

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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.

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

### 1. Request Information (1 of 3)

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**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*):

**Michigan Traumatic Brain Injury Program**

**C. Type of Request:** new

**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**

**New to replace waiver**

Replacing Waiver Number: \_\_\_\_\_

**Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

**Base Waiver Number:** \_\_\_\_\_

**Amendment Number**

(if applicable): \_\_\_\_\_

**Effective Date:** (*mm/dd/yy*) \_\_\_\_\_

**Waiver Number:** MI.0968.R00.00

**Draft ID:** MI.02.00.00

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

Regular Waiver

**E.**

**Proposed Effective Date:** (*mm/dd/yy*)

01/01/12

### 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

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

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

**Nursing Facility**

Select applicable level of care

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

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

This program will serve persons who have suffered a qualifying traumatic brain injury within 15 months of admission to the Michigan Traumatic Brain Injury Program (MTBIP) and who have the capacity to benefit from the program services. Individuals must be age 18 or older and meet the Michigan Medicaid Nursing Facility Level of Care as documented by the Michigan Medicaid Level of Care Determination tool.

**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 Eligibility 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

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**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.

Michigan is committed to providing the highest quality care to residents who have suffered a traumatic brain injury (TBI). The Michigan TBI Program (MTBIP) provides necessary services and supports to persons suffering recent TBI injuries who, but for the provision of these services, would otherwise be served within a nursing facility or another institutional setting. The program is designed to provide critical rehabilitation and support in the initial post-injury period with the goal of assisting the participant in becoming capable of living in the most independent setting that they might choose.

The MTBIP primarily operates through an Organized Health Care Delivery System (OHCDS) in which an independent contractor acts as the state's agent and enrolls providers into a health system specializing in TBI. The exact nature of that entity or entities will be further defined as MDCH solicits bids for program providers. To ensure provider choice, MDCH also retains the ability to enroll service providers.

There are essentially two levels of services provided by the Michigan TBI Program. The first, Transitional Residential Rehabilitation (TRR) Services, are generally required immediately upon release from an acute care facility, often a hospital. The second, Home and Community-based Services, are more focused toward providing necessary supports in a community setting.

TRR services are post-acute rehabilitative services provided in a congregate setting. These are short-term services for participants who can benefit from the advanced level of rehabilitative therapies offered. Research indicates that this type of treatment given at this juncture post-injury is crucial in determining the longer-term prospects of the participant. Providers of Transitional Residential Rehabilitation services must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and have the expertise and experience to treat this highly specialized and complex population. Twenty program slots are reserved to ensure there is available capacity for participants transitioning from acute care facilities.

Upon completion of TRR, participants are placed into a more homelike setting and provided home and community-based services to support an independent living environment. The HCBS portion of the MTBIP program will provide TBI-focused services using providers experienced in serving this population. Continuing rehabilitative therapies will help assist the participant in returning to a community living situation. It is hoped that some of the participants will eventually seek employment in the community. Not all MTBIP participants must initially enter through the TRR service. Many participants will not require that intensive rehabilitation, but can benefit immediately from the home and community-based supports.

Research literature in the TBI field indicates that TBI patients eventually "plateau" in their recovery. Michigan data indicates that roughly 24 months post-injury, persons with a TBI are stable enough to require only a maintenance level of support to live independently or might even require no supports at all. To keep program slots available for persons needing TBI-specific services, the MTBIP will transition participants who continue to meet the nursing facility level of care standard to Michigan's MI Choice waiver, the state's HCBS-ED program, after 24 months of support. Participants who might need more than 24 months of TBI-specific support may request an extension that will be reviewed by MDCH.

MDCH recognizes that this program will neither fully address the needs of all persons with TBI issues in the state nor begin to address the service void of persons with acquired or other types of brain injuries. It is designed specifically to address the immediate needs of persons suffering recent TBI injuries who can benefit from these this type of services and supports.

## 3. Components of the Waiver Request

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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

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- 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

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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

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*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:

The Michigan Traumatic Brain Injury Program has been constructed in conjunction with a wide array of state departments, providers, advocates, caregivers, stakeholders, and organizations. The Michigan TBI Council serves as the central platform for discussions and brings together many of the TBI providers in the state along with the Brain Injury Association of Michigan and many department representatives who provide care and rehabilitation to this population in a disparate fashion. A number of caregivers and TBI patients have augmented the group to widen the scope of experience and discussion.

The development process has been conducted with a high degree of visibility, with regular status reports given at related conferences and meetings. The established Medicaid community has been updated through letters, announcements, and other communications. Each point of the development has been available for review, input, and comment up to and including the final draft of the waiver application.

Updates have been sent to Tribal Government contacts inviting each to participate in the discussions and planning process and later notifying them of MDCH's intent to submit this waiver application.

**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)

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

**Last Name:** Coleman

**First Name:** Jacqueline

**Title:** Waiver Coordinator

**Agency:** Medical Services Administration, Actuarial Division

**Address:** P.O. Box 30479

**Address 2:** 400 S. Pine, 7th Floor

**City:**

**State:** Lansing  
**Michigan**  
**Zip:** 48909-7979  
**Phone:** (517) 241-7172 **Ext:**  **TTY**  
**Fax:** (517) 335-5112  
**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

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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:** Oct 6, 2011

**Last Name:** Fitton

**First Name:** Stephen F.

**Title:** Director

**Agency:** Medical Services Administration

**Address:** P.O. Box 30479

**Address 2:** 400 South Pine Street

**City:** Lansing

**State:** Michigan

**Zip:** 48909

**Phone:** (517) 241-7882

**Fax:** (517) 335-5007

**E-mail:** FittonS@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:

**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

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### 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

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- 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.*  
The state Medicaid agency will contract with an agency or agencies to handle administrative and operational responsibilities for the waiver. Each entity will operate as an Organized Health Care Delivery System (OHCDS).
- Each OHCDS will be responsible for identifying and contracting with potential TBI service providers. They will provide assistance with enrolling participants including assisting participants with completion of the Medicaid eligibility application (DHS 1171) to demonstrate financial eligibility. They will manage enrollments against approved limits, review service plans to verify that waiver requirements are met, and ensure that standards of health and safety are met. They will conduct quality management reviews and institute corrective action plans when necessary. They will conduct utilization reviews and provide financial and other reports as requested. They will assist participants in transitioning to the MI Choice program or to independent living at an appropriate time.
- 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

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

## Appendix A: Waiver Administration and Operation

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- 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) is primarily responsible for providing administrative oversight and assessing the performance of the OHCDS. This section is situated within the Bureau of Medicaid Policy and Health System Innovation of the Medical Services Administration, the single state Medicaid agency for

the State of Michigan. The Medical Services Administration is part of the Michigan Department of Community Health (MDCH).

## **Appendix A: Waiver Administration and Operation**

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- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

MDCH conducts annual on-site reviews of each OHCDs using the Traumatic Brain Injury Site Review Protocol (TBISRP). The TBISRP is structured in accordance with the CMS Protocol and the CMS Quality Framework and is closely modeled after the review framework in place for the MI Choice program. Each review area in the TBISRP is separated into two parts: Structure (policies and procedures that each OHCDs is required to have) and Process (evidence that the OHCDs actually performs activities according to their published policies and procedures). The TBISRP also contains requirements for person-centered planning (PCP).

Each review 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 all requirements are met. If required items are not evident, MDCH staff discuss the missing elements with OHCDs staff prior to issuing a final report. The final report verifies one of three findings: 1) there was evidence that required item(s) were met as required, 2) no such evidence was found, or 3) incomplete evidence was found.

The on-site visit also verifies the OHCDs meets administrative and program policy and procedural requirements, including that program records are maintained for six years, that program records are locked and controlled access is maintained according to the HIPAA requirements, that program policies and procedures are accessible to OHCDs employees, and that the OHCDs follows proper accounting procedures. MDCH staff also review agreements with providers, perform provider reviews, and may conduct interviews with both supports coordinators and MTBIP participants.

Following a review, MDCH prepares an administrative report. The report identifies problem areas and instances where required documentation was either not evident or not found. The report is then sent to the OHCDs. The OHCDs has 30 days to respond with a corrective action plan. After receiving the OHCDs's written response and engaging in any necessary clarifying discussion, MDCH accepts or amends the corrective action plan. Corrective action plans are then monitored to ensure implementation within established timelines.

MDCH staff conducts annual on-site reviews to discuss the progress OHCDs make at implementing their individual quality management plans. A progress report is compiled for each visit, noting exemplary model practices and MDCH recommendations for strengthening plans.

MDCH will conduct annual on-site quality assurance reviews of clinical records for the OHCDs. This clinical review also includes home visits to active MTBIP participants. The review utilizes the TBISRP to measure compliance to specified requirements. The data collected are compiled into reports submitted to MDCH. MDCH staff then generates a report to the OHCDs summarizing significant findings of compliance 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 TBISRP.

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

1. Routinely monitors expenditures and administrative data from the Medicaid data warehouse.
2. Verifies licensure for each registered nurse and social worker supports coordinator employed at the OHCDs to confirm active licensure. MDCH houses this information on a public website.
3. Reviews, analyzes, and compiles all TBI waiver 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. Investigates and monitors through resolution complaints received regarding operations of the TBI 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.

6. Produces a Summary Expenditure Report as needed and analyzes it by comparing individual OHCDs results with statewide OHCDs results, if applicable. This report details total expenditures and total units for each service by number of participants receiving each service. Care management and administrative expenditures are also included in this report.
7. Conducts annual reimbursement reconciliations with each OHCDs to close out and settle final waiver expenditures.
8. Monitors the implementation of the Critical Incidence Management Reporting System and reviews and evaluates OHCDs reports submitted annually.
9. Reviews and analyzes OHCDs Quality Management (QM) Plan Reports submitted annually, currently on September 30. The reports provide detail regarding annual progress in quality assurance and quality improvement activities. The reports compile and compare individual OHCDs quality indicators to statewide averages. OHCDs and MDCH staff review QM summaries.

## Appendix A: Waiver Administration and Operation

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

## Appendix A: Waiver Administration and Operation

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### 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:**

**Percent of OHDCS that substantially meet Administrative Quality Assurance Review standards. Numerator = Number of OHDCS that substantially meet Administrative Quality Assurance Review standards. Denominator = All OHDCS.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Percent of OHDCS that substantially meet Clinical Quality Assurance Review standards. Numerator = Number of OHDCS that substantially meet Clinical Quality Assurance Review standards. Denominator = All OHDCS.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Percent of OHCDs Quality Management Plans that are reviewed and approved by MDCH. Numerator = Number of OHCDs with Quality Management Plans reviewed and approved by MDCH. Denominator = All OHCDs.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Percent of OHCDs sub-contractor monitoring reports that are reviewed and approved by MDCH. Numerator = Number of OHCDs sub-contractor monitoring reports reviewed and approved by MDCH. Denominator = All OHCDs sub-contractor monitoring reports.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**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.  
MDCH conducts annual administrative and clinical reviews of the OHCDS to ensure compliance with program policies and procedures. Summary reports of analyzed findings are compiled and sent to the OHCDS. Reviews can be more frequent when necessary.

When areas of deficiency are determined, MDCH notifies the OHCDS. The OHCDS then has 30 days to submit a corrective action plan, which is reviewed and amended or approved by MDCH. The plan is then monitored for implementation to established guidelines.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	18		<input checked="" type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

A participant must have suffered a qualifying traumatic brain injury within 15 months prior to the date of acceptance into the MTBIP. Qualifying injuries include cranio-cerebral head trauma arising from blunt or penetrating trauma or from acceleration-deceleration forces that is associated with any of these symptoms or signs attributed to the injury: decreased level of consciousness, amnesia, other neurological or neuropsychological abnormalities, skull fracture, or diagnosed intracranial lesions.

When the number of program participants receiving and applying for MTBIP services exceeds program capacity, a waiting list will be utilized and actively monitored by the OHCDS. Priority will first be given to persons requiring transitional residential rehabilitation services and then by date of placement on the waiting list subject to continuing participant eligibility.

Participants in the MTBIP may receive services for a 24-month period beginning with the date they are enrolled in the program. At the conclusion of the 24-month period, participants are re-evaluated. Participants who demonstrate the need for continued TBI-specific supports may request an extension from the program coordinator in MDCH. Extensions may be granted for a specific period, but must be reviewed every two months.

Persons who no longer need TBI-specific supports, but still meet the nursing facility level of care and require continued support will be transitioned to the MI Choice program as a priority population. Otherwise, the participant will receive support coordination and transition assistance to the appropriate available programs.

**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:*

---

**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	100
Year 2	100
Year 3	100

**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	

**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).**

Purpose(s) the State reserves capacity for:

Purposes
Reservation for Transitional Residential Rehabilitation

**Appendix B: Participant Access and Eligibility**

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

**Purpose** (*provide a title or short description to use for lookup*):

Reservation for Transitional Residential Rehabilitation

**Purpose** (*describe*):

Michigan reserves 20 waiver slots for individuals who require transitional residential rehabilitation services immediately following acute or post-acute TBI treatment. Individuals who receive rehabilitation early in the course of this type of injury generally require fewer life-long services and have a greater chance at independence. Because intensive rehabilitation can have lasting benefit to the individual, we want to assure that there is always the opportunity to provide services during this "window of opportunity". Early intervention offers unique benefits that we are seeking to protect by creating this reservation.

To clarify, any participant in the MTBIP program can receive TRR services, however, MDCH wished to reserve 20 slots specifically for persons who require TRR services.

**Describe how the amount of reserved capacity was determined:**

Michigan has analyzed the number of unique individuals served by Medicaid who have received similar intensive rehabilitation services following a TBI through an existing TBI Memorandum of

Understanding program. The average case load over the past five years indicates that 20 slots should be adequate to meet the needs of Michigan residents. While extraordinary conditions might result in demand exceeding this reserve, there remains the ability to address this shortage through provisional state funding. There is no expectation that this should occur.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20

## Appendix B: Participant Access and Eligibility

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

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

All participants of 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. Participants must be given information on all programs for which they qualify. Participants must indicate their choice and document they have been informed of their options via the Michigan Freedom of Choice Form that is provided at the conclusion of the LOCD. This form must be placed in the participant's record and retained for six years.

When the number of program participants receiving and applying for the MTBIP exceeds program capacity, a procedure is implemented giving priority in descending order to the following groups for enrollment in the program: Priority will first be given to persons requiring transitional residential rehabilitation services and then by date of placement on the waiting list subject to continuing participant eligibility.

## Appendix B: Participant Access and Eligibility

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

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

**Appendix B: Participant Access and Eligibility****B-4: Eligibility Groups Served in the Waiver**

a.

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

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

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

- No  
 Yes

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

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

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

*Select one:*

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

Specify percentage:

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

Participants must have suffered a qualifying traumatic brain injury within fifteen months prior to entry into the program. A qualifying TBI is one that meets the definition of the Center for Disease Control (CDC) as amended.

**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:**

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- 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:*

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## 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.**

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

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## 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).

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

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## 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: 2

**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:*

The contracted OHCDS.

- 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, i.e., physician, registered nurse (RN), licensed practical nurse (LPN), licensed social worker (MSW or BSW), 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 on one of seven doors for nursing facility level of care. These doors are: Door 1: activities of daily living (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 for examination AND at least four physician order changes in the last 14 days,  
OR
2. At least two physician visits for examination 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. These conditions are:

- Stage 3-4 Pressure Sore
- IV or Parenteral Feedings
- Intravenous Medications
- End-Stage Care
- Daily Tracheotomy Care, Daily Respiratory Care, Daily Suctioning
- Pneumonia Within the Last 14 Days
- Daily Oxygen Therapy
- Daily Insulin with Two Order Changes in the Last 14 days
- Peritoneal or Hemodialysis

Scoring Door 5: The individual must have required at least 45 minutes of active physical therapy, occupational therapy or speech therapy (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 delusion 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 or 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 is entered into the MDCH database only once. Re-evaluations are conducted by the TBI Supports Coordinator. The determination must be noted in the case record and signed and dated by the individual conducting the reassessment signifying that the participant meets the nursing home level of care.

- 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:*

Every three months or upon a 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*):

Evaluations and re-evaluations to ensure that the participant meets the nursing facility level of care are to be noted by the supports coordinator in the participant's plan of service and maintained in the participant's record. The plan of service must also document any explanation of any and all variances to the re-evaluation schedule.

The OHCDS must periodically review participant plans of service to ensure timely re-evaluations. The schedule for such reviews must be identified in the approved Quality Management Plan for the OHCDS.

MDCH monitors participant plans of service and OHCDS review schedules during annual administrative and clinical review processes or whenever circumstances dictate.

- 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 written plans of service will be maintained by supports coordinators employed by the OHCDS for a minimum period of six years.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

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### **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:**

**Number and percent of newly enrolled waiver participants who meet NFLOC criteria prior to the receipt of services. Numerator = Number of newly enrolled**

waiver participants who have been determined to meet NFLOC criteria prior to the receipt of services. Denominator = All new enrollees.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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:**

**Number and percent of enrolled participants who have a NFLOC determination completed within 365 days of the previous evaluation. Numerator = Number of enrolled participants with a NFLOC determination completed within 365 days of the previous evaluation. Denominator = All enrolled participants.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

		Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

**Number and percent of LOC evaluations where the OHCDs accurately applied LOC criteria. Numerator = Number of initial LOC evaluations where the LOC criteria is accurately applied. Denominator = All initial LOC evaluations.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: 

**Performance Measure:**  
**Number and percent of LOC reevaluations where the OHCDS accurately applied LOC criteria. Numerator = Number of LOC reevaluations where the LOC criteria is accurately applied. Denominator = All LOC reevaluations.**

**Data Source** (Select one):  
**Operating agency performance monitoring**  
 If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**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.  
MDCH requires the NFLOC determination be entered into the single sign on system. Edits in the Medicaid claim system (CHAMPS) assure the valid NFLOC determination was put in this system prior to the receipt of services. Claims for services rendered prior to the data entry of the NFLOC determination are rejected. The system also rejects claims for persons who do not meet NFLOC criteria.

MDCH will review case records to assess whether the OHCDS performed a reevaluation of the participant’s LOC within 365 days of the initial evaluation. MDCH will require corrective action for any participant who did not have a reevaluation of the LOC within 365 days of the initial evaluation.

MDCH will review initial assessment data and compare this to the initial LOC evaluation. MDCH will determine if assessment data and the LOC evaluation are congruent. If not, MDCH will require corrective action from the OHCDS.

MDCH will review reassessment data and compare this to the LOC reevaluation. MDCH will determine if reassessment data and the LOC reevaluation are congruent. If not, MDCH will require corrective action from the OHCDS.

**ii. Remediation Data Aggregation**

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 covered nursing facility care, MI Choice, PACE, or MTBIP services 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 all available benefit options and select, in writing, if they choose to receive services in one of those specific programs. This election must take place prior to initiating one of those services under Medicaid.

The applicant or their legal representative must be informed by the persons completing the LOCD or the supports coordinator of the services available to persons meeting the nursing facility level 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 in the participant's record for a period of three years. The Freedom of Choice form must also be witnessed by an applicant's representative if available.

- 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 service for a period of at least six 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 staff are required to provide language and culturally sensitive information to all applicants for the MTBIP. Brochures are printed in Spanish, French, Arabic, Polish, and Chinese. In meeting with individual applicants or participants, agencies 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	Pre-Vocational Employment Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Statutory Service	TBI Day Program		
Statutory Service	TBI Personal Care Services		
Statutory Service	TBI Supports Coordination		
Extended State Plan Service	Private Duty Nursing		
Other Service	Assistive Technology & Enhanced Supplies		
Other Service	Community Transitions		
Other Service	Environmental Accessibility Adaptations (EAA)		
Other Service	Home Delivered Meals		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response System (PERS)		
Other Service	TBI Counseling		
Other Service	TBI Nursing Services		
Other Service	TBI Occupational Therapy		
Other Service	TBI Physical Therapy		
Other Service	TBI Speech Language Pathology Therapy		
Other Service	TBI Transitional Residential Rehabilitation Services		
Other Service	Training and Educational Services for Unpaid Caregivers		

## 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:**

Prevocational Services

**Alternate Service Title (if any):**

## Pre-Vocational Employment Services

**Service Definition** (*Scope*):

Rehabilitation services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented but instead aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitate rather than to achieve explicit employment activities. Any transportation required to a training site is included in the service rate.

Documentation shall be maintained in the case record that the services received are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

**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
Agency	Physical Therapist
Agency	Occupational Therapist
Agency	Prevocational Rehabilitation Specialist
Agency	Speech Language Pathologist

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Pre-Vocational Employment Services**

**Provider Category:**

Agency

**Provider Type:**

Physical Therapist

**Provider Qualifications****License** (*specify*):

MCL 333.17801 - 17831

**Certificate** (*specify*):

American Academy for the Certification of Brain Injury Specialists (AACBIS) Preferred

**Other Standard** (*specify*):

At least one member of the facility staff shall have a working knowledge of the Workers' Disability Compensation Act

Commission on Accreditation of Rehabilitation Facilities (CARF) accredited and/or Comprehensive Vocational Evaluation Services and Employee Development Services accreditation

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

Either the contracting OHCDs or MDCH.

**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: Pre-Vocational Employment Services**

**Provider Category:**

Agency

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License (specify):**

Occupational Therapist - MCL 333.19301 - 18317

**Certificate (specify):**

American Academy for the Certification of Brain Injury Specialists (AACBIS) Preferred

**Other Standard (specify):**

At least one member of the facility staff shall have a working knowledge of the Workers' Disability Compensation Act

CARF accredited or Comprehensive Vocational Evaluation Services and Employee Development Services accreditation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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: Pre-Vocational Employment Services**

**Provider Category:**

Agency

**Provider Type:**

Prevocational Rehabilitation Specialist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

American Academy for the Certification of Brain Injury Specialists (AACBIS) Preferred

Prevocational Rehabilitation Specialist - Possess a master's degree in a field related to rehabilitation counseling and as a Vocational Rehabilitation Counselor or the equivalent experience in the evaluation and training of persons with disabilities. In regards to education, fields related to rehabilitation counseling will be considered to be guidance and counseling, special education, social work, sociology or psychology.

**Other Standard (specify):**

At least one member of the facility staff shall have a working knowledge of the Workers' Disability Compensation Act

CARF accredited or Comprehensive Vocational Evaluation Services and Employee Development Services accreditation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to the delivery of services and annually thereafter.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Pre-Vocational Employment Services**

---

**Provider Category:**

Agency

**Provider Type:**

Speech Language Pathologist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

American Academy for the Certification of Brain Injury Specialists (AACBIS) Preferred

Speech Language Pathologist - Requires a master's degree in a speech-language pathology program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology. Speech-language pathology therapists will be knowledgeable in anatomy, physiology, and the development of the areas of the body involved in speech, language, and swallowing; the nature of disorders; principles of acoustics; and psychological aspects of communication. Graduate students also learn to evaluate and treat speech, language, and swallowing disorders and receive supervised clinical training in communication disorders.

Must have current certification through the American Speech Language and Hearing Association.

**Other Standard (specify):**

At least one member of the facility staff shall have a working knowledge of the Workers' Disability Compensation Act

CARF accredited or Comprehensive Vocational Evaluation Services and Employee Development Services accreditation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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### 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):****Service Definition (Scope):**

Respite services provided to participants unable to care for themselves that are furnished on a short-term basis because of the need for relief of those persons normally providing uncompensated care for the participant. Respite can be inside the participant's home or outside of the home such as a Medicaid certified hospital or a licensed group home, which includes adult foster care homes and homes for the aged.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a State-approved facility that is not a private residence.

Respite services include:

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

Personal care and rehabilitation aides may perform higher-level, non-invasive tasks, such as maintenance of catheters and feeding tubes, minor dressing changes, or stage I wound care if the direct care worker has been individually trained and supervised by an RN for each participant requiring such care. The supervising RN must assure, in writing, each worker's competence and confidence in the performance of each task required.

**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
Agency	Nursing Facility
Individual	Individual
Agency	Adult Foster Care Home

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Facility

**Provider Qualifications****License** (*specify*):

Michigan Public Health Code ACT 368 of 1978, Article 17, Part 215, Section 333 21511

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

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

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

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

Either the contracting OHCDS or MDCH.

**Frequency of Verification:**

Prior to delivery of service annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):

Required to take the Michigan Public Service Agency TBI Training Course

**Other Standard** (*specify*):

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

Individuals (personal care/rehabilitation aide) providing respite services must have relevant experience specifically dealing with TBI.

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

Either the contracting OHCDS or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

## Agency

**Provider Type:**

Adult Foster Care Home

**Provider Qualifications****License (specify):**

Michigan Compiled Laws (MCL) 400.701ff

**Certificate (specify):**

N/A

**Other Standard (specify):**

1. Each respite service provider shall demonstrate a working relationship with a hospital or other health care facility for the provision of emergency health care services as might be necessary. With the assistance of the participant and/or the participant's caregiver, the OHCDs and direct service provider shall determine an emergency notification plan for each participant pursuant to each visit.

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

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

Either the contracting OHCDs or MDCH.

**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:**

Supported Employment

**Alternate Service Title (if any):**

Supported Employment

**Service Definition (Scope):**

Supported employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports and who need supports because of their disabilities, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or to develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for necessary adaptations and supervision and training required by participants receiving services as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

**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
Agency	Supported Employment Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Agency

**Provider Qualifications**

**License** (*specify*):

Providers must be properly licensed for the specific occupation as stipulated in the Occupational Code defined in P.A. 299 of 1980.

**Certificate** (*specify*):

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard** (*specify*):

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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:**

Day Habilitation

**Alternate Service Title (if any):**

TBI Day Program

**Service Definition (Scope):**

A flexible way to receive all of the benefits of an inpatient comprehensive rehabilitation program while residing at home or in a community setting. The TBI Day Program consists of a minimum of physical, occupational and speech therapies. Services are furnished three (3) or more hours per day on a regularly scheduled basis for three (3) or more days per week or as specified in the service plan in a non-institutional, community based setting. It encompassing both health and social services needed to ensure the optimal functioning, both physically and cognitively, of the participant. The focus of the day program ranges from active treatment and recovery to social interaction, pre-vocational, and quality of life activities. Meals provided as part of these services shall not constitute a "full nutritional regimen" ( 3 meals per day). Transportation between the participant's place of residence and the TBI Day Program Center will be 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  
 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	Day Program Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: TBI Day Program**

**Provider Category:**

Agency

**Provider Type:**

Day Program Provider

**Provider Qualifications****License (specify):****Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

Each program shall have CARF accreditation.

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

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

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 three (1:3) participants.

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 TBI 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.

If the provider operates its own vehicles for transporting participants to and from the program site, the provider shall meet the standards set forth for Non-Medical Transportation services defined in the waiver.

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.

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 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.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

##### **Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## **Appendix C: Participant Services**

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### **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):**

TBI Personal Care Services

#### **Service Definition (Scope):**

TBI Personal Care Services are delivered within a framework that specifically addresses the physical and cognitive needs of the person with a TBI. Services are provided by TBI personal care aides, certified nursing assistants, or rehabilitation aides with TBI training and experience and are intended to facilitate the participant's independence and promote reasonable participation in the community as specified in the individual plan of service.

TBI Personal Care services include:

A. Assisting\* [see note below], reminding, cueing, observing, guiding and 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 or guidance with such activities as:

- money management
- 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, or observing of medication administration.

D. 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.

When transportation incidental to the provision of TBI Personal Care Services 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).

TBI Personal Care Services do not include the cost associated with room and board.

\* 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 include that the provider qualifications and training requirements are more stringent for TBI Personal Care Services tasks as provided under the waiver than the requirements for similar types of services under the State Plan.

Services may be furnished outside the participant's home.

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

TBI Personal Care Services cannot be provided in circumstances where they would be a duplication of services available under the Medicaid 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	TBI Personal Care Services Aide
Agency	Certified Nursing Assistant (CNA)
Agency	Rehabilitation Aide
Agency	TBI Personal Care Services Aide

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: TBI Personal Care Services**

**Provider Category:**

## Individual

**Provider Type:**

TBI Personal Care Services Aide

**Provider Qualifications****License** (*specify*):

N/A

**Certificate** (*specify*):

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard** (*specify*):

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDs.

A registered nurse, licensed to practice nursing in the State Of Michigan, shall supervise all TBI Personal Services providers. Such supervision shall be available at all times that direct care workers are providing services.

Service providers may perform higher-level, non-invasive tasks, such as maintenance of catheters and feeding tubes, minor dressing changes, or stage I wound care if the direct care worker has been individually trained and supervised by an RN for each participant requiring such care. The supervising RN must assure, in writing, each worker's competence and confidence in the performance of each task required.

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

Either the contracting OHCDs or MDCH.

**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: TBI Personal Care Services****Provider Category:**

## Agency

**Provider Type:**

Certified Nursing Assistant (CNA)

**Provider Qualifications****License** (*specify*):

N/A

**Certificate** (*specify*):

Must be certified through an accredited CNA training program.

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard** (*specify*):

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDs.

A registered nurse, licensed to practice nursing in the State Of Michigan, shall supervise all TBI Personal Services providers. Such supervision shall be available at all times that direct care workers are providing services.

Services providers may perform higher-level, non-invasive tasks, such as maintenance of catheters and feeding tubes, minor dressing changes, or stage I wound care if the direct care worker has been

individually trained and supervised by an RN for each participant requiring such care. The supervising RN must assure, in writing, each worker's competence and confidence in the performance of each task required.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: TBI Personal Care Services**

---

**Provider Category:**

Agency

**Provider Type:**

Rehabilitation Aide

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

A registered nurse, licensed to practice nursing in the State Of Michigan, shall supervise all TBI Personal Services providers. Such supervision shall be available at all times that direct care workers are providing services.

Services providers may perform higher-level, non-invasive tasks, such as maintenance of catheters and feeding tubes, minor dressing changes, or stage I wound care if the direct care worker has been individually trained and supervised by an RN for each participant requiring such care. The supervising RN must assure, in writing, each worker's competence and confidence in the performance of each task required.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: TBI Personal Care Services**

---

**Provider Category:**

Agency

**Provider Type:**

TBI Personal Care Services Aide

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDs.

A registered nurse, licensed to practice nursing in the State Of Michigan, shall supervise all TBI Personal Services providers. Such supervision shall be available at all times that direct care workers are providing services.

Services providers may perform higher-level, non-invasive tasks, such as maintenance of catheters and feeding tubes, minor dressing changes, or stage I wound care if the direct care worker has been individually trained and supervised by an RN for each participant requiring such care. The supervising RN must assure, in writing, each worker's competence and confidence in the performance of each task required.

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

Either the contracting OHCDs or MDCH.

**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:**

Case Management

**Alternate Service Title (if any):**

TBI Supports Coordination

**Service Definition (Scope):**

TBI Supports Coordination is a service designed to inform, assist and coordinate services to address the range of needs of the participant. Supports coordinators utilize all available services and supports before authorizing MTBIP services when planning care with the participant, family members, or guardian. Supports coordinators work in partnership with the participant and their allies to determine service and support needs when planning the participant's care. Supports coordinators incorporate choices and preferences into the planning process to assure a person-focused approach to the receipt of services and supports. Supports coordinators arrange formal services based upon participant choice and approval. The participant's support team and the supports coordinator explore other funding options and intervention opportunities when personal goals expand beyond meeting basic needs. Supports coordinators assist in arranging for services and supports and monitor the quality of services received. Supports coordination includes valuing the cultural backgrounds of participants in the decision making process.

TBI Supports Coordinators will conduct baseline evaluations for functional, health, cognitive and other service needs specific to the TBI participant along with all level of care assessments and reassessments, They are integral to the development of an individual service plan as well as monitoring and follow-up.

TBI Supports Coordinators will assist in the admission to and transfer from the Transitional Residential Rehabilitation Program to the Home and Community Based Service Program.

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	Social Worker
Agency	Transitional Residential Rehabilitation Case Manager
Individual	Registered Nurse

## Appendix C: Participant Services

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

Service Type: Statutory Service  
Service Name: TBI Supports Coordination

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License (specify):

MCL 333.18501 ... 333.19518

Certificate (specify):

AACBIS Certification Preferred

Other Standard (specify):

Must have experience working with TBI clientele.

Verification of Provider Qualifications

Entity Responsible for Verification:

Either the contracting OHCDs or MDCH.

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: Statutory Service  
Service Name: TBI Supports Coordination

Provider Category:

Agency

Provider Type:

Transitional Residential Rehabilitation Case Manager

Provider Qualifications

**License (specify):**

MCL 333.18501 - 18518

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

Must be employed by a CARF accredited facility/agency.

Must have experience working with TBI clientele.

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

Either the contracting OHCDs or MDCH.

**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: TBI Supports Coordination****Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications****License (specify):**

MCL 333.17201 ... 333.17242

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

Must have experience working with TBI clientele.

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

Either the contracting OHCDs or MDCH.

**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:**

Extended State Plan Service

**Service Title:**

Private Duty Nursing

**Service Definition (Scope):**

Individual and continuous neuro-rehabilitative 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 residing at home or in a community setting. PDN for MTBIP participants 18-21 years old are provided by the Medicaid State Plan. PDN services for participants older than 21 years are not available through the Medicaid State Plan.

This service may include medication administration as defined under MCL 333.1722

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

Services paid for with MTBIP funds shall not duplicate nor replace services available through the Michigan Medicaid state 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	Licensed Practical Nurse
Individual	Registered Nurse
Agency	Home Care Agency

## Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service  
**Service Name:** Private Duty Nursing

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications**

**License** (specify):

MCL 333.17201-17242

**Certificate** (specify):

AACBIS Certification Preferred

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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:** Extended State Plan Service  
**Service Name:** Private Duty Nursing

**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications****License** (*specify*):

MCL 333.17201-17242

**Certificate** (*specify*):

AACBIS Certification Preferred

**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to deliver of services and annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Private Duty Nursing****Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications****License** (*specify*):

Services must be provided by a Registered Nurse or a Licensed Practical Nurse.

MCL 333.17201-17242

**Certificate** (*specify*):

AACBIS Certification Preferred

**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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:**

Assistive Technology &amp; Enhanced Supplies

**Service Definition (Scope):**

Assistive technology and enhanced supplies includes devices, controls, or appliances specified in the plan of service which enable recipients 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, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment 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. MTBIP funds are also used to cover the costs of maintenance and upkeep of equipment. The coverage includes assessment of and training the participant or caregivers in the operation and maintenance of the equipment or the use of a supply when initially purchased. Items purchased through the MTBIP 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 individual or are considered experimental. The purchase or lease of a vehicle, insurance, and routine repairs are not covered. Personal Emergency Response System units are not included in this service and are considered a separate covered service. Similarly, PERS monthly charges are not included in this service.

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

Lifetime cap of \$20,000.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agency Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology & Enhanced Supplies****Provider Category:**

Agency

**Provider Type:**

Agency Provider

**Provider Qualifications****License (specify):**

Enrolled Medicaid provider.

**Certificate (specify):**

N/A

**Other Standard (specify):**

Each direct service provider must enroll in Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.

The OHCDs or direct service provider must pursue payment by Medicare, Medicaid State Plan or other entities, as applicable before the authorization of MTBIP payment.

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

Either the contracting OHCDs or MDCH.

**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:**

Community Transitions

**Service Definition (Scope):**

Community Transition services are non-recurring expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a private residence, where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) Housing deposit - a one time expense to secure housing or obtain a lease, (b) Utility hook ups and deposits – a one time expense to initiate and secure utilities (cable is not included); (c) Furniture, appliances and moving expenses – one time expenses necessary to occupy and safely reside in a community residence (TVs, DVD Players and VCRs are not included); d) Cleaning – a one time cleaning expense to ensure a clean environment, including pest eradication, allergen control and overall cleaning; e) Coordination and support services to facilitate transitioning of individuals to a community setting. e) Other services deemed necessary and documented within the plan of service to accomplish the transition into a safe community setting.

Community Transition services are furnished only to the extent that they are necessary and clearly stipulated in the individual service plan and the person is unable to meet such expenses and the service cannot be obtained through other sources. Community Transition services do not include monthly rental or mortgage expense, food, regular utility charges, household appliances, or items that are intended for purely diversional or recreational purposes.

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

Lifetime cap of \$5,000.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Contract Provider
Individual	Contract Provider

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Community Transitions**

---

**Provider Category:**

Agency

**Provider Type:**

Contract Provider

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

Services must be authorized and coordinated by a Registered Nurse, Clinical Social Worker, or otherwise qualified supports coordinator.

Providers must be properly licensed for the specific occupation as stipulated in the Occupational Code defined in P.A. 299 of 1980.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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 Transitions**

---

**Provider Category:**

Individual

**Provider Type:**

Contract Provider

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

Services must be authorized and coordinated by a Registered Nurse, Clinical Social Worker, or otherwise qualified supports coordinator.

Providers must be properly licensed for the specific occupation as stipulated in the Occupational Code defined in P.A. 299 of 1980.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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:**

Environmental Accessibility Adaptations (EAA)

**Service Definition (Scope):**

Physical adaptations to the home required by the MTBIP participant's service plan, which are necessary to ensure the health, welfare, and safety of the TBI participant or that enable the participant to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may 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 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 waiver participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. Assessments and specialized training needed in conjunction with the use of the EAA are included as part of the cost of the service.

OHCDs may not approve environmental accessibility adaptations for AFC (should be handicap accessible) or for rental property without close examination of the rental agreement and the landlord's responsibility (including both legal and monetary) to furnish such adaptations.

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

Lifetime limit of \$20,000.

Prior evaluation by a licensed Occupational Therapist or a licensed physical therapist.

**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	Contracted Provider
Agency	Contracted Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations (EAA)**

**Provider Category:**

Individual

**Provider Type:**

Contracted Provider

**Provider Qualifications****License (specify):**

Providers must be properly licensed for the specific occupation as stipulated in the Occupational Code defined in P.A. 299 of 1980.

**Certificate (specify):**

N/A

**Other Standard (specify):**

N/A

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

Either the contracting OHCDs or MDCH.

**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: Environmental Accessibility Adaptations (EAA)****Provider Category:**

Agency

**Provider Type:**

Contracted Provider

**Provider Qualifications****License (specify):**

Providers must be properly licensed for the specific occupation as stipulated in the Occupational Code defined in P.A. 299 of 1980.

**Certificate (specify):**

N/A

**Other Standard (specify):**

N/A

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

Either the contracting OHCDs or MDCH.

**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:**

## Home Delivered Meals

**Service Definition** (*Scope*):

Home Delivered Meals (HDM) is the provision of at least one nutritionally sound meal per day to persons who are dependent 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 Boards of the National Research Council of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets as indicated in the plan of service. 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:**

Shall not constitute a full daily nutritional program.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Delivered Meal Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Other Service**

**Service Name: Home Delivered Meals**

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**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*):

Each HDM provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) 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 5 days per week.

Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow or ice storms), loss of power, physical plant malfunction, 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.

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

The provider shall deliver food at safe temperatures as defined in HDM service standards.

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

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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### 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

**Service Definition (Scope):**

Services offered to enable participants to gain access to MTBIP and other community services, activities and resources as 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 MTBIP 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:**

Transportation services are limited to those activities outlined in the plan of service and are not covered by state plan services or other types of providers.

**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

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

**Service Type:** Other Service

**Service Name:** Non-Medical Transportation

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**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 provided by the MTBIP.
2. The provider must cover all vehicles with no fault automobile insurance.
3. All drivers for transportation providers paid by the MTBIP shall be physically capable and willing to assist persons requiring help to get into and out of vehicles.
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:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of service and annually thereafter.

## Appendix C: Participant Services

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

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**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 provided by the MTBIP.
2. The provider must cover all vehicles with no fault automobile insurance.
3. All drivers for transportation providers paid by the MTBIP shall be physically capable and willing to assist persons requiring help to get into and out of vehicles.
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 Organized Health Care Delivery System

**Frequency of Verification:**

Either the contracting OHCDs or MDCH.

## 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 (PERS)

**Service Definition (Scope):**

PERS is an electronic device that enables 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 and systems are also provided.

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

PERS installation is not inclusive of monthly telephone service fees normally associated with phone service.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PERS Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response System (PERS)**

**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 standard 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.
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 employ a first call - first served basis.

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

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of service and annually thereafter.

## Appendix C: Participant Services

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### 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:**

TBI Counseling

**Service Definition (Scope):**

Counseling services to improve the individual's emotional and social well-being through the resolution of personal problems or changes in an individual's self-image and social situation. TBI Counseling must address disability adjustment and provide patient education of TBI in addition to behavioral management and cognitive therapy. Any cognitive or thought patterns causing maladaptive behavior and emotional responses must be addressed. This therapy focuses on the present and is a problem solving approach directly related to the brain injury. The behavior therapy not only addresses issue of maladaptive behavior such as aggressive behavior, anger management, and anxiety disorders, but can be used to address organic disorders such as incontinence and insomnia.

**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	Board Certified Behavioral Analyst
Individual	Certified Rehabilitation Counselor

Provider Category	Provider Type Title
Individual	MSW, CSW, LSW
Individual	Psychologist

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: TBI Counseling**

**Provider Category:**

Individual

**Provider Type:**

Board Certified Behavioral Analyst

**Provider Qualifications**

**License (specify):**

MCL 333.18201-18237

**Certificate (specify):**

AACBIS Certification Preferred

Board Certified Behavior Analyst (BCBA) certification

**Other Standard (specify):**

Minimal of a Masters Degree from an accredited school in Psychology.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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: TBI Counseling**

**Provider Category:**

Individual

**Provider Type:**

Certified Rehabilitation Counselor

**Provider Qualifications**

**License (specify):**

MCL 333.18101-18117

**Certificate (specify):**

AACBIS Certification Preferred

The Commission on Rehabilitation Counselor Certification

**Other Standard (specify):**

Graduate of an accredited psychology program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: TBI Counseling**

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**Provider Category:**

Individual

**Provider Type:**

MSW, CSW, LSW

**Provider Qualifications**

**License (specify):**

MCL 333.18501 ...333.18518

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: TBI Counseling**

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**Provider Category:**

Individual

**Provider Type:**

Psychologist

**Provider Qualifications**

**License (specify):**

MCL 333.18201 ... 333.18237

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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### 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:**

TBI Nursing Services

**Service Definition (Scope):**

TBI Nursing Services are services listed in the participant's plan of service that are within the scope of the Michigan Public Health Code Act 368 of 1978 Part 172 and are provided by a registered professional nurse, or a licensed practical or a vocational nurse under the direct supervision of a registered nurse licensed to practice in the State. Nursing services are provided on an intermittent basis (as opposed to a continuous basis which establishes the standard for Private Duty Nursing Services) that is established by separate intervals of time.

TBI Nursing Services may include, but are not limited to:

- Administering prescribed medications that cannot be self-administered.
- Changing an indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Observation and evaluation of the participant as further defined below.
- Training for participant.
- Other nursing support as indicated by physician orders.

Treatments of decubitus ulcers are subject to a physician's orders. Bathing the skin, applying creams, and similar unskilled activities are not covered under this service. Stage I and II decubiti generally do not require nursing care.

Training activities for family members or other unpaid caregivers are covered under the Training service.

Administration of oral medications does not usually require the skills of a nurse in the home setting. Similarly, placing medication into envelopes or cups and giving cues or reminders to assist the participant to take the medications does not constitute a nursing service. TBI Nursing Services may only be used for such situations if the complexity of the participant's condition or the number of drugs prescribed requires the skill or judgment of a nurse to detect and evaluate possible adverse reactions.

If the participant's attending physician determines that the participant's condition is unstable and that significant changes might occur, TBI Nursing Services may be used for observation or evaluation purposes. The service may be extended until the participant's condition is stabilized.

All need for TBI Nursing Services must be defined in the participant's plan of service by type of nursing activity, amount, and duration prior to the provision of such services.

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

TBI Nursing Services cannot be provided to MTBIP participants receiving Private Duty Nursing Services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Home Care Agency
Individual	Vocational Nurse
Individual	Licensed Practical Nurse

## Appendix C: Participant Services

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

---

**Service Type: Other Service**  
**Service Name: TBI Nursing Services**

---

**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications**

**License (specify):**

MCL 333.17201 ... 333.17242

**Certificate (specify):**

AACBIS Certification preferred.

**Other Standard (specify):**

Must have experience working with TBI clientele.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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: TBI Nursing Services**

---

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

Services must be provided by a Registered Nurse or by a Licensed Practical Nurse.

MCL 333.17201 - 333.17242

**Certificate (specify):**

AACBIS Certification preferred.

**Other Standard (specify):**

Must have experience working with TBI clientele.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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: TBI Nursing Services**

---

**Provider Category:**

Individual

**Provider Type:**

Vocational Nurse

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Provider must be enrolled in or have graduated from a nursing education program approved by the Michigan Board of Nursing.

Provider may only provide services under the direct supervision of a licensed registered nurse.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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: TBI Nursing Services**

---

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications**

**License (specify):**

MCL 333.17201 ... 333.17242

**Certificate (specify):**

AACBIS Certification preferred

**Other Standard (specify):**

Must have experience working with TBI clientele.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**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:**

TBI Occupational Therapy

**Service Definition (Scope):**

For the participant, a TBI can affect skills to perform everyday activities such as eating, dressing, bathing, personal care or more complex activities such as time management, decision-making, meal preparation and planning, return to work activities and more. Because of individual differences in brain function and location and spread of the TBI injury, the individual TBI participant will require treatment unique only to them. It is this focus that makes TBI Occupational Therapy different in scope and provider qualifications than services available under the state plan. TBI Occupational Therapy will result in significant functional and cognitive improvement in the participant's ability to perform mobility skills appropriate to their status, such as eating, dressing, bathing, personal care, taking medications, or more complex activities such as time management, decision making, meal preparation and planning, return to work activities, and more. The overall goal is to increase the participant's independence in all facets of their life.

MDCH expects Occupational Therapists (OT) and Certified Occupational Therapy Assistants (COTA) to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and the appropriate national professional association. MDCH does not cover Occupational Therapy interventions provided by other practitioners (e.g., Rehabilitation Counselor, RN, PT, SLP, personal care or rehabilitation aide, family members, or caregivers).

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

Occupational therapy is not covered for the following purposes:

for educational, vocational, or recreational purposes; if services are required to be provided by another public agency (e.g., community mental health services provider, school-based services); if therapy requires PA and service is rendered before prior authorization is approved; if therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past; if therapy is designed to facilitate the normal progression of development without compensatory techniques or processes; for development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered.

**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	Occupational Therapist (OT)
Individual	Certified Occupational Therapy Assistant (COTA)
Individual	Occupational Therapy Student

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: TBI Occupational Therapy**

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist (OT)

**Provider Qualifications**

**License (specify):**

MCL 333.18301 ... 333.18311

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Occupational Therapy**

**Provider Category:**

Individual

**Provider Type:**

Certified Occupational Therapy Assistant (COTA)

**Provider Qualifications**

**License (specify):**

MCL 333.18301 ... 333.18311

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Must operate under the supervision of a registered Occupational Therapist.

Must follow the evaluation and treatment plan of a registered Occupational Therapist. All documentation must be reviewed and signed by the appropriately credentialed supervising O.T.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Training in cardio-pulmonary resuscitation may be waived if providing services for a participant with an established "Do Not Resuscitate" (DNR) order.

Individuals must have relevant experience specifically dealing with TBI and be deemed capable by the OHCDS of performing the required tasks.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Occupational Therapy**

---

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapy Student

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Must be currently enrolled in an accredited program and completing his/her clinical affiliation.

May only provide services under the direct supervision (i.e., in the presence of) a registered O.T. All documentation must be reviewed and signed by the appropriately credentialed supervising O.T.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Training in cardio-pulmonary resuscitation may be waived if providing services for a participant with an established "Do Not Resuscitate" (DNR) order.

Individuals must have relevant experience specifically dealing with TBI and be deemed capable by the OHCDS of performing the required tasks.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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:**

TBI Physical Therapy

**Service Definition (Scope):**

Along with the need for examination and treatment of musculoskeletal and neuromuscular problems to improve mobility to go about their activities of daily living, the MTBIP participant will also need specific treatment focusing on strength, mobility and endurance; improving reduced muscle tone and spasticity; reducing the effects of immobility on bones and muscles and; focusing on managing their environment to maximize independence. Because of individual differences in brain function and location and spread of the TBI injury, the participant will require treatment unique to them. It is this focus that makes TBI Physical Therapy different in scope and provider qualifications than services available under the state plan. Physical therapy (PT) will result in significant functional improvement in the participant's ability to perform mobility skills appropriate to their own functional and cognitive status.

MDCH does not cover PT interventions provided by other practitioners than those listed (e.g., Rehabilitation Counselor, RN, OT, SW, SLP, personal care or rehabilitation aide, family members, or caregivers).

**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	Physical Therapist/Physical Therapy Assistant Student
Individual	Physical Therapist
Individual	Certified Physical Therapy Assistant

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: TBI Physical Therapy**

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist/Physical Therapy Assistant Student

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Must be currently enrolled in an accredited program and completing their clinical affiliation.

May only provide services under the direct supervision (i.e., in the presence of) a registered Physical Therapist. All documentation must be reviewed and signed by the appropriately credentialed supervising therapist.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally

and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Physical Therapy**

---

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**

**License (specify):**

MCL 333.17801 ... 333.17821

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Physical Therapy**

---

**Provider Category:**

Individual

**Provider Type:**

Certified Physical Therapy Assistant

**Provider Qualifications**

**License (specify):**

MCL 333.17801 ... 333.17831

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

Must possess an Associate Degree Diploma in Physical Therapy Assistant Training from an accredited school.

Must be directly supervised (i.e., in the physical presence of) by a licensed Physical Therapist. All documentation must be reviewed and signed by the appropriately credentialed supervising therapist.

Must follow the evaluation and treatment plan of a licensed Physical Therapist.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Training in cardio-pulmonary resuscitation may be waived if providing services for a participant with an established "Do Not Resuscitate" (DNR) order.

Individuals must have relevant experience specifically dealing with TBI and be deemed capable by the OHCDS of performing the required tasks.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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:**

TBI Speech Language Pathology Therapy

**Service Definition (Scope):**

Speech Language Pathology Therapy (SLP) services are unique for the MTBIP participant. A TBI injury can affect skills such as eating, swallowing, verbal and non-verbal communication, memory, sequencing, problem-solving, articulation, rhythm, language and more. Because of individual differences in brain function and location and spread of the TBI injury, the participant will require treatment unique only to them. Speech therapy must relate to the TBI medical diagnosis and will provide extensive rehabilitative service for the participant for the following types of treatment: articulation, language, rhythm, swallowing, training in the use of a speech generating device, training in the use of an oral-pharyngeal prosthesis, voice and other treatment, such as comprehensive skills for cognitive memory impairment.

This service does not cover SLP interventions provided by other practitioners (e.g., Rehabilitation Counselor, RN, P.T., O.T., SW, personal care/rehabilitation aide, family members, or caregivers).

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

For beneficiaries of all ages, therapy is not covered: for educational, vocational, social/emotional, or recreational purposes; if services are required to be provided by another public agency; when intended to improve communication skills beyond pre-morbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status); if it requires prior authorization but is rendered before such authorization is approved; if it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax or semantics (which are developmental) or articulation errors that are within the normal developmental process; if it is designed to facilitate the normal progression of development without compensatory techniques or processes; if continuation is maintenance in nature; if provided to meet developmental milestones; if Medicare does not consider the service medically necessary.

**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	Speech Language Pathologist Candidate
Individual	Speech Language Pathologist
Individual	Student Speech Language Pathologist

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: TBI Speech Language Pathology Therapy**

**Provider Category:**

Individual

**Provider Type:**

Speech Language Pathologist Candidate

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

An SLP candidate currently performing their clinical fellowship year (CFY), or having completed all requirements but has not obtained an ASHA certificate.

Must perform clinical fellowship in a CARF accredited facility or agency.

Must follow the evaluation and treatment plan of a licensed Speech Language Pathologist. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

Individuals must have relevant experience specifically dealing with TBI and be deemed capable by the OHCDS of performing the required tasks.

Must be knowledgeable in anatomy, physiology, and the development of the areas of the body involved in speech, language, and swallowing; the nature of disorders; principles of acoustics; and psychological aspects of communication. Graduate students also learn to evaluate and treat speech, language, and swallowing disorders and receive supervised clinical training in communication disorders.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Speech Language Pathology Therapy**

**Provider Category:**

Individual

**Provider Type:**

Speech Language Pathologist

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

AACBIS Certification Preferred

Must have current certification through the American Speech Language and Hearing Association.

**Other Standard (specify):**

Master's degree in speech-language pathology program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology. Speech-language pathology therapists will be knowledgeable in anatomy, physiology, and the development of the areas of the body involved in speech, language, and swallowing; the nature of disorders; principles of acoustics; and psychological aspects of communication. Graduate students also learn to evaluate and treat speech, language, and swallowing disorders and receive supervised clinical training in communication disorders.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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: TBI Speech Language Pathology Therapy**

**Provider Category:**

Individual

**Provider Type:**

Student Speech Language Pathologist

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

Required to take the Michigan Public Service Agencies TBI Training Course.

**Other Standard (specify):**

A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing, have the ability to follow instructions, be trained in first aid and cardio-pulmonary resuscitation, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.

Must be knowledgeable in anatomy, physiology, and the development of the areas of the body involved in speech, language, and swallowing; the nature of disorders; principles of acoustics; and psychological aspects of communication. Graduate students also learn to evaluate and treat speech, language, and swallowing disorders and receive supervised clinical training in communication disorders.

Must follow the evaluation and treatment plan of a licensed Speech Language Pathologist.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of service and annually thereafter.

## Appendix C: Participant Services

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### 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:**

TBI Transitional Residential Rehabilitation Services

**Service Definition (Scope):**

TBI Transitional Residential Rehabilitation service is a program of coordinated and integrated medical, physical and cognitive rehabilitation services that specialize in the rehabilitative treatment of the TBI Medicaid beneficiary. The MTBIP participant must have received acute rehabilitation post-injury and must undergo a complete neuropsychological evaluation prior to admission. The participant must attend a minimum of 21 hours per week for a combination of Physical Therapy, Occupational Therapy, Speech Language Pathology therapy, and Counseling, and must show continued progress to continue in this program.

A case manager, usually a social worker, oversees an interdisciplinary team that provides rehabilitative treatment to the participant. Bi-monthly case management meetings are held with the participant and family members, the interdisciplinary team, the MDCH Clinical Nurse Specialist who oversees the MTBIP and other participant advocates. A plan of service is developed at admission and updated or revised during the meetings or as the participant's individual rehabilitation requirements change. Discharge planning occurs at admission and is part of the participant's plan of service. The goal is to return the participant to a home or community-based setting.

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

Provision of services must be pre-authorized prior to admission by MDCH. Re-authorization must be conducted every 60 days.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	TBI Rehabilitation Facility

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: TBI Transitional Residential Rehabilitation Services**

**Provider Category:**

Agency

**Provider Type:**

TBI Rehabilitation Facility

**Provider Qualifications**

**License (specify):**

Social Worker - MCL 333.17201-17242

Registered Nurse - MCL 333.17201 – 17242

Physical Therapist - MCL 17801-17831

Occupational Therapist - MCL 333.18301-18311

Speech Language Pathology Therapist - Certified ASLHA

Psychologist - MCL 333.18201-18237

AFC Home Supervisor

COTA/PTA and/or Students Interns

Rehabilitation aide

**Certificate (specify):**

CARF accreditation in Transitional Residential Rehabilitation and Home and Community Based Rehabilitation.

**Other Standard (specify):**

AACBIS Certification Preferred

Non-professional staff are required to take the Michigan Public Service Agencies TBI Training Course.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**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 and Educational Services for Unpaid Caregivers

**Service Definition (Scope):**

Training to a MTBIP participant or unpaid caregiver in either an individual situation or on a group basis to teach a variety of independent living skills that are required to maintain the participant in a home or community-based

setting. The training needs must be identified in plan of service. Training in the following areas may be covered: activities of daily living; adjustments 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. This service may not be provided in order to train paid caregivers. All training for individuals who provide unpaid support to the participant must be included in the participant's service plan.

**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	Social Worker
Individual	Occupational Therapist
Individual	Physical Therapist
Individual	Registered Nurse
Individual	Speech Therapist
Individual	Certified Rehabilitation Counselor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training and Educational Services for Unpaid Caregivers**

**Provider Category:**

Individual

**Provider Type:**

Social Worker

**Provider Qualifications**

**License** (*specify*):

MCL 333.18501 ... 333.18518

**Certificate** (*specify*):

AACBIS Certification Preferred

**Other Standard** (*specify*):

Possession of a Master or Bachelor of Social Work degree with requisite experience dealing with TBI.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDS or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Training and Educational Services for Unpaid Caregivers**

---

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License (specify):**

MCL 333.18301 ... 333.10811

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

---

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Training and Educational Services for Unpaid Caregivers**

---

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**

**License (specify):**

MCL 333.17801 ... 333.17821

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

---

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of service and annually thereafter.

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Training and Educational Services for Unpaid Caregivers**

---

**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications****License (specify):**

MCL 333.17201 ... 333.17242

**Certificate (specify):**

AACBIS Certification Preferred

**Other Standard (specify):**

---

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

Either the contracting OHCDs or MDCH.

**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: Training and Educational Services for Unpaid Caregivers**

---

**Provider Category:**

Individual

**Provider Type:**

Speech Therapist

**Provider Qualifications****License (specify):**

N/A

**Certificate (specify):**

AACBIS Certification Preferred

American Speech Language and Hearing Association Certification

**Other Standard (specify):**

---

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

Either the contracting OHCDs or MDCH.

**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: Training and Educational Services for Unpaid Caregivers**

---

**Provider Category:**

Individual

**Provider Type:**

Certified Rehabilitation Counselor

**Provider Qualifications**

**License** (*specify*):

MCL 333.18101 ... 333.18117

**Certificate** (*specify*):

Commission on Rehabilitation Counselor Certification

AACBIS Certification Preferred

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Either the contracting OHCDs or MDCH.

**Frequency of Verification:**

Prior to delivery of services and annually thereafter.

## Appendix C: Participant Services

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### 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:

## Appendix C: Participant Services

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### 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 OHCD and direct care provider of home-based services must conduct a criminal background review through the Michigan State Police for each paid or unpaid staff person who will be entering participant homes or coming in direct contact with participants. The criminal background review must be completed prior to authorizing the employee to furnish services.

Similarly, MDCH is required to perform such background checks on any provider enrolling with MDCH and providing MTBIP services.

MDCH and OHCD will conduct administrative reviews annually to verify that the mandatory criminal background checks have been conducted in compliance with operating standards and that adequate documentation is retained in the provider's record.

**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	
Adult Foster Care (AFC) Home	
TBI Rehabilitation Facility	

**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 four types of Adult Foster Care (AFC) that may be used by waiver participants. Capacity limits for AFC Family and Small Group Homes is (1-6); AFC Small Group Home (7-12); and AFC Large Group Homes (12-20) and homes for the aged (21+). TBI rehabilitation facilities are generally licensed AFC homes operating in conjunction with a TBI rehabilitation center. A home-like character is maintained in these settings supported by the licensing criteria that have been established for this purpose. These criteria 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, being

SS16.109, 400.710 and 400.713 of the Michigan Compiled Laws) Rules 400.1401 – 400.1442 and 400.14102 – 400.14601. These rules address licensee responsibilities to residents' rights, physical environmental specifications and maintenance.

The licensing criteria reflect an attempt to make a person's stay in the AFC much like it would be in their own 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 and 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 and 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, the 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 with own standard real bed for sleeping (not rollaway beds, cots, double decked beds, stacked bunks, hide-a-beds or day beds), and the right to make own decisions.

AFC licensing standards can be obtained through the state website at [www.Michigan.gov](http://www.Michigan.gov).

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

Adult Foster Care (AFC) Home

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (EAA)	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
TBI Speech Language Pathology Therapy	<input checked="" type="checkbox"/>
TBI Personal Care Services	<input checked="" type="checkbox"/>
TBI Transitional Residential Rehabilitation Services	<input type="checkbox"/>
TBI Nursing Services	<input type="checkbox"/>
Respite	<input type="checkbox"/>
TBI Physical Therapy	<input checked="" type="checkbox"/>
TBI Counseling	<input checked="" type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Assistive Technology & Enhanced Supplies	<input checked="" type="checkbox"/>
Community Transitions	<input checked="" type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Pre-Vocational Employment Services	<input checked="" type="checkbox"/>

Waiver Service	Provided in Facility
TBI Supports Coordination	<input checked="" type="checkbox"/>
Private Duty Nursing	<input checked="" type="checkbox"/>
Training and Educational Services for Unpaid Caregivers	<input checked="" type="checkbox"/>
TBI Day Program	<input checked="" type="checkbox"/>
TBI Occupational Therapy	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

N/A

**Scope of Facility Standards.** 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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**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:**

TBI Rehabilitation Facility

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (EAA)	<input type="checkbox"/>

Waiver Service	Provided in Facility
Home Delivered Meals	<input type="checkbox"/>
TBI Speech Language Pathology Therapy	<input type="checkbox"/>
TBI Personal Care Services	<input type="checkbox"/>
TBI Transitional Residential Rehabilitation Services	<input checked="" type="checkbox"/>
TBI Nursing Services	<input type="checkbox"/>
Respite	<input type="checkbox"/>
TBI Physical Therapy	<input type="checkbox"/>
TBI Counseling	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Assistive Technology & Enhanced Supplies	<input type="checkbox"/>
Community Transitions	<input checked="" type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Pre-Vocational Employment Services	<input checked="" type="checkbox"/>
TBI Supports Coordination	<input type="checkbox"/>
Private Duty Nursing	<input type="checkbox"/>
Training and Educational Services for Unpaid Caregivers	<input checked="" type="checkbox"/>
TBI Day Program	<input type="checkbox"/>
TBI Occupational Therapy	<input type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

N/A

**Scope of Facility Standards.** 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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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:

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## Appendix C: Participant Services

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

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

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

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

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

MDCH and each OHCDs may pay relatives of MTBIP participants to furnish services as long as the relatives meet the provider qualifications for the service as specified in Appendix C-1/C-3 and they are neither legally

responsible for nor the legal guardian of the participant. MDCH or the OHCDS and the supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed services. In the event that the relative fails to meet specified goals and outcomes or fails to render services, remediative action must be taken by the supports coordinator and payments are not authorized.

The supports coordinator may not authorize respite services to replace program services provided by a relative. Instead, the number of service hours provided by the relative is reduced and the supports coordinator assists the individual in identifying another provider to make up the difference.

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

**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:

Any willing and qualifies provider may enroll with either an OHCDS or directly with MDCH to provide MTBIP services. Providers enrolling with MDCH will do so through the established Medicaid provider enrollment process.

The OHCDS is responsible for securing qualified service providers to deliver services. Eligible provider applicants include public and private non-profit or for-profit organizations that provide services that meet established standards, certifications, and licensing requirements.

The OHCDS mails service provider application packages to potential service providers as requested. Provider applicants complete and submit all agreement and assurance forms to the OHCDS. The OHCDS reviews all applicant requests to determine that providers are qualified to provide requested services prior to the provision of any services or supports. There are no limits on the number of providers with which an OHCDS may contract so long as all requirements and provisions have been met.

After a potential service provider's 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 OHCDS the responsibility 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:**

**Number and percent of MTBIP service providers that meet initial credentialing standards prior to the provision of MTBIP services. Numerator = Number of providers of MTBIP services that meet credentialing standards prior to the provision of TBI waiver services. Denominator = All provider applicants for provision of TBI Waiver services.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of MTBIP service providers that continue to meet credentialing standards. Numerator = Number of providers of MTBIP services that continue to meet credentialing standards. Denominator = All providers of MTBIP services.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

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

**Number and percent of non-licensed or non-certified MTBIP providers that initially meet provider qualifications. Numerator = Number of non-licensed or non-certified MTBIP providers that initially meet provider qualifications. Denominator = All non-licensed or non-certified MTBIP providers.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of non-licensed or non-certified MTBIP providers that continue to meet provider qualifications. Numerator = Number of non-licensed or

**non-certified MTBIP providers that continue meet provider qualifications.**  
**Denominator = All non-licensed or non-certified MTBIP providers.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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:**

**Number and percent of MTBIP providers that meet staff training requirements.**

**Numerator = Number of waiver service providers that meet staff training requirements. Denominator = All MTBIP providers.**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**b. Methods for Remediation/Fixing Individual Problems**

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

As part of the Administrative Quality Assurance Review process, MDCH will examine OHCDs records to assure providers meet credentialing standards prior to the provision of MTBIP services. As part of their review, MDCH will examine OHCDs records to assure providers continue to meet credentialing standards when furnishing MTBIP services.

MDCH will examine OHCDs records to assure non-licensed or non-certified MTBIP providers meet provider qualifications prior to furnishing MTBIP services and will review to assure that such providers continue to meet qualifications.

- ii. **Remediation Data Aggregation**

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

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

- 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:*

- Social Worker.**

*Specify qualifications:*

Must meet the qualifications as specified in Appendix C-1/C-3.

- Other**

*Specify the individuals and their qualifications:*

Occupational Therapists, Speech Therapists, Physical Therapists, and Certified Rehabilitation Counselors may be used to develop the individual service plan subject to the qualifications in Appendix C-1/C-3.

## 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:*

Development of the individual plan of service for participants in the MTBIP is a core component of the waiver. Persons with a TBI require more than a generic set of long-term care supports. In addition to being person-centered, the service plan must address the unique needs of the individual as well as focus on the specific nuances resulting from the TBI.

To that end, TBI Supports Coordination is delivered as a waiver service. The supports coordinator must be familiar with both the idiosyncrasies of the condition and the specific needs of the individual. Professionals with such an exact background are often likely to be involved with treatment and therapy protocols as well, subject to the provisions defined in Appendix C-1/C-3.

It is the contracting OHCDs who is ultimately responsible to assure that services ordered are in the best interest of the participant. Oversight is conducted regularly prior to implementation of the plan of service. It is through this process and the involvement of family or allies of the participant's choice in the person-centered planning process that assures the interest of the participant.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **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 person-centered planning process and the development of the individual plan of service are built upon knowledgeable choices made by the participant. This is only possible when there is a complete knowledge and understanding of the options and procedures offered by the MTBIP program. The OHCDs will provide the participant, their allies, their family, or their legal representatives with written information about the right to participate in the person-centered planning process at the initial assessment or upon enrollment into the program. Such information is also made available 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 face-to-face meetings. Continuing assistance from a supports coordinator is available throughout the service planning process.

(b) Participant's authority to determine who is included:

The participant has the authority to determine who will be involved in the person-centered planning process. The participant may select 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, the goals and objectives 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**

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### **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 development of the initial individual plan of service begins after the medical and financial eligibility has been determined by the OHCDs and the participant has been accepted into the MTBIP program. The plan of service focuses on the expressed needs and desires of the participant. A pre-planning session occurs prior to the first person-centered planning meeting. During pre-planning, the participant works with the supports coordinator to identify expectations, goals, and items pertaining to the planning meeting. This includes any topics to be discussed, who to invite, who will facilitate the meeting and who will record the meeting. The participant and selected allies design the agenda for the person-centered planning meeting.

The person-centered planning meeting is conducted when a participant is not in crisis and at a time of the participant's convenience. 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 expounding and defining their goals and desires.

The individual plan of service is updated at least every 90 days, upon the request of the participant, when the need for services changes, or participant circumstances change.

An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the person is not ready to fully participate in the 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.

(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 supports coordinator conducts a detailed, standardized assessment. It evaluates health status information and functional status. It assesses the participant's strengths, capacities, needs, preferences, risk factors and goals. A comprehensive assessment system based on 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. Health care needs are discussed and addressed in the individual plan of service as approved by the participant. As described in Paragraph (a), input is gleaned from the participant and chosen allies.

(c) How the participant is informed of the services that are available under the waiver:

The participant is informed of available services primarily by the supports coordinator. This occurs through direct communication as well as written information provided to the participant regarding program services and other types of available community services and supports. The participant is offered information on all possible service providers. The individual plan of service includes both authorized program services as well as outside 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.

The OHCDs also plays a role in assuring that the participant is adequately informed about the service options available.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

As an addendum to the standard OHCDs contract, Michigan has developed "Person-Centered Planning for Community-Based Long Term Care, A Guideline for Policy Development" that is used in the MTBIP program. This

document has been revised from guidelines used in the MI Choice program to meet the needs of the population served in the MTBIP. It establishes clear guidelines on incorporating the principles and values of person-centered planning into the development of the individual service plan. The plan clearly aligns the participant's needs, goals and preferences with the services specified to meet them. Whenever possible, specific 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 service plan defines the types of services needed from both paid and non-paid providers. The amount (units), frequency, and duration of each service to be provided are included in the plan. The supports coordinator ensures that services and supports are implemented as outlined and oversees the coordination of state plan and MTBIP services included in the service plan. This oversight ensures that program services in the service plan 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 service, 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, or relevant others designated by the participant. The OHCDS, the 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 requests, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the participant. The OHCDS is required to contact participants monthly. Face-to-face reassessments occur on a quarterly basis.

(g) How and when the plan is updated:

The plan is updated at 90 day intervals, 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.

Many participant risks are automatically identified in the MDS-HC Assessment System Caps and Triggers Reports. Others might be identified during other assessments or reassessments. Supports coordinators review the participant's risk and inform the participant so as to make informed choices with regard to these risks. 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 the person-centered planning process. Participant-approved risk strategies are documented and written into the service plan.

Participants are required to acknowledge situations in which their choices might 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.

Service providers are informed of a participant's risk status when services are ordered. Agency providers, including the OHCDS, are required to have contingency plans in place in the event of emergencies that pose a threat to participant health and welfare (e.g., inclement weather, natural disasters, and unavailable personal caregiver).

Each individual service plan describes back-up plans that are to be implemented when selected service providers are unable to furnish services as prescribed. This may involve the following: developing lists of alternative qualified providers, using a provider agency, using informal supports, or contacting the supports coordinator when planned for services are not available. Additionally, emergency plans are developed for each participant that clearly describes 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. All contingency plans are routinely reviewed as part of the Quality Improvement Strategy.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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 TBI supports coordinator provides participants with information and training on selecting qualified service providers. In addition, information can be shared by the participant's support circle of trusted allies. Any provider selected must meet the minimum standards established by MDCH.

Participants may choose among qualified providers suggested to them or may employ providers that they identify, subject to the provision that they meet the minimum standards. Participants may receive assistance to identify and select qualified providers at any time from 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 OHCS.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The standard contract between MDCH and the OHCS mandates that the service plan is developed in accordance with MTBIP Operating Standards, the program monitoring plan, and any updates to these documents. Adherence to applicable standards is monitored through administrative reviews conducted annually.

In addition, MDCH reviews and evaluates participant service plans and case records for plan approval and service authorization concurrence. The individual service plan and case record reviews are conducted on-site.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

*Specify the other schedule:*

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

- Medicaid agency**
- Operating agency**
- Case manager**
- Other**

*Specify:*

Copies of the individual service plans are to be maintained by the responsible OHCDs for at least six years. The OHCDs determine the storage needs for the plans of service documentants and makes these records available for MDCH to review upon request.

## **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) The OHCDs is responsible for monitoring the implementation of the individual plan of service in conjunction with the TBI supports coordinator. Allies of the participant may be incorporated as feasible and identified in the individual plan of service. MDCH conducts retrospective monitoring reviews to ensure that this is being done according to plan. The supports coordinator establishes a system with the participant's supports and allies to adequately monitor the health and welfare of the participant.

b) Within two weeks of service implementation, the OHCDs is required to contact the participant to ensure that services are implemented as planned. When services are not implemented as planned, the OHCDs implements corrective actions to resolve problems and issues. The supports coordinator is 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 whether additional needs have emerged since the previous contact. Participants and their families are provided with telephone numbers to contact the OHCDs and supports coordinators at any time when new needs emerge that require interventions and additional services support.

In addition to making personal contacts, other methods of monitoring and following up 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 service have been accessed and provided in accordance with the plan. This can be done by the supports coordinator, the OHCDs, or MDCH as appropriate and necessary.

c) Support coordinators make contact with participants at least monthly by telephone or through other methods determined through the planning process. The supports coordinator reviews the individual plan of service with the participant at least quarterly, unless a more frequent review is warranted.

In-person reassessments are conducted upon participant request, annually, or whenever the participant experiences a status change. The supports coordinator evaluates the effectiveness of back-up plans and the health and welfare of the participant at reassessment or more frequently as necessary.

**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:*

It is possible that the entities that monitor the implementation of the plan of service and the health and welfare of the participant also administer services through the MTBIP. The community of providers that focus on the needs of individuals with TBI is usually limited. The expertise needed to assure that the participant is receiving condition-appropriate support is likely to be a service provider in the TBI field. Instances where there might be a possible conflict between the roles of monitoring and providing program services should be addressed in the development of the plan of service. An additional layer of oversight might be necessary and could be provided by the OHCDs, independent participant support, or a combination of parties.

Participants may choose to monitor their own plan of service implementation and alert their supports coordinator 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 plan implementation, but are also provided with a supports coordinator as a safeguard in doing so.

The OHCDS is responsible for on-going monitoring of plan of service implementation and of provision of services in the MTBIP. MDCH reviews monitoring activities and reports 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, the OHCDS and MDCH maintain a written complaint log of all participant and non-participant complaints received regarding the program. These logs document the complaint by date, actions taken to resolve each complaint and date complaint is resolved. All 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:

**Number and percent of enrollees whose plan of service includes services and supports that align with their assessed needs. Numerator = Number of enrollees whose plan of service includes services and supports that aligned with their assessed needs. Denominator = All MTBIP enrollees.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of enrollees whose plan of service have adequate strategies to address their assessed health and safety risks. Numerator = Number of enrollees whose plan of service have adequate strategies to address their assessed health and safety risks. Denominator = All enrollees.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <hr/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <hr/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <hr/>
	<input type="checkbox"/> <b>Other</b> Specify: <hr/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of enrollees whose plan of service includes goals and preferences. Numerator = Number of enrollees whose plan of service includes goals and preferences. Denominator = All enrollees.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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:**

**Number and percent of enrollee plans of service that are developed in accordance with policies and procedures established by MDCH. Numerator = Number of enrollee plans of service that are developed in accordance with policies and procedures established by MDCH. Denominator = All enrollee plans of service.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

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

**Data Aggregation and Analysis:**

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

**Number and percent of enrollees whose plan of service are updated within a year (365 days) of their previous plan of service. Numerator = Number of enrollees**

whose plan of service are updated within a year (365 days) of their previous plan of service. Denominator = All enrollees.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of enrollees whose plans of service change as the enrollee's needs change. Numerator = Number of enrollees whose plans of service change as the enrollee's needs change. Denominator = All enrollees whose needs changed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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:

**Number and percent of enrollee plans of service in which services and supports are provided as specified in the plan, including type, scope, amount, duration, and frequency. Numerator = Number of enrollee plans of service in which services and supports are provided as specified in the plan, including type, scope, amount, duration, and frequency. Denominator = All enrollee plans of service.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

**Number and percent of enrollees who are offered the choice between MTBIP services or services in a nursing facility or institutional setting. Numerator = Number of enrollees who are offered the choice between MTBIP services or services in nursing facilities or institutional setting. Denominator = All enrollees.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95 %
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of enrollees who are offered the choice of MTBIP services.**  
**Numerator = Number of enrollees who are offered the choice of MTBIP services.**  
**Denominator = All enrollees.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95 %
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**  
**Number and percent of enrollees who are offered the choice of providers.**  
**Numerator = Number of enrollees who are offered the choice of providers.**  
**Denominator = All enrollees.**

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95 %
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**b. Methods for Remediation/Fixing Individual Problems**

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

As part of the Clinical Quality Assurance Review process, MDCH will examine case records of MTBIP participants to determine whether plans of service are aligned with the assessed needs of the participants, include adequate strategies to address each participant's assessed health and safety risks, include goals and preferences, and whether the plans are developed in accordance with established MDCH policies and procedures.

The review will examine case whether plans of service are updated within 365 days and whether the participant experienced a change of condition in the meantime that would require an update of the plan of service.

As part of the review process, MDCH will examine case records of MTBIP participants to determine whether

service and supports are provided as specified in the plan of service, including type, scope, amount, duration, and frequency. The review will examine case records for a properly completed freedom of choice form and will determine whether the OHCDs provided the choice of services and providers.

Any records found non-compliant will require corrective action.

**ii. Remediation Data Aggregation**

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

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

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**E-1: Overview (1 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (4 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix F: Participant Rights

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### 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.

MDCH has established an administrative appeals process that conforms to the requirements of the Medicaid fair hearing requirements found under 42 CFR Part 431, Subpart E. Through this process, the MTBIP has notice and appeals requirements for each OHCDs to follow when programmatic action has been taken affecting applicants and participants.

The OHCDs must send an Adequate Action Notice informing applicants or participants of OHCDs actions or determinations under the following circumstances: when new applicants are determined ineligible for program services based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool, when the OHCDs is unable to accept new MTBIP applicants due to operating at 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 their right to an immediate review and their right to file a formal appeal via the Medicaid Fair Hearing procedure.

An Advance Action Notice letter must be sent to MTBIP 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 Advance Action Notice letter is sent when a 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 or number of program 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 Advance Action Notice informs the applicant of their right to an immediate review as well as their right to file a formal appeal via the Medicaid Fair Hearing process. The Advanced Action and Adequate Action Notices are posted on the MDCH web site at the following location:

<http://www.michigan.gov/mdch>

Click on the "Providers" tab and then the "Departmental Forms" tab.

The provider must supply a copy of the DCH-0092, Request for Hearing form, to any participant or applicant who believes a 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. An individual has the right to request both a review and appeal simultaneously if they so desire.

The OHCDs is required to maintain copies of all Advanced Action and Adequate Action Notices for a minimum of six years.

## Appendix F: Participant-Rights

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### 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**

**a. 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.

Retrospective reviews of waiver program determinations have historically been undertaken by an independent entity under contract with MDCH. The selection of such a contractor is currently incomplete pending approval of the waiver application and a contractual bid process.

Similarly, MDCH is in the process of establishing secondary review criteria that are appropriate for the TBI population.

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 Action 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**

**a. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

**b. 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).

Sentinel events involving any persons receiving MTBIP services are reported, reviewed, investigated and acted upon initially at the local level by the OHCDS. Sentinel event information is reported in the aggregate to MDCH annually.

Types of critical events or incidents that must be reported to MDCH:

Exploitation

Illegal activity in the home with potential to cause a serious or major negative event

Incidents that involve arrest or conviction of the participant

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 or alcohol on the job

Medication errors

Suspicious or unexpected death that is also reported to law enforcement and is related to providing services, supports, or care giving.

Michigan law requires the mandatory reporting of the issues above to the Adult Foster Care Licensing Division of MDHS within 48 hours for persons in licensed residential settings. In addition, issues must be reported for all program participants to MDCH. There is specific language in law to establish the duty to report to law enforcement suspected abuse and neglect. The reporting of sentinel events is the primary responsibility of residential workers for persons in licensed settings, and TBI Supports Coordinators for all others. This information is reviewed for trends and becomes a focus of the on-site visitation conducted by MDCH.

Aggregated data are shared with the Michigan TBI Council and the MDCH Quality Management group. Information is used by MDCH to take corrective action as needed or to make recommendations for system improvements.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The OHCDS trains participants and their allies on how to identify and report suspected abuse, neglect and exploitation, including the reporting of incidents to Adult Protective Services (APS) and 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 service planning and annually thereafter. Training is provided more frequently in instances 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 MDCH 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.

The OHCDS is responsible for direct, initial response to reported critical events or incidents. All reported incidents must be addressed within 24 hours of being reported to the OHCDS. The supports coordinator may assist the participant in filing reports with APS or with local law enforcement or other authorities.

MDCH must receive notification from an OHCDS of any suspicious death within 48 working hours of the event. In addition, the OHCDS is required by contract to submit critical incident reports on an annual basis. MDCH then discusses any concerns over the results with the OHCDS within 60 days of their receipt. The MDCH Quality Management Strategy 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 is responsible for oversight of reporting and response to critical incidents. It is required that OHCDS report suspicious deaths to MDCH within 48 hours. Details of this process are outlined in the Quality Management Strategy.

## 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 providers from using restraints.

Supports coordinators discuss the topic with each program participant and their allies throughout the planning process. Similar information is communicated to unpaid care givers and informal support providers. At each visit, the supports coordinator is alert for signs of such violations and use discovery methods to elicit information from program participants and others.

Other reviews, such as administrative and retrospective reviews also check for signs of use of restraints. Any communication is thoroughly investigated.

MDCH conducts both administrative reviews and in-home visits of participants. Part of these reviews are a discovery process to examine the use of restraints by family and informal care givers.

- 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.

It is the responsibility of the supports coordinator to discuss the prohibition on using restrictive interventions with participants and their allies. The OHCDs must ensure that providers know and understand the policy and adhere to it. Program staff and providers must be vigilant for possible signs at every interaction.

Any in-home assessment or visit is an opportunity to assess the possible use of restrictive interventions. All complaints must be thoroughly investigated and acted upon. The OHCDs and MDCH also play a monitoring role through administrative, peer, or other program reviews.

- 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)*

**a. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The primary responsibility for managing medication regimens rests with the prescribing medical professional.

All MTBIP participants are subject to secondary (second-line) management practices. The nature of this oversight is determined by the participant's status in the program as described below. Supports coordinators have secondary management responsibilities for all participants. Medication regimens must be defined in the participant's plan of service with the exception of medications used to treat short-term illnesses.

Medication management responsibilities for MTBIP participants who are receiving TBI Transitional Residential Rehabilitation services, both primary and secondary oversight, lie with the TRR provider. The participant's supports coordinator must work with the TRR staff to ensure that the plan of service reflects the proper medication regimen and to track future medication expectations.

Secondary medication management responsibilities for those participants receiving home and community-based supports are overseen by the participant's supports coordinator and pertinent medical professionals. The supports coordinator is responsible for ensuring that the participant's plan of service adequately reflects the proper medication regimen. Therefore, the frequency of such monitoring would coincide with any updates to that plan. The supports coordinator must also ensure that providers understand their roles and responsibilities in providing medication oversight.

- 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.

All MTBIP service providers play a role in the effective management and oversight of medications. It is a coordinated approach that provides on-going protections for the participants.

(a) Each provider is instructed to communicate concerns regarding potential medication harm to supervisors, medical professionals, and the supports coordinator. The supports coordinator must then investigate the medication concerns with the relevant parties; the participant, prescribing professional, caregivers, family, etc. as required. The supports coordinator must also be sensitive to potential medication issues during each 90-day assessment.

(b) When potentially harmful medication practices are identified, the waiver agency, in concert with all relevant parties (participant, caregivers, prescribing professional, etc.) must develop a corrective plan which is detailed in the participant's plan of service. The supports coordinator will then review the efficacy of the corrective plan and adjust as necessary until the issue is resolved.

(c) MDCH will review agency response to potentially harmful practices during the annual administrative review process. The waiver agency might be required to develop a corrective action plan for systemic deficiencies. MDCH will then review each plan for efficacy and follow through. MDCH will provide review, support, and monitoring functions for the waiver agency in situations that are particularly difficult or complex.

## Appendix G: Participant Safeguards

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

#### c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

**Not applicable.** *(do not complete the remaining items)*

- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- i. 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).

Administration of medications by waiver providers is subject to the provisions set forth in the services definitions and provider qualifications in Appendix C. All providers administering medications to MTBIP participants are subject to the provisions and limitations established by any licensing parameters established by the State Of Michigan. Residential providers are similarly bound to the rules and regulations established by their licensing requirements.

- ii. 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:

Reports of medication errors are to be submitted to MDCH within 24 hours of identification. MDCH staff will collect, monitor, and analyze such reports for immediate corrective action and for trends.

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

All medication errors that come to the attention of any MTBIP provider must be noted in the participant record whether or not it meets the standard of a sentinel event.

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

As specified in Appendix G-1-b, any medication error that meets the standard of a sentinel event must be reported to MDCH. Specifically, any medication error that requires emergency intervention or treatment, that requires hospitalization, or that causes death must be reported. When MTBIP providers are unsure of whether or not to report a medication error to MDCH, they are encouraged to submit a report.

- 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:

---

- iii. 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.

MDCH is responsible for monitoring the medication management and administration activities performed for participants of each MTBIP waiver agency. This oversight is conducted through error reports and critical incident reports that are submitted to the department within 24 hours of identification. In addition, MDCH will annually review agency procedures to ensure that each agency monitors the medication activity conducted by their sub-contracting providers.

## 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:**

**Number and percent of critical incidents investigated within required timeframes.**

**Numerator = Number of critical incidents investigated within required timeframes.**

**Denominator = All critical incidents.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator = Number of records that indicate the enrollee received information about reporting abuse, neglect, exploitation and other critical events listed in the waiver. Denominator = All enrollees.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of critical incidents reported for MTBIP enrollees. Numerator = Number of critical incidents reported for MTBIP enrollees. Denominator = All MTBIP enrollees that experienced a critical incident.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Performance Measure:**

Number and percent of participant deaths from unexplained, untimely, or suspicious causes where investigation identifies preventable causes. 1. Numerator = Number of participant deaths from unexplained, untimely, or suspicious causes where investigation identifies preventable causes. Denominator = All participant deaths investigated.

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

Specify:
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**Data Aggregation and Analysis:**

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

OHCDS are responsible for identifying, investigating, evaluating, and follow-up for critical incidents that occur with participants. OHCDS are held accountable for tracking and responding to individual critical incidents using the Critical Incident Management Report form. 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, 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 and summaries are submitted to MDCH annually. 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 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 exploitation. The policies and procedures must include procedures for follow-up activities with DHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect, and exploitation, as well as the referral to DHS-APS, must be maintained in the participant's case record.

MDCH reviews, evaluates, and trends the incident reports submitted by 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. DHS-APS receives notification of all suspected abuse, neglect, and exploitation, and investigates these reported incidents as prescribed by Michigan law (Public Act 5 19 of 1982). Training is provided to OHCDS as necessary to educate staff on abuse and to strengthen preventive interventions and strategies.

**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.

OHCDS submit critical incident reports and summaries to MDCH and DHS-APS is notified of all suspected abuse, neglect and exploitation. MDCH reviews, evaluates, and trends the incident reports submitted by OHCDS. When noncompliance is identified, the OHCDS has 30 days to respond with a corrective action plan. MDCH reviews the corrective action plan and either approves it or works with OHCDS staff to amend the plan to meet MDCH requirements. Once approved, MDCH sends the OHCDS an approval letter and monitors the implementation of each corrective action plan to assure that the OHCDS meets established time lines for implementing corrective action. MDCH retains all documents generated from this process on file.

**ii. Remediation Data Aggregation**

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

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

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### 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 OHCDs that administer the MTBIP. The state agency responsible for establishing the components of the quality management plan is MDCH. 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, TBI Site Review Protocol (TBISRP), and Critical Incident Management (CIM) system.

#### Quality Management Plans

MDCH establishes a QMP annually, which includes statewide goals and strategies. The QMP focuses on meeting CMS assurances and requirements for protecting the health and welfare of MTBIP participants, MDCH contract requirements, and targeted participant outcome improvement goals. MDCH requires each OHCDs to have its own QMP and reviews them annually. 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 formally update its QMP at least annually. However, the OHCDs may update its QMP as frequently as 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 MTBIP 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.

#### TBI Site Review Protocol

MDCH has plans to fully develop the TBISRP with input from advocates, the Michigan Brain Injury Association, the Michigan Disability Rights Coalition, and other stakeholders. MDCH plans to update the TBISRP annually or more frequently if needed to incorporate general improvements, policy changes, CMS initiatives, and MDCH priorities. The TBISRP will have two parts, the administrative review and the clinical review that will also include a participant home visit protocol (HVP). Additionally, MDCH intends to develop a scoring system and algorithms to weigh each standard in the TBISRP. The system will allow MDCH to calculate compliance equitably for each OHCDS based on data obtained from the administrative and clinical reviews.

The administrative review will focus on assuring that each OHCDS has policies and procedures consistent with waiver requirements. MDCH will complete the administrative review annually for each OHCDS. During the on-site administrative review, MDCH will examine OHCDS policies and procedures, contract templates, financial systems, claims accuracy, and the QMP in detail seeking evidence of compliance to the administrative review standards.

MDCH plans to contract with qualified registered nurse reviewers (RNRs) to complete the clinical review. RNRs will evaluate the OHCDS enrollment, assessment, level of care evaluations, service planning, and reassessment activities annually seeking evidence of compliance to the clinical review standards. The RNRs will collect and review both qualitative and objective data and evaluate both the assessment and supports coordinator's actions to assure that the service plan addresses each participant need identified in the assessment. The RNRs determine the OHCDS level of compliance to the standards included in the TBISRP. The RNRs then compile the data from each clinical review and forward reports to MDCH.

Once administrative review and clinical review data are complete, MDCH will compile reports to send to the OHCDS. Each report will include a summary of successes in practice and deficiencies in practice. MDCH 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. MDCH works with the OHCDS to assure the corrective action plan will produce quality improvements. Once the OHCDS and MDCH agree on the final corrective action plan, MDCH sends written documentation detailing the plan and approval to the OHCDS. MDCH applies algorithms to final administrative review and clinical review data to determine an overall quality score for each OHCDS.

#### Critical Incident Management System

MDCH developed the CIM system with assistance from stakeholders. MDCH requires each OHCDS to annually report all critical incidents to MDCH. MDCH defines procedures for reporting critical incidents in the contract. OHCDS manage critical incidents at the local level by identifying and evaluating each incident. OHCDS 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, MDCH monitors and reviews them. This includes an evaluation of individual and summary CIM reports, the prevention strategies and interventions used, and verification that OHCDS reports incidents of abuse, neglect, and exploitation to the Department of Human Services Adult Protective Services as required. MDCH provides technical assistance and training as necessary to improve reports and quality outcomes for the participants involved and checks that the OHCDS uses appropriate related planned services and supportive interventions to reduce or ameliorate further incidents. MDCH compiles a CIM summary report and trends and analyzes report submissions for review by MDCH and OHCDS.

#### Additional QIS Activities

1. OHCDS conduct risk management (RM) planning with participants during person-centered planning

(PCP). RM planning includes strategies and methods for addressing health and welfare issues negotiated with the participant through the PCP process. Supports coordinators and participants monitor and evaluate effectiveness of RM plans, noting successful strategies and modifying unsuccessful strategies. RM planning and updates occur during reassessment or more frequently if needed. Supports coordinators document RM planning in the service plan.

2. OHCDS trains participants, workers, and staff 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 participant health status outcomes. The OHCDS runs and monitors the reports quarterly then submit them annually to MDCH. 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. MDCH reviews the OHCDS 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 participants per reviewed provider to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Other</b> 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

MDCH compiles data from OHCDS quality management and QI reports and disseminates the information to MDCH, OHCDS, and other stakeholders annually. This information includes statistics for each QI in the MDCH QMP, individual OHCDS QI data, and progress in meeting established benchmarks. MDCH presents this information as requested.

Administrative and Clinical Reviews

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

improve compliance and common reasons for deficiencies.

#### CIM Reports

MDCH annually compiles critical incident reports received from each OHCDS. MDCH summarizes the number of incidents in each category, changes from previous summaries, methods of remediation, and whether or not the OHCDS resolved the incident. MDCH monitors reported incidents that did not include a resolution until the OHCDS finalizes interventions to the satisfaction of the participant involved.

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

Stakeholders review the QMP and which QIs to include in it annually. During the review, stakeholders 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 requirements into its own QMP.

MDCH updates service standards and contract requirements routinely as needed to assure the health and welfare of MTBIP 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 Provider Monitoring Plan, and billing procedures and coding systems.

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

MDCH compiles data to identify common deficiencies on an ongoing basis. When warranted, MDCH or other appropriate experts provide training to OHCDS staff to clarify issues and improve compliance to the TBISRP. MDCH 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:

The 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 Department 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 the Department 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 the Department in State and Federal grant funding must submit to the Department 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 Department grant funding must submit to the Department 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 (a. and b. above) 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 – Office of 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 the Department 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 MTBIP services sub-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 program 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).

The OHCDS processes payments for all verified claims by 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. 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 program participant. This information is then processed into MMIS.

Providers not wishing to have payments voluntarily reassigned must submit their bills directly to MDCH. These billings are suspended until such time as they can be manually verified by MDCH as they would by an OHCDS. Any provider who contracts directly with MDCH will similarly submit bills to MDCH through established Medicaid claims procedures. These claims are suspended until proper verification can be made. The claims are paid at the prevailing local rate for similar services as established by the local OHCDS subcontracting rate.

The MMIS edits all claims for proper eligibility. Each OHCDS also utilizes eligibility edits for all claims to ensure that payments are made only for authorized services from enrolled providers for eligible clients.

Each OHCDS is required to maintain all participants' records, including assessments, plans of service, 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 services.

MTBIP reimbursement is annually reconciled to data contained in Michigan's MMIS system. This annual reconciliation process ensures MDCH deducts any claim amounts rejected by MMIS from the total payments provided to the OHCDS. This process assures that only claims that have been approved by the Michigan MMIS system and 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 MTBIP participants. All funds that OHCDS receives from the Department for services or operations must be used directly or indirectly for the provision of services to its MTBIP 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 reviews 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 the 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 this 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:**

**Number and percent of claims adhering to the reimbursement methodology described in the waiver application. Numerator = Number of claims adhering to the reimbursement methodology described in the waiver application. Denominator = Number of MTBIP claims.**

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**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.

MDCH conducts annual administrative reviews to verify that that each OHCDS has financial systems in place to edit and safeguard each claim for assurance of appropriateness prior to reimbursement. OHCDS financial systems must be adequate to verify participant eligibility as well as inclusion of the service in the participant's plan of service.

In addition, each OHCDS is required to send claims data to MDCH to load into CHAMPS, the Medicaid claim system. Claims are subjected to additional editing and screening during the process of loading into CHAMPS.

MDCH works with the OHCDS immediately upon the identification of a coding, eligibility, or other claim

issue to correct, clarify, or delete the improper claim. Any claim which remains unresolved is omitted from the cost reconciliation process at the end of the fiscal year.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 each OHCDS to operate and administer the MTBIP. 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 the individual provider. MDCH does not play a role in this process.

The contract between the OHCDS and MDCH requires that rates be adequate to assure access to services needed by participants. MDCH 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.

Service providers are required by contract to provide a copy of the signed and dated invoice with number of 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, claims would be processed through the Medicaid claims processing system and suspend until a manual determination of a rate can be made. The rate used would be that which is paid had the contract been 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:

The MTBIP reimbursement system operates with individual providers of program services billing the OHCDs for services that are provided as authorized in the individual plan of service. The OHCDs then reviews individual providers to assure that all claims submitted are for services rendered. Any other providers are required to bill through normal claims procedures.

## Appendix I: Financial Accountability

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### 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

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### 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 on the date of service.

All claims submitted to the Michigan's 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 is included in the participant's approved service plan.

The OHCDS is responsible for assuring that only services authorized in a participant's plan of service 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.

Claims submitted by providers contracting directly with MDCH are suspended until the described validations can be done manually by MDCH. When each claim has been successfully validated, the claim is manually released for payment by the claims system.

c) FFP is only made when the services are 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, each OHCDS has systems in place 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.

- 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 primarily through a network of enrolled providers 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 a contracted through 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 provider 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 of providers for participants, participants are not required to receive services solely through an OHCDS.

Billing process:

1. Providers of waiver service 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 a 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 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 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.

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## 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.

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## 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.*

## Appendix I: Financial Accountability

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### 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:*

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

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- 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

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### 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

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### I-3: Payment (7 of 7)

#### 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.

A provider may directly bill the state Medicaid agency or voluntarily reassign their right to direct payment to the contracting 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) 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 qualified to provide a service 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. Any description beyond this is not possible until MDCH has the opportunity to prepare and execute a bid process.
- 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 provider. 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 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 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 program 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 and 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 OHCDS are monitoring and reviewing providers according to contract requirements. Administrative reviews 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. OHCDS are cost settled annually to ensure that approved expenditures are reimbursed. The MDCH Audit section also conducts financial audits every 2 – 2.5 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:

## 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:

**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:

All providers contracting with a TBI OHCDS must be able to segregate room and board costs from the costs of waiver services provided. This must be stipulated in all contractual agreements between the OHCDS and service providers.

In addition to this restriction, all providers, including those providing services in residential settings, are required to bill services under a specific set of HCPCS (Healthcare Common Procedure Coding System) codes. The MDCH claims processing system edits all incoming claims and rejects any claim submitted under any other HCPCS code.

Administrative reviews conducted by the department verify that contractual safeguards are in place and that proper billing procedures are maintained.

## 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	20176.00	4627.05	24803.05	31168.61	3148.06	34316.67	9513.62
2	24779.91	4785.76	29565.67	31393.11	3231.86	34624.97	5059.30
3	29193.37	4936.79	34130.16	31586.57	3317.24	34903.81	773.65

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 7)

**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	100	100	

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 2	100	100	
Year 3	100	100	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 7)

- 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 (ALOS) in the MTBIP is based on an expected enrollment pattern that will maximize the available program slots in an even monthly fashion. For the 20 slots reserved for the Transitional Residential Rehabilitation (TRR) Program, it assumes 3 new enrollees for the first 2 months of operation and 2 per month thereafter, filling all 20 available slots. It is anticipated that all TRR participants will then be transitioned to a home or community-based setting and begin receiving services there.

The ALOS calculation assumes that the available HCBS-only slots will fill at the rate of 5 per month until the saturation point is filled. That saturation point reserved capacity to allow participants completing the TRR program to begin receiving home and community-based services without putting the waiver over its enrollment limit. Under such constraints, HCBS-only participants will be accepted through the first year of the waiver with new participant in waiver years two and three coming through the TRR program.

Studies done by the department on persons suffering TBI injuries indicate that individuals receiving adequate care immediately post-injury exhibit improved rates of recovery and by two years post-injury require little or no continuing acute or therapeutic services. Based on these studies, the Michigan TBI Waiver program has been designed to provide participants with 24 months of TBI specific home and community based services. It is expected that, at that time, participants will be able to be transitioned to the state's MI Choice Waiver program.

Based on the expected influx of participants into the program described above and the anticipated length of service of 4 months for TRR participants and 24 months for those receiving home and community based services, the total number of expected participant days are derived for each waiver year. The total for each year is then divided by the number of participants to derive the average length of stay used in the appendix.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 7)

- 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:

In developing the estimates used in the Factor D derivation, services have been divided into three groups based on state experience in providing that set of services. The first service is the Transitional Residential Rehabilitation (TRR) Program, which operates as a distinct program within the waiver. The second group of services is the therapeutic and rehabilitation services offered in the home and community-based settings. The third group is the basic support serviced provided to allow the participant to live outside an institutional setting. Each group represents a different challenge in estimating costs and utilization throughout the waiver period.

The Transitional Residential Rehabilitation service is intended to supplant similar services offered through the MDCH TBI Memorandum of Understanding program. The 20 slots reserved for this portion of the

waiver are based on historical experience of the MOU program. Similarly, the cost of the service reflects what is being paid under the MOU program.

Estimates for the cost and utilization of therapeutic and rehabilitative services rely heavily on historical experience reported by the main TBI providers in the state. Data reported by these providers have been averaged to determine unit rates for services and their average utilization rates have been applied to the expected number of waiver participants to determine the expected number of users.

The remaining support services are directly analogous to similar service offered in the MI Choice waiver. Historical data from that program has been used to estimate the expected utilization and cost of these services.

- 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:

The D' derivation includes estimates for state plan services based on the fee for service and waiver experience of similar TBI patients who are in the MI Choice waiver or the MOU program. Data from a three year period is trended forward through the waiver period to form the basis of the estimate.

- 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 G Factor is based on the trended institutional data for TBI Medicaid beneficiaries who are not in either the MI Choice waiver or the TBI MOU program. It includes utilization and claims data for inpatient hospital stays as well as for nursing facility stays. Data from a three year period is trended forward through the waiver period to form the basis of the estimate.

- 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 G' Factor includes all non-institutional costs for TBI Medicaid beneficiaries who are not in the MI Choice waiver or TBI MOU program. Data was gleaned from the Michigan MMIS system for a three year period and trended forward through the waiver period. The calculation uses the same algorithm as is used in the MI Choice waiver application.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 7)

**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	
Pre-Vocational Employment Services	
Respite	
Supported Employment	
TBI Day Program	
TBI Personal Care Services	
TBI Supports Coordination	
Private Duty Nursing	
Assistive Technology & Enhanced Supplies	
Community Transitions	
Environmental Accessibility Adaptations (EAA)	
Home Delivered Meals	
Non-Medical Transportation	
Personal Emergency Response System (PERS)	
TBI Counseling	
TBI Nursing Services	

<b>Waiver Services</b>	
<b>TBI Occupational Therapy</b>	
<b>TBI Physical Therapy</b>	
<b>TBI Speech Language Pathology Therapy</b>	
<b>TBI Transitional Residential Rehabilitation Services</b>	
<b>Training and Educational Services for Unpaid Caregivers</b>	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 7)

#### 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
<b>Pre-Vocational Employment Services Total:</b>						32400.00
Pre-Vocational Employment Services	1240	12	100.00	27.00	32400.00	
<b>Respite Total:</b>						49104.00
Respite	12276	12	1023.00	4.00	49104.00	
<b>Supported Employment Total:</b>						32400.00
Supported Employment	1240	12	100.00	27.00	32400.00	
<b>TBI Day Program Total:</b>						145728.00
TBI Day Program	558	16	36.00	253.00	145728.00	
<b>TBI Personal Care Services Total:</b>						324000.00
TBI Personal Care Services	86400	48	1800.00	3.75	324000.00	
<b>TBI Supports Coordination Total:</b>						88350.00
TBI Supports Coordination	5320	62	75.00	19.00	88350.00	
<b>Private Duty Nursing Total:</b>						30360.00
Private Duty Nursing	3036	11	276.00	10.00	30360.00	
<b>Assistive Technology &amp; Enhanced Supplies Total:</b>						7308.00
Assistive Technology & Enhanced Supplies	2436	21	116.00	3.00	7308.00	
<b>Community Transitions Total:</b>						1440.00
<b>GRAND TOTAL:</b>						2017592.00
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						20176.00
Average Length of Stay on the Waiver:						148

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transitions	6	3	2.00	240.00	1440.00	
<b>Environmental Accessibility Adaptations (EAA) Total:</b>						20000.00
Environmental Accessibility Adaptations (EAA)	20	10	2.00	1000.00	20000.00	
<b>Home Delivered Meals Total:</b>						31590.00
Home Delivered Meals	6318	26	243.00	5.00	31590.00	
<b>Non-Medical Transportation Total:</b>						5904.00
Non-Medical Transportation	5904	12	492.00	1.00	5904.00	
<b>Personal Emergency Response System (PERS) Total:</b>						9450.00
Personal Emergency Response System (PERS)	315	35	9.00	30.00	9450.00	
<b>TBI Counseling Total:</b>						1188.00
TBI Counseling	22	2	11.00	54.00	1188.00	
<b>TBI Nursing Services Total:</b>						80600.00
TBI Nursing Services	7956	31	260.00	10.00	80600.00	
<b>TBI Occupational Therapy Total:</b>						101080.00
TBI Occupational Therapy	2468	19	133.00	40.00	101080.00	
<b>TBI Physical Therapy Total:</b>						101080.00
TBI Physical Therapy	2468	19	133.00	40.00	101080.00	
<b>TBI Speech Language Pathology Therapy Total:</b>						101080.00
TBI Speech Language Pathology Therapy	2468	19	133.00	40.00	101080.00	
<b>TBI Transitional Residential Rehabilitation Services Total:</b>						851200.00
TBI Transitional Residential Rehabilitation Services	2240	20	112.00	380.00	851200.00	
<b>Training and Educational Services for Unpaid Caregivers Total:</b>						3330.00
Training and Educational Services for Unpaid Caregivers	335	37	9.00	10.00	3330.00	
<b>GRAND TOTAL:</b>						2017592.00
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						20176.00
Average Length of Stay on the Waiver:						148

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 7)

#### 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
<b>Pre-Vocational Employment Services Total:</b>						44928.00
Pre-Vocational Employment Services	1640	16	100.00	28.08	44928.00	
<b>Respite Total:</b>						68090.88
Respite	16368	16	1023.00	4.16	68090.88	
<b>Supported Employment Total:</b>						44928.00
Supported Employment	1640	16	100.00	28.08	44928.00	
<b>TBI Day Program Total:</b>						198918.72
TBI Day Program	738	21	36.00	263.12	198918.72	
<b>TBI Personal Care Services Total:</b>						442260.00
TBI Personal Care Services	113400	63	1800.00	3.90	442260.00	
<b>TBI Supports Coordination Total:</b>						121524.00
TBI Supports Coordination	9248	82	75.00	19.76	121524.00	
<b>Private Duty Nursing Total:</b>						43056.00
Private Duty Nursing	4140	15	276.00	10.40	43056.00	
<b>Assistive Technology &amp; Enhanced Supplies Total:</b>						10133.76
Assistive Technology & Enhanced Supplies	3248	28	116.00	3.12	10133.76	
<b>Community Transitions Total:</b>						1996.80
Community Transitions	8	4	2.00	249.60	1996.80	
<b>Environmental Accessibility Adaptations (EAA) Total:</b>						31200.00
Environmental Accessibility Adaptations (EAA)	30	15	2.00	1040.00	31200.00	
<b>Home Delivered Meals Total:</b>						35380.80
Home Delivered Meals	6804	28	243.00	5.20	35380.80	
<b>Non-Medical Transportation Total:</b>						8186.88
Non-Medical Transportation	7872	16	492.00	1.04	8186.88	
<b>Personal Emergency Response System (PERS) Total:</b>						13197.60
Personal Emergency Response System (PERS)	423	47	9.00	31.20	13197.60	
<b>GRAND TOTAL:</b>						2477991.36
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						24779.91
Average Length of Stay on the Waiver:						316

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>TBI Counseling Total:</b>						1235.52
TBI Counseling	22	2	11.00	56.16	1235.52	
<b>TBI Nursing Services Total:</b>						108160.00
TBI Nursing Services	10452	40	260.00	10.40	108160.00	
<b>TBI Occupational Therapy Total:</b>						138320.00
TBI Occupational Therapy	3264	25	133.00	41.60	138320.00	
<b>TBI Physical Therapy Total:</b>						138320.00
TBI Physical Therapy	3264	25	133.00	41.60	138320.00	
<b>TBI Speech Language Pathology Therapy Total:</b>						138320.00
TBI Speech Language Pathology Therapy	3264	25	133.00	41.60	138320.00	
<b>TBI Transitional Residential Rehabilitation Services Total:</b>						885248.00
TBI Transitional Residential Rehabilitation Services	2240	20	112.00	395.20	885248.00	
<b>Training and Educational Services for Unpaid Caregivers Total:</b>						4586.40
Training and Educational Services for Unpaid Caregivers	443	49	9.00	10.40	4586.40	
<b>GRAND TOTAL:</b>						2477991.36
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						24779.91
Average Length of Stay on the Waiver:						316

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 7)

#### 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
<b>Pre-Vocational Employment Services Total:</b>						58400.00
Pre-Vocational Employment Services	2000	20	100.00	29.20	58400.00	
<b>Respite Total:</b>						88387.20
<b>GRAND TOTAL:</b>						2919336.88
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						29193.37
Average Length of Stay on the Waiver:						322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	20460	20	1023.00	4.32	88387.20	
<b>Supported Employment Total:</b>						58400.00
Supported Employment	2000	20	100.00	29.20	58400.00	
<b>TBI Day Program Total:</b>						246276.00
TBI Day Program	900	25	36.00	273.64	246276.00	
<b>TBI Personal Care Services Total:</b>						562716.00
TBI Personal Care Services	138600	77	1800.00	4.06	562716.00	
<b>TBI Supports Coordination Total:</b>						154125.00
TBI Supports Coordination	6488	100	75.00	20.55	154125.00	
<b>Private Duty Nursing Total:</b>						53753.76
Private Duty Nursing	4968	18	276.00	10.82	53753.76	
<b>Assistive Technology &amp; Enhanced Supplies Total:</b>						10147.68
Assistive Technology & Enhanced Supplies	3132	27	116.00	3.24	10147.68	
<b>Community Transitions Total:</b>						2595.80
Community Transitions	10	5	2.00	259.58	2595.80	
<b>Environmental Accessibility Adaptations (EAA) Total:</b>						43264.00
Environmental Accessibility Adaptations (EAA)	40	20	2.00	1081.60	43264.00	
<b>Home Delivered Meals Total:</b>						55214.46
Home Delivered Meals	10206	42	243.00	5.41	55214.46	
<b>Non-Medical Transportation Total:</b>						10627.20
Non-Medical Transportation	9840	20	492.00	1.08	10627.20	
<b>Personal Emergency Response System (PERS) Total:</b>						16646.85
Personal Emergency Response System (PERS)	513	57	9.00	32.45	16646.85	
<b>TBI Counseling Total:</b>						1927.53
TBI Counseling	33	3	11.00	58.41	1927.53	
<b>TBI Nursing Services Total:</b>						112528.00
TBI Nursing Services	10400	40	260.00	10.82	112528.00	
<b>TBI Occupational Therapy Total:</b>						172607.40
<b>GRAND TOTAL:</b>						2919336.88
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						29193.37
Average Length of Stay on the Waiver:						322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
TBI Occupational Therapy	3980	30	133.00	43.26	172607.40	
<b>TBI Physical Therapy Total:</b>						172607.40
TBI Physical Therapy	3980	30	133.00	43.26	172607.40	
<b>TBI Speech Language Pathology Therapy Total:</b>						172607.40
TBI Speech Language Pathology Therapy	3980	30	133.00	43.26	172607.40	
<b>TBI Transitional Residential Rehabilitation Services Total:</b>						920662.40
TBI Transitional Residential Rehabilitation Services	2240	20	112.00	411.01	920662.40	
<b>Training and Educational Services for Unpaid Caregivers Total:</b>						5842.80
Training and Educational Services for Unpaid Caregivers	540	60	9.00	10.82	5842.80	
<b>GRAND TOTAL:</b>						2919336.88
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						29193.37
Average Length of Stay on the Waiver:						322