenditures with regard to assuring efficient and legal expenditure of tax payer resources. This office is constitutionally mandated and has complete autonomy from all branches of government.

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:
HCBSS staff conducts a biennial AQAR and oversees contracted RNRs who conduct annual CQARs for each OHCDS. Section VII of the MICSRP addresses financial integrity. HCBSS staff uses data to formulate recommendations for improvement. OHCDS staff monitors 10% of providers annually to assure financial accountability including an examination of accounting practices and an audit of billed services.

Data Source (Select one):
Financial records (including expenditures)
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):*
☑ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

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):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

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.

Financial Monitoring and Audit

MDCH requires OHCDS to conduct annual financial monitoring according to the OHCDS MI Choice Waiver Program Provider Monitoring Plan, Attachments J, of the MDCH contract. This methodology is designed to ensure and verify that:

1) Direct service providers comply with minimum service standards and conditions of participation in the Medicaid program;

2) Providers deliver services according to the MI Choice participant POC;

3) Providers maintain an adequate number of trained staff through recruitment, training, and staff supervision and support; and

4) Providers maintain participant case record documentation to support claims.

OHDCS staff reviews, evaluates, and compares direct provider records to work orders, care plans, service claims, and reimbursements. OHCDS staff compares payment records to MI Choice care plan authorization (work orders) and other OHCDS service documentation to ensure that they match. OHCDS staff evaluates provider records for date of service, time of service delivery, staff providing the service, and supervision of staff providing services. OHDCS staff notes any discrepancies during the review and include them in written findings. The OHCDS staff provides written findings of the review and corrective action requirements (as necessary) to the provider within thirty days following completion of the initial review. The OHCDS submits provider monitoring reports to MDCH within 30 days of completion of the monitoring process. HCBSS staff reviews and evaluates these reports for completeness and integrity of the process.

MDCH also requires the OHCDS to conduct in home participant visits to gauge accurately the effectiveness of service delivery. The OHCDS reviewer conducts two home visits with participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned. MDCH reviews all OHCDS provider monitoring reports either as completed and submitted to MDCH or during the biennial on site AQAR.

Additionally, HCBSS staff conducts on site reviews to verify that the OHDCS maintains administrative and financial accountability. HCBSS staff biennially conducts financial reviews of OHCDS using a methodology similar to Attachment J OHCDS monitoring plan during the AQAR process. HCBSS staff reviews and evaluates a sample of participants' claims from the POC during a 3- month period. This process includes reviewing the service record from inception through approved payment, to work order, to case record documentation at both the OHCDS level and the provider level, to claim generation, and Medicaid payment to verify that records match by date of service, amount, duration, and type of service.

The MDCH Audit Office also conducts an audit on a sample of OHCDS every 2-3 years to validate that OHCDS use generally acceptable accounting procedures and that OHCDS meet financial assurances. The specific criteria used for each audit changes depending on identified or suspected problems or issues.

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.
When the OHCDS reviews the provider agency, the OHCDS written review includes citations of both positive findings and areas needing corrective action in the OHCDS written review. It is the OHCDS responsibility to monitor a provider's performance in completing the necessary corrective actions. OHCDS may suspend new referrals to a provider agency and/or transfer participants to another provider when findings warrant immediate action to protect a participant's health and welfare. OHCDS make provider billing adjustments on the computerized client tracking system to the Medicaid Management Information System using individual claim adjustment to date of service or through gross adjustment methodology. The OHDCS deducts over payments made to a provider from the next warrant issued and due the provider from the OHCDS. OHCDS may suspend or terminate a provider who demonstrates a failure to correct deficiencies following subsequent reviews. The OHCDS may reinstate providers after verifying that the provider has corrected deficiencies and/or changed procedural practices as required.

The HCBSS staff compiles reports for each AQAR and CQAR upon completion of the review and sends the completed reports to the OHCDS. When the AQAR and CQAR reports indicate a need for corrective action, the OHCDS has 30 days to respond with a corrective action plan. HCBSS staff reviews the corrective action plan, including any revised policies and procedures, training materials, information from staff meetings, or case record documentation supporting the corrective action plan and either approve the plan or work with OHCDS staff to amend the plan to meet MDCH requirements. Once approved, HCBSS staff sends the OHCDS an approval letter. HCBSS staff monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. HCBSS staff retains all documents generated from this process on file. The AQAR results in similar actions of claim adjustment and corrective actions when HCBSS staff finds deficiencies.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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).

MDCH contracts with OHCDS to operate and administer the MI Choice program. The OHCDS is responsible for sub-contracting with provider agencies and assuring access to services. The process of rate determination resides in the contract negotiation between the OHCDS and provider. MDCH does not play a role in this process. Per Michigan law, MDCH is prohibited from setting fee screens or setting rates for waiver services.

The contract between the OHCDS and MDCH requires that rates be adequate to assure access to services needed by waiver participants. MDCH staff oversees the adequacy of access as opposed to monitoring the establishment of individual rate levels. Each OHCDS must demonstrate adequate working relationships with agencies providing home-based care for referrals and resource coordination to ensure participants in need of services from those agencies have access to them.

The initial MI Choice waiver contract amount was determined by historical experience when the program was developed. In order to assure the proper distribution of funds, a work group comprised of the 21 OHCDS entities developed a formula to distribute any additional funding that may be granted by the Michigan legislature in future annual budget appropriations.

Service providers are required by contract to provide a copy of the signed and dated invoice with units billed and the amount of reimbursement to both the waiver participant and the OHCDS upon the delivery of service.

If a provider were to elect to bill MDCH directly for services provided (none have elected to do so thus far), claims would be processed through the Medicaid claims processing system and would pend or suspend for manual determination of a rate. The rate used would be that which is paid per the contract held between the OHCDS and the

provider.

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:

Currently, the traditional MI Choice system operates with individual providers of waiver services billing the OHCDS for services that are provided as authorized in the individual plan of care. Each OHCDS then reviews individual providers to assure that all claims submitted are for services rendered. In the self-determination option, workers submit timesheets to the fiscal intermediary who, in turn, submits claims to the OHCDS for reimbursement. OHCDS cost settle with fiscal intermediaries on a monthly or annual basis. While providers have the ability to bill Medicaid directly for services, none have elected to do so.

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) FFP is only made available when the individual is eligible for Medicaid waiver payment on the date of service.

All claims submitted to the Michigan MMIS system must contain a valid Medicaid beneficiary identification number for the claim to be approved. The MMIS uses an editing process that compares claims to an eligibility table within the system. This eligibility table is maintained by the Michigan Department of Human Services (DHS), the state agency responsible for Medicaid eligibility determination. Any claim submitted for an ineligible person is rejected at this point in the claims submission process.

b) FFP is only made when the service was included in the participant's approved service plan.

The OHCDS is responsible for assuring that only services authorized in a participant's plan of care are submitted for reimbursement. The OHCDS utilizes their information system to compare bills submitted by provider agencies to authorized waiver services in each participant's service plan. Only those services contained within the approved service plan are paid. Claims paid by the OHCDS are then submitted to MMIS for approval. Claims not approved in MMIS are not eligible for FFP.

c) FFP is only made when the services were provided.

Each OHCDS periodically monitors service provider agencies. This monitoring includes an audit of the paid services compared to documentation including in-home logs kept by paid caregivers, time sheets, and other source documents. Additionally, some OHCDS have systems for participants and service provider agencies to notify the supports coordinator when services are not delivered as planned. Verification of the provider no-show rate is part of the overall Quality Management Plan described in Appendix H. Additionally, some OHCDS entities have implemented a method within their respective information systems to track services not provided.

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:

MDCH carries out its obligations through a network of enrolled providers, including Area Agencies on Aging (AAAs), that operate in compliance with the requirements of an OHCDS, as defined as 42 CFR 447.10(b) and (g)(4) to provide services in this waiver.

MDCH is able to assure that an entity submitting claims for waiver services is either a directly enrolled provider of specific services or an OHCDS. Each OHCDS has an agreement with the single state agency that meets provider agreement requirements including the provision of at least one direct waiver service.

Each OHCDS uses written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under subcontract meet provider standards elsewhere described in this waiver application. Subcontracts assure that providers of services receive full reimbursement for services delivered according to the participant's plan of care. Any provider that meets provider requirements and is willing and able to provide services is permitted to participate in the waiver program.

To assure freedom of choice for participants, participants are not required to receive services solely through an OHCDS.

Billing process:
1. Providers of waiver services contracting with the OHCDS submit bills to the OHCDS detailing the date of service, type of service, unit cost, and number of units provided for each waiver participant served.

2. Provider bills are matched and verified against the participant's approved care plan by the OHCDS prior to the submission of claims, utilizing the MI Choice Information System (MICIS), or a comparable computer data base system that generates claims to MMIS.

Payment process:
1. The OHCDS processes payment for all verified claims submitted by waiver providers. The right to payment from the OHCDS is voluntarily reassigned to the OHCDS by the providers as indicated through agreements between the OHCDS and each direct provider of service, according to requirement contained within federal regulations and the contract between the OHCDS and MDCH. Those providers who do not choose to have payment voluntarily reassigned submit their bills directly to the single state agency. The single state agency verifies such bills with the OHCDS MICIS data and MMIS.
2. The OHCDS submits electronic invoices to MDCH detailing claims paid by type of service, data of service and amount of service for each waiver participant using HIPPA universal billing formats and procedure codes. This information is loaded into the MMIS.
3. MDCH verifies the eligibility of all waiver participants for whom waiver service payments are being

requested before submitting claims to CMS.
4. All MMIS requirements are met for waiver service claims approvals. All MMIS edits are applied to these claims. Payments are made only for authorized services from enrolled providers for eligible claims.

MDCH conducts financial and administrative reviews of the OHCDS annually. Protocols (criteria) that address required assurances are used to determine whether each OHCDS is in full compliance with requirements. When deficiencies are found, MDCH provides the OHCDS 30 days to propose a written correction to the deficiency to bring them into compliance. These reviews result in written reports from MDCH to each OHCDS. OHCDS respond to the review with a corrective action plan, if needed. Corrective actions are monitored and followed up on by MDCH waiver operations to ensure that the OHCDS implements corrections as planned, and that OHCDS policy and procedures are corrected and updated as needed.

☐ **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.*

Fourteen of the 20 OHCDS are Area Agencies on Aging (AAA) organizations. These entities are quasi-public organizations that generally report to a board with some county oversight. In addition to the AAAs, Northern Lakes Community Mental Health Authority and Macomb-Oakland Regional Center are Community Mental Health Boards, A & D Home Health Care, Inc. is a home health agency, Home Health Services is a stand-alone care management agency and The Information Center and Senior Services Inc. are aging agencies that function as an OHCDS.

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

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

As noted previously in this application, individual providers have the option of billing the Medicaid agency directly for services provided to waiver participants. However, all have chosen to voluntarily reassign these rights to the OHCDS.

ii. Organized Health Care Delivery System. *Select one:*

○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) Fourteen Area Agencies on Aging, two Community Mental Health Boards, one home health agency, one stand alone case management agency (JACO accredited), and two other aging organizations are the 20 OHCDS that comprise the MI Choice service delivery networks. Each entity meets MDCH OHCDS readiness review criteria that coincide with the provisions of 42 CFR §447.10 for an OHCDS (i.e. the entity is organized for the purpose of delivering health care, provides at least one service directly, maintains and contracts with a network of providers to furnish waiver services, provides free choice of any provider who is qualified to provide a service and who is willing and able to furnish that service, and is organized and able to act as a fiscal agent in reimbursing Medicaid providers for waiver services rendered, accounting for these payments and submitting OHCDS claims to MMIS).

b) Service providers have the option to enroll directly with the state Medicaid agency through the Michigan Medicaid Provider Enrollment process, just as other Medicaid providers enroll. Applicant providers submit a Medicaid provider enrollment form to MDCH stipulating waiver services they want to provide, describing how they meet provider standards for each service. The enrollment application is reviewed by MDCH. An OHCDS conducts a review of the applicant provider prior to the provision of services to verify that the provider is qualified to furnish each waiver service per applicable service standard. The Medicaid provider enrollment form is Medicaid's agreement with qualified providers to provide Medicaid services. Following successful review, Medicaid signs the enrollment application agreeing the provider is entitled to provide service.

c) The MI Choice contract between the OHCDS and MDCH specifies that participant choice for provider is assured. Michigan uses a person centered planning process to identify participant needs and provider preferences. When a preferred provider is identified by a participant who is not currently a part

of the OHCDS network of service providers, the OHCDS contacts that provider to make arrangements for a qualified service provider review (verification that the provider meets standards prior to delivery of each service) and to either contract with OHCDS as part of their network of service providers or to inform the provider how to apply for enrollment in Medicaid directly. Procedures in part (b) above are then applied.

d) It is required by contract that each OHCDS has responsibility for verification that providers meet the standards for each service defined in the waiver prior to service delivery. All waiver service providers are subject to a qualified service provider review by the OHCDS that verifies that the provider meets standards prior to delivery of services. On an annual basis the OHCDS is required to review providers according to the MDCH provider monitoring plan to ensure that providers continue to meet service standards. When providers do not meet standards on a continuing basis, a corrective action plan is implemented by the OHCDS or providers are not used again until they meet service standards. OHCDS provider monitoring reports are reviewed annually by MDCH. MDCH also conducts an administrative review of the OHCDS annually to verify that the OHCDS are monitoring and reviewing providers according to contract requirements. (These reviews are ongoing and conducted throughout each FY.) Administrative review result in a written report of findings, with corrective actions, if necessary.

e) During the MDCH annual administrative review of the OHCDS, a sample of provider sub-contracts is reviewed to ensure compliance with requirements.

f) MDCH conducts annual financial reviews and spot check monitoring of the OHCDS. MDCH uses specified criteria that follows and reviews a sample of claims for a three month time period from care plan authorization to service work order to the provider to provider documentation in the case records and on worker task logs that the service was rendered to provider bills submitted to the OHCDS to OHCDS processing and verification of the claims and generation of the claim into a claim set submitted to MMIS for approval. MMIS processing contains eligibility edits. All OHCDS are cost settled annually to ensure that approved expenditures are reimbursed to presumptive payments. The MDCH Audit section also conducts financial audits of select OHCDS every two to two and a half years according to their audit plan.

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:

☑ **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:

a) Local governmental entities can contribute tax dollars to enhance the waiver services offered in their jurisdictions.
b) These funds are received by MDCH and the state. Available waiver slots are allocated to take advantage of the increased funding opportunities.
c) These funds are transmitted via IGT to the state. MDCH then amends the contract with the appropriate OHCDS to reflect the additional funding for services in the area that provided the funding.

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) Local municipal and county governments
b) Local milleage funds and county taxes
c) Local contribution via IGT to the state

☐ **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:

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

I-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:

Residential service providers are limited to billing under a finite set of Healthcare Common Procedure Coding System (HCPCS) codes for their services. The codes do not include reimbursement for room and board. The MDCH payment system processes incoming claims and rejects any services other than these codes for waiver participants.

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: Nursing Facility

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	8889.27	6294.58	15183.85	52067.01	5238.68	57305.69	42121.84
2	8860.18	6057.83	14918.01	51218.14	5027.80	56245.94	41327.93
3	9074.03	5894.35	14968.38	50528.74	4867.61	55396.35	40427.97
4	11643.90	4576.29	16220.19	32091.68	2534.31	34625.99	18405.80
5	12099.20	4759.34	16858.54	33375.35	2635.69	36011.04	19152.50

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:
		Nursing Facility
Year 1	9517	9517
Year 2	12745	12745
Year 3	14163	14163
Year 4	11929	11929
Year 5	12214	12214

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 estimate for the Average Length of Stay is the same as that used for the previous waiver amendment. The number of participant days for FY 2004 through FY 2008 is trended through the remaining waiver period. The original estimates appear to be a reasonable expectation based on current utilization data.

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:

Factor D values for Waiver Years 1 through 3 remain the same as the previous waiver amendment. These represent fiscal yeas 2008 through 2010. Inasmuch as these periods are completed, the Factor D numbers have not changed.

The Factor D values for Waiver Years 4 and 5 (FY 2011 and 2012) are based on actual utilization data for FY 2010 that is gleaned from the Community Health Automated Medicaid Processing System (CHAMPS). This data is trended through the remaining two waiver years using the participant growth rates estimated in Appendix B-3-a for the number of participants and a straight 4% economic growth factor.

There are some comparability issues between the values calculated previously and those for the remaining waiver years. The implementation of the CHAMPS system brought a change in some of the underlying claims coding. Procedure codes remain essentially the same, so service utilization data is unaffected. Eligibility codes are essentially the same, however, new CHAMPS coding has changed the manner in which some of the data is identified. Provider codes are significantly changed and crosswalks to previous summary data are problemmatic. The integrity of the data in the aggregate is robust, but comparability of some of the drill-down numbers can be tricky. Values for the D', G and G' factors are similarly affected.

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:

MDCH is attempting to standardized cost calculations for the D' values between the cost effectiveness demonstration and the CMS 372 report. By synchronizing data algorithms, MDCH aims to improve comparability between the estimates provided in the waiver application and the costs eventually reported in the CMS 372 report.

The effect of the changes in the manner in which the costs are calculated can be seen when comparing the first three waiver years with the estimates for the final two. The set of claims that now go into the Factor D' derivation is now more narrowly defined than previous waiver applications. Specifically, costs for waiver participants that accrue prior to enrollment into MI Choice and those that accrue subsequently to disenrollment are no longer included.

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:

The estimates for Factor G are subject to the same CHAMPS coding variations described above. Once again, the underlying costs might fall into different "buckets", but the aggregate costs are unaffected. The Factor G estimates are based on FY 2010 actual costs for Medicaid beneficiaries served in nursing facilities with a 4% annual economic growth factor applied to each of the remaining waiver years.

The relative drop in the Factor G values between those previously estimated and the estimates for the final two waiver years are linked to a couple of factors. The first stems from the evolving algorithm referenced above. Calculation no longer includes costs for Medicaid beneficiaries for periods prior to entering nursing facility or after they have permanently left a nursing facility. The second factor relates to the switch to the CHAMPS system. MDCH is still working to ensure that the data obtained from CHAMPS is comparable to that obtained from the legacy system. There remain some uncertainties regarding the populating of certain data fields, the lag time of some claims to be reported in the system, and the crosswalks of prior coding systems with the new coding structure.

Ultimately, the cost basis of the factor estimates is sound given the current level of experience with the new claims system. At the margin, the cost effectiveness of MI Choice is confirmed.

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:

The discussion of Factor G' values continues naturally continues along the lines of the previously covered factors. The G' values are based on the FY 2010 actual non-institutional Medicaid costs for the nursing facility population trended for the two remaining waiver years at a 4% growth rate.

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
Adult Day Health
Homemaker
Personal Care
Respite
Specialized Medical Equipment and Supplies
Fiscal Intermediary
Goods and Services
Chore Services
Community Living Supports
Counseling
Environmental Accessibility Adaptations
Home Delivered Meals
Non-Medical Transportation
Nursing Facility Transition Services
Personal Emergency Response System
Private Duty Nursing
Residential Services
Training

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
Adult Day Health Total:						**2321679.02**
Adult Day Health	15 Minutes	391	1879.05	3.16	**2321679.02**	
Homemaker Total:						**16505316.16**
Homemaker	15 Minutes	5709	800.86	3.61	**16505316.16**	
Personal Care Total:						**40920485.13**
Personal Care	15 Minutes	6997	1670.94	3.50	**40920485.13**	
Respite Total:						**7135804.87**
Respite - Per Diem					**172717.21**	

	Per Diem	96	34.84	51.64		
Respite	15 Minutes	1808	1091.01	3.53	6963087.66	
Specialized Medical Equipment and Supplies Total:						1087087.28
Specialized Medical Equipment and Supplies	Item	3236	119.55	2.81	1087087.28	
Fiscal Intermediary Total:						97970.00
Fiscal Intermediary	Month	97	10.10	100.00	97970.00	
Goods and Services Total:						5700.00
Goods and Services	Item	19	1.00	300.00	5700.00	
Chore Services Total:						447343.32
Chore Services	15 Minutes	829	80.54	6.70	447343.32	
Community Living Supports Total:						3167204.28
Community Living Supports	15 Minutes	310	2799.12	3.65	3167204.28	
Counseling Total:						178109.47
Counseling	Visit	286	11.61	53.64	178109.47	
Environmental Accessibility Adaptations Total:						683007.27
Environmental Accessibility Adaptations	Item	381	1.72	1042.25	683007.27	
Home Delivered Meals Total:						5226674.74
Home Delivered Meals	Meal/Prep	4051	253.98	5.08	5226674.74	
Non-Medical Transportation Total:						652068.85
Non-Medical Transportation	Trip/Mile	1903	482.61	0.71	652068.85	
Nursing Facility Transition Services Total:						228939.69
Nursing Facility Transition Services	Transition	391	2.49	235.15	228939.69	
Personal Emergency Response System Total:						1364166.16
Personal Emergency Response System	Month/Install	5425	8.78	28.64	1364166.16	
Private Duty Nursing Total:						4576916.74
Private Duty Nursing	15 Minutes	1713	278.32	9.60	4576916.74	
Residential Services Total:						0.00
Residential Services	Per Diem	0	0.00	40.00	0.00	
Training Total:						751.98
Training	15 Minutes	10	8.30	9.06	751.98	

GRAND TOTAL:	84599224.96
Total Estimated Unduplicated Participants:	9517
Factor D (Divide total by number of participants):	8889.27
Average Length of Stay on the Waiver:	257

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
Adult Day Health Total:						3072984.56
Adult Day Health	15 Minutes	522	1857.08	3.17	3072984.56	
Homemaker Total:						21321828.61
Homemaker	15 Minutes	7476	781.38	3.65	21321828.61	
Personal Care Total:						52700049.93
Personal Care	15 Minutes	9014	1665.66	3.51	52700049.93	
Respite Total:						9422958.24
Respite - Per Diem	Per Diem	128	34.12	51.67	225661.49	
Respite	15 Minutes	2422	1075.75	3.53	9197296.74	
Specialized Medical Equipment and Supplies Total:						1463203.47
Specialized Medical Equipment and Supplies	Item	4334	115.62	2.92	1463203.47	
Fiscal Intermediary Total:						175130.00
Fiscal Intermediary	Month	166	10.55	100.00	175130.00	
Goods and Services Total:						9900.00
Goods and Services	Item	33	1.00	300.00	9900.00	
Chore Services Total:						540469.31
Chore Services	15 Minutes	1085	71.88	6.93	540469.31	
Community Living Supports Total:						7062642.49
Community Living Supports	15 Minutes	687	2793.59	3.68	7062642.49	

Counseling Total:						**231845.60**
Counseling	Visit	383	11.30	53.57	**231845.60**	
Environmental Accessibility Adaptations Total:						**940465.46**
Environmental Accessibility Adaptations	Item	509	1.84	1004.17	**940465.46**	
Home Delivered Meals Total:						**6554884.80**
Home Delivered Meals	Meal/Prep	5307	242.66	5.09	**6554884.80**	
Non-Medical Transportation Total:						**877470.30**
Non-Medical Transportation	Trip/Mile	2550	491.58	0.70	**877470.30**	
Nursing Facility Transition Services Total:						**262278.81**
Nursing Facility Transition Services	Transition	577	1.90	239.24	**262278.81**	
Personal Emergency Response System Total:						**1778709.57**
Personal Emergency Response System	Month/Install	7265	8.51	28.77	**1778709.57**	
Private Duty Nursing Total:						**6057168.44**
Private Duty Nursing	15 Minutes	2294	275.62	9.58	**6057168.44**	
Residential Services Total:						**450000.00**
Residential Services	Per Diem	150	75.00	40.00	**450000.00**	
Training Total:						**991.85**
Training	15 Minutes	13	8.80	8.67	**991.85**	
				GRAND TOTAL:		**112922981.44**
				Total Estimated Unduplicated Participants:		**12745**
				Factor D (Divide total by number of participants):		**8860.18**
				Average Length of Stay on the Waiver:		256

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
Adult Day Health Total:						**3403242.36**

Adult Day Health	15 Minutes	581	1842.00	3.18	3403242.36	
Homemaker Total:						22889642.69
Homemaker	15 Minutes	8118	766.20	3.68	22889642.69	
Personal Care Total:						54817443.79
Personal Care	15 Minutes	9352	1665.22	3.52	54817443.79	
Respite Total:						10130627.94
Respite - Per Diem	Per Diem	142	33.08	51.76	243135.35	
Respite	15 Minutes	2690	1041.26	3.53	9887492.58	
Specialized Medical Equipment and Supplies Total:						1642439.84
Specialized Medical Equipment and Supplies	Item	4815	112.95	3.02	1642439.84	
Fiscal Intermediary Total:						242592.00
Fiscal Intermediary	Month	224	10.83	100.00	242592.00	
Goods and Services Total:						13200.00
Goods and Services	Item	44	1.00	300.00	13200.00	
Chore Services Total:						543080.13
Chore Services	15 Minutes	1180	67.09	6.86	543080.13	
Community Living Supports Total:						11064479.02
Community Living Supports	15 Minutes	1070	2802.34	3.69	11064479.02	
Counseling Total:						252713.08
Counseling	Visit	426	11.08	53.54	252713.08	
Environmental Accessibility Adaptations Total:						1072957.23
Environmental Accessibility Adaptations	Item	567	1.96	965.48	1072957.23	
Home Delivered Meals Total:						6828267.88
Home Delivered Meals	Meal/Prep	5761	232.86	5.09	6828267.88	
Non-Medical Transportation Total:						971657.81
Non-Medical Transportation	Trip/Mile	2833	504.38	0.68	971657.81	
Nursing Facility Transition Services Total:						306313.78
Nursing Facility Transition Services	Transition	704	1.84	236.47	306313.78	
Personal Emergency Response System Total:						1953557.01
Personal Emergency Response System	Month/Install	8073	8.33	29.05	1953557.01	

Private Duty Nursing Total:						6697597.42
Private Duty Nursing	15 Minutes	2549	274.56	9.57	6697597.42	
Residential Services Total:						5684640.00
Residential Services	Per Diem	600	227.75	41.60	5684640.00	
Training Total:						1080.66
Training	15 Minutes	14	9.30	8.30	1080.66	
				GRAND TOTAL:		128515532.64
				Total Estimated Unduplicated Participants:		14163
				Factor D (Divide total by number of participants):		9074.03
				Average Length of Stay on the Waiver:		256

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2421623.28
Adult Day Health	15 Minutes	392	1954.94	3.16	2421623.28	
Homemaker Total:						25866762.60
Homemaker	15 Minutes	6455	1110.04	3.61	25866762.60	
Personal Care Total:						46582948.99
Personal Care	15 Minutes	7207	1674.50	3.86	46582948.99	
Respite Total:						11647179.25
Respite - Per Diem	Per Diem	193	38.79	71.13	532512.61	
Respite	15 Minutes	1800	1651.02	3.74	11114666.64	
Specialized Medical Equipment and Supplies Total:						1589597.62
Specialized Medical Equipment and Supplies	Item	5689	349.27	0.80	1589597.62	
Fiscal Intermediary Total:						1893028.30
Fiscal Intermediary	Month	1804	9.35	112.23	1893028.30	

Goods and Services Total:						97225.32
Goods and Services	Item	431	3.79	59.52	97225.32	
Chore Services Total:						503622.86
Chore Services	15 Minutes	902	38.06	14.67	503622.86	
Community Living Supports Total:						22499923.94
Community Living Supports	15 Minutes	2798	2594.01	3.10	22499923.94	
Counseling Total:						201055.79
Counseling	Visit	258	13.80	56.47	201055.79	
Environmental Accessibility Adaptations Total:						1005641.48
Environmental Accessibility Adaptations	Item	535	1.47	1278.71	1005641.48	
Home Delivered Meals Total:						6082718.65
Home Delivered Meals	Meal/Prep	4659	248.21	5.26	6082718.65	
Non-Medical Transportation Total:						797222.49
Non-Medical Transportation	Trip/Mile	2333	495.24	0.69	797222.49	
Nursing Facility Transition Services Total:						1733087.72
Nursing Facility Transition Services	Transition	920	8.15	231.14	1733087.72	
Personal Emergency Response System Total:						1044484.90
Personal Emergency Response System	Month/Install	5746	8.40	21.64	1044484.90	
Private Duty Nursing Total:						9728305.45
Private Duty Nursing	15 Minutes	2068	513.56	9.16	9728305.45	
Residential Services Total:						5183786.61
Residential Services	Per Diem	595	250.64	34.76	5183786.61	
Training Total:						21908.32
Training	15 Minutes	526	3.66	11.38	21908.32	
				GRAND TOTAL:		138900123.58
				Total Estimated Unduplicated Participants:		11929
				Factor D (Divide total by number of participants):		11643.90
				Average Length of Stay on the Waiver:		255

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2579132.79
Adult Day Health	15 Minutes	401	1954.94	3.29	2579132.79	
Homemaker Total:						27510953.85
Homemaker	15 Minutes	6609	1110.04	3.75	27510953.85	
Personal Care Total:						49548103.36
Personal Care	15 Minutes	7379	1674.50	4.01	49548103.36	
Respite Total:						12404728.82
Respite - Per Diem	Per Diem	198	38.79	73.97	568120.67	
Respite	15 Minutes	1843	1651.02	3.89	11836608.16	
Specialized Medical Equipment and Supplies Total:						1688633.13
Specialized Medical Equipment and Supplies	Item	5825	349.27	0.83	1688633.13	
Fiscal Intermediary Total:						2015690.20
Fiscal Intermediary	Month	1847	9.35	116.72	2015690.20	
Goods and Services Total:						103459.04
Goods and Services	Item	441	3.79	61.90	103459.04	
Chore Services Total:						536655.13
Chore Services	15 Minutes	924	38.06	15.26	536655.13	
Community Living Supports Total:						23930520.45
Community Living Supports	15 Minutes	2865	2594.01	3.22	23930520.45	
Counseling Total:						213965.14
Counseling	Visit	264	13.80	58.73	213965.14	
Environmental Accessibility Adaptations Total:						1071282.02
Environmental Accessibility Adaptations	Item	548	1.47	1329.86	1071282.02	
Home Delivered Meals Total:						6476270.50
Home Delivered Meals	Meal/Prep	4770	248.21	5.47	6476270.50	
Non-Medical Transportation Total:						840021.14

Non-Medical Transportation	Trip/Mile	2389	495.24	0.71	840021.14	
Nursing Facility Transition Services Total:						1845546.15
Nursing Facility Transition Services	Transition	942	8.15	240.39	1845546.15	
Personal Emergency Response System Total:						1112381.17
Personal Emergency Response System	Month/Install	5883	8.40	22.51	1112381.17	
Private Duty Nursing Total:						10361078.14
Private Duty Nursing	15 Minutes	2117	513.56	9.53	10361078.14	
Residential Services Total:						5517927.32
Residential Services	Per Diem	609	250.64	36.15	5517927.32	
Training Total:						23337.51
Training	15 Minutes	539	3.66	11.83	23337.51	
				GRAND TOTAL:		147779685.87
				Total Estimated Unduplicated Participants:		12214
				Factor D (Divide total by number of participants):		12099.20
				Average Length of Stay on the Waiver:		255