MSA Medical Services Administration Bulletin

Michigan Department of Health and Human Services

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Subject: New Medicaid Provider Manual Chapter for MI Health Link

Effective: December 1, 2015

Programs Affected: Medicaid, MI Health Link

The purpose of this proposed policy notice is to notify providers of the addition of a MI Health Link Chapter in the Medicaid Provider Manual. The chapter gives providers information about the new MI Health Link program that began March 1, 2015. The MI Health Link program is a partnership among the Centers for Medicare & Medicaid Services (CMS), the Michigan Department of Health and Human Services (MDHHS), and Integrated Care Organizations (ICOs) through a Three-Way Contract to coordinate Medicare and Medicaid services for individuals who are dually eligible for full Medicare and full Medicaid.

This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for enrolled individuals. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

Information within the enclosed MI Health Link Chapter has been developed in accordance with the signed Three-Way Contract, federal and state policy, rules, and regulations, and other supporting documentation. This chapter also includes references to other chapters within the Medicaid Provider Manual as other Medicaid policy also applies to MI Health Link.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Chris Priest, Director
Medical Services Administration

MI HEALTH LINK

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SECTION 1 – GENERAL INFORMATION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program, called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

CMS and MDHHS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. Section 2 provides a list of the regions and related counties

SECTION 2 – ELIGIBILITY AND SERVICE AREA

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

Region	Counties in the Region
1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
7	Wayne
9	Macomb

Excluded Populations:

- Individuals under age 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56
- Individuals not living in one of the four demonstration regions
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
- Individuals without full Medicaid coverage (they have spenddowns or deductibles)
- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services

SECTION 3 – ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways: 1) voluntary enrollment, and 2) passive enrollment. For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the State for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Eligible individuals who do not voluntarily enroll in the program receive a notification letter at least 60 days prior to the enrollment effective date informing them they will be passively enrolled. Eligible individuals will have a period of 60 days to opt out of the program if they choose to do so prior to the enrollment effective date. Individuals may opt out by calling the entities as indicated in the notification letter. Individuals who do not opt out of the program prior to the effective date will be passively enrolled and an ICO will be assigned to them. Prior to the enrollment effective date, and at any time thereafter, individuals will have the opportunity to select a different ICO than the one assigned to them if there is another ICO option in the region.

After enrollment, individuals are issued an ID card that is specific to the MI Health Link program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the ICO responsible for coverage along with the MI Health Link logo. Individuals will be enrolled in the benefit plan called ICO-MC, which is a benefit plan specific to the MI Health Link program (Refer to the Beneficiary Eligibility Chapter for additional information).

Individuals who are enrolled in the MI Choice waiver or the Program of All-Inclusive Care for the Elderly (PACE) are not passively enrolled into MI Health Link. These individuals may enroll in MI Health Link voluntarily, but must disenroll from MI Choice or PACE before the MI Health Link enrollment is effective. MDHHS will assist in this process to ensure a smooth transition between programs. Individuals who are enrolled in MI Choice or PACE and wish to enroll in MI Health Link must call the enrollment broker to start the enrollment process. The enrollment broker will send a message to MDHHS notifying MDHHS that the individual has chosen to enroll in MI Health Link. MDHHS staff will contact the appropriate MI Choice waiver agency or PACE organization to obtain current information and assessments for the individual. MDHHS will review the information received to determine if the individual's needs can be met through MI Health Link. MDHHS will contact the individual to discuss whether his or her needs can be met in MI Health Link. If the individual still chooses to join MI Health Link at that time, MDHHS will initiate the formal enrollment in the program and will notify the ICO accordingly.

Individuals may choose to disenroll from MI Health Link at any time. Disenrollment is effective on the first day of the following month.

SECTION 4 – LEVEL OF CARE CODES

Level of care (LOC) codes specific to the MI Health Link program are as follows:

Level of Care Code	Description
03	Individual meets nursing facility level of care based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD), lives in the community, and participates in the MI Health Link HCBS waiver program.
05	Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility.
07	General population in the community.
15	Resident of a County Medical Care Facility.

SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services
- Dental services
  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.
- Long Term Supports and Services (LTSS)
  - Nursing facility services
  - State Plan personal care services
  - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.
  - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD
- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

Hospice is not a covered benefit. If an individual elects to receive hospice services, the individual is disenrolled from the ICO effective the last day of the same month in which the hospice enrollment is effective. For example, if the individual elects to receive hospice services on March 15, he or she will be disenrolled from MI Health Link effective April 1. The ICO is responsible for non-hospice related services until the individual is disenrolled from the ICO (the remainder of the month). After disenrollment from the ICO, the individual's option for Medicaid services in the demonstration regions will be through fee-for-service (FFS). Medicare will cover the hospice services as well as any other non-hospice related services traditionally covered by Medicare. Individuals will not be eligible for the MI Health Link program as long as they continue to be enrolled in hospice.

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services also may be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.

5.1.A. PROVIDER QUALIFICATIONS

A criminal history screen must be conducted for all personal care providers. In addition, the provider must meet the following qualifications:

- Be 18 years of age or older;
- Be able to follow instructions, personal care procedures, perform the services required and handle emergencies;
- Be physically able to perform the needed services;
- Be knowledgeable about when to seek assistance from appropriate sources in the event of an emergency;
- Be dependable and able to meet job demands; and
- Be willing to participate in available training programs if necessary.

5.1.B. ASSESSMENT REQUIREMENTS

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The face-to-face, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration and payment of services. The reassessment must be face-to-face.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

Independent	The individual performs the activity with no human assistance.
Verbal assistance	The individual performs the activity with verbal assistance such as reminding, guiding or encouraging.
Minimal human assistance	The individual performs the activity with some direct physical assistance and/or assistance technology.
Moderate human assistance	The individual performs the activity with a great deal of human assistance and/or assistive technology.
Dependent	The individual does not perform the activity even with human assistance and/or assistance technology.

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater. In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible for IADL services. Once an individual is determined eligible for personal care services, his or her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

5.1.C. Personal Care Services and the MI Health Link HCBS Waiver

If an individual ranks at a level 1 or 2, he or she will not be eligible for State Plan Personal Care Services through MI Health Link. If an individual ranks at a level 2, he or she may be eligible for ADL assistance through the MI Health Link HCBS waiver Expanded Community Living Supports (ECLS) benefit if the individual requires prompting, cueing, guiding, teaching, observing, or reminding to complete ADLs. Through the MI Health Link HCBS waiver, an individual may receive IADL assistance if he or she receives prompting, cueing, guiding, etc. to complete ADLs.

ECLS may be provided in addition to State Plan Personal Care Services if the individual requires hands-on assistance with some ADLs, as covered under Personal Care Services, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs and IADLs independently to ensure safety, health, and welfare of the individual.

5.1.D. Reasonable Time and Task

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

5.1.E. Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed for individuals whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or individual may be required in order to perform.

- Eating and feeding
- Catheters or legs bags
- Colostomy care
- Bowel program
- Suctioning
- Specialized skin care
- Range of motion exercises
- Peritoneal dialysis
- Wound care
- Respiratory treatment
- Ventilators
- Injections

The ICO Care Coordinator will allocate time for each task assessed a rank of 3 or greater based on interviews with the individual and provider, observation of the individual's abilities and use of the RTS as a guide. When hours exceed the RTS, a rationale must be provided and maintained in the individual's record.

An assessment of need at a ranking of 3 or greater does not automatically guarantee the maximum allotted time allowed by the RTS. The ICO Care Coordinator must assess each task according to the actual time required for its completion.

5.1.F. Reimbursement and Rates

After enrollment and according to the requirements of the three-way contract, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with individual approval. An ICO should use the Medicaid Home Help Payment Schedule (found in the Directory Appendix) to continue paying providers as scheduled. An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule, which should be defined in the contract between the ICO and the personal care provider. The ICO must publish a pay cycle and must pay these claims on the next available pay cycle date.

Furthermore, an ICO should use the Individual and Agency County Rates (found in the Directory Appendix) to determine payment rates for the transition period until the ICO

and personal care provider agree upon a rate that is defined in the ICO and personal care provider contract.

After the transition period, payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs except for administering medications) and responsible relatives able and available to assist.

If the individual does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) must be **prorated by one half** in shared living arrangements where other adults reside in the home, as personal care services are only for the benefit of the individual. This does not include situations where others live in adjoined apartments, flats or in a separate home on shared property and there is no shared common living area. In shared living arrangements, where it can be clearly documented that IADLs for the enrolled individual are completed separately from others in the home, hours for IADLs do not need to be prorated.

5.1.G. Responsible Relatives and Guardians

Adult children (18 years of age or older) may provide personal care services to a parent. An individual's spouse **cannot** be paid to provide personal care services to the individual as they are considered responsible relatives. Couples who are separated must provide verification that they are no longer residing in the same home. Verification may include a driver's license, rent receipt or utility bill reflecting their separate mailing address. A spouse who is legally separated from a spouse cannot be paid to provide personal care services. ADLs may be approved when an individual's spouse is unavailable or unable to provide these services. "Unavailable" means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. "Unable" means the responsible person has disabilities of their own which prevent them from providing care.

Shopping, laundry, or light housecleaning shall not be approved when a responsible relative of the individual resides in the home, unless they are unavailable or unable to provide these services. These findings must be documented.

5.1.H. Individuals in Adult Foster Care Facilities and Home for the Aged

For individuals in adult foster care facilities or home for the aged, a flat monthly supplement rate is established annually by the state legislature for those Medicaid beneficiaries who, according to a standardized assessment, have a documented need for personal care services. The supplement rate is included in the ICO rates, and the ICOs

must pay this rate to adult foster care homes and homes for the aged providers for individuals enrolled in MI Health Link. ICOs and Adult Foster Care facilities and Homes for the Aged must use the billing invoice provided by MDHHS.

5.2 SUPPLEMENTAL SERVICES

MI Health Link supplemental services are available for any individuals who live in the community, wish to move from a nursing facility to the community, do not meet LOCD and are not enrolled in the MI Health Link HCBS waiver. The four supplemental services are Adaptive Medical Equipment and Supplies, Community Transition Services, Personal Emergency Response System, and Respite.

5.2.A. ADAPTIVE MEDICAL EQUIPMENT AND SUPPLIES

This service includes devices, controls, or appliances specified in the Individual Integrated Care and Supports Plan (IICSP) that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State Plan and Medicare that are necessary to address individual functional limitations. This will also cover the costs of equipment maintenance. The coverage includes training the individual and/or caregivers in the operation and/or maintenance of the equipment and the use of a supply when initially purchased. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not approved by the United States Food and Drug Administration (FDA).

All items shall meet applicable standards of manufacture, design, and installation. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment (DME) provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter. The ICO may obtain some items directly from a retail store that offers the item to the general public. When utilizing retail stores, the ICO must ensure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific individual who received the purchased item. Items must be of direct medical or remedial benefit to the individual, and this benefit must be documented in the individual's record.

It must be documented on the Individual Integrated Care and Supports Plan (IICSP) or Care Bridge Record that the item is the most cost-effective alternative to meeting the individual's needs. There must be documentation on the IICSP or Care Bridge record that the best value in warranty coverage was obtained at the time of purchase. Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with Michigan Scope of Practice laws). Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the individual's physician.

5.2.B. COMMUNITY TRANSITION SERVICES

Community Transition Services (CTS) include non-reoccurring expenses for individuals transitioning from a nursing facility to another residence where the individual is responsible for his or her own living arrangement. Person-centered planning must be used throughout the entire community transition process. The ICO shall begin CTS no more than six months before the expected discharge from the nursing facility. Allowable transition costs include the following:

- Housing or security deposit: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television service and internet are excluded).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
- Cleaning: A one-time cleaning expense to ensure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of an individual to a community setting.
- Other services deemed necessary and documented within the individual's plan of service to accomplish the transition into a community setting.

Ongoing monthly rental or mortgage expense, ongoing utility charges, or items that are intended for purely diversional or recreational purposes are excluded under this service.

5.2.C PERSONAL EMERGENCY RESPONSE SYSTEM

A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once the "help" button is activated. The PERS provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The individual must reside in an area where cellular or mobile coverage is reliable. When the individual uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The PERS provider must ensure at least monthly testing of each PERS unit to maintain proper functioning.

PERS does not cover monthly telephone charges associated with phone service. This service is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The ICO may authorize PERS units for individuals who do not live alone if both the waiver individual and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

The Federal Communication Commission (FCC) must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. The response center must maintain the monitoring capacity to respond to all incoming emergency signals. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put on a first call, first serve basis. The provider will furnish each responder with written instructions and provide training, as appropriate.

5.2.D. RESPITE

Respite services may be provided at the individual's home, in the home of another person, or at another setting outside the individual's home. Respite service criteria are different depending on the setting. Respite services are limited to a total of 14 overnight stays per 365 days regardless of the setting. The ICO may provide more respite services as an optional benefit. For individuals receiving respite services through the PIHP, they must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.

5.2.D.1. RESPITE PROVIDED AT THE INDIVIDUAL'S HOME OR IN THE HOME OF ANOTHER PERSON

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Respite services include:

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

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in the payment for respite services.

5.2.D.2 RESPITE PROVIDED OUTSIDE THE HOME

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in Michigan Compiled Law (MCL) 400.701ff, which includes adult foster care homes and homes for the aged. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.

Respite services include:

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

Out-of-home respite may be scheduled for several days in a row, depending upon the needs of the individual and the individual's caregivers.

SECTION 5.3 – MI HEALTH LINK HCBS WAIVER SERVICES

These services are intended for individuals who meet all of the following criteria:

- are enrolled in the MI Health Link program,
- meet nursing facility level of care as determined by the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool,
- demonstrate a need for one or more of the services listed below, which must be identified in the Individual Integrated Care and Supports Plan (IICSP).

Individuals must receive at least one waiver service each month to remain on the waiver. The ICO and direct service providers must adhere to the service definition and operating standards to be eligible to receive payment of waiver expenses.

5.3.A. ADAPTIVE MEDICAL EQUIPMENT AND SUPPLIES

For the definition of the Adaptive Medical Equipment and Supplies service, refer to subsection 5.2.A of this chapter.

5.3.B. ADULT DAY PROGRAM

Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the IICSP, in a non-

institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the individual's residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the ICO will pay for the transportation to and from the Adult Day Program center separately.

Individuals cannot receive personal care services or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services, but cannot be provided at the same time unless the specific component of the service includes laundry, housecleaning, etc., that does not require the individual to be present.

Adult Day Program may be authorized only if the individual meets at least one of the following criteria:

- Requires regular supervision to live in his or her own home or the home of a relative
- If he or she has a caregiver, the individual must require a substitute caregiver while his or her regular caregiver is unavailable
- Has difficulty or is unable to perform ADLs without assistance
- Capable of leaving the residence with assistance to receive services
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization

A referral from an ICO for a waiver individual shall replace any screening or assessment activities performed for other Adult Day Program individuals at the setting. The direct Adult Day Program service provider shall accept copies of the ICO's assessments and Individual Integrated Care and Supports Plan (IICSP) to eliminate duplicate assessment and service planning activities.

Each program shall provide directly, or coordinate with the ICO to arrange for the provision of the following services.

- Transportation
- Personal Care
- Nutrition: one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Individuals in attendance from eight to fourteen hours

per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration individual choice, health, religious and ethnic diet preferences

- Recreation: consisting of planned activities suited to the needs of the individual and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction

If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. The ICO shall provide care coordination.

Each program shall keep all individuals' files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.

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

Each program shall establish written procedures (reviewed and approved by a consulting Pharmacist, Physician, or RN) that govern the assistance given by staff to individuals taking their own medications while participating in the program. The policies and procedures must minimally address:

- Written consent from the individual or individual's representative to assist with medications.
- Verifications of the individual's medication regimen, including prescriptions and dosages.
- The training and authority of staff to assist individuals with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
- Procedures for medication set up.
- Secure storage of individuals' medications. Medications must be returned to the individual.
- Instructions for entering medication information in individual files, including times and frequency of assistance.

Program staff shall have basic first-aid training and any other training as required by MDHHS and the ICO.

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

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

The provider shall maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each Adult Day Program center must have the following furnishings:

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

Each provider shall post emergency procedures (fire, severe weather, etc.) in each room of the program site. Practice drills of emergency procedures must occur once every six months. The program shall maintain a record of all practice drills.

Each Adult Day Program center must document that it is in compliance with:

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

Adult Day Program settings must be compliant with the HCBS Final Rule as indicated in subsection 9.3 of this chapter.

5.3.C. ASSISTIVE TECHNOLOGY

The Assistive Technology service includes technology items used to increase, maintain, or improve an individual's functioning and promote independence. The service may include assisting the individual in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the individual's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the individual and specified under the IICSP. Some examples of assistive technology include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks,

power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener and specialized alarm or intercom.

Cost limits for this service are as follows:

- $15,000 maximum for van lifts, including tie-downs, for the duration of the 5-year waiver period
- $5,000 yearly (waiver year) maximum for all other assistive technology devices

Items must be of direct medical or physical benefit to the individual. Where feasible, the ICO and/or direct service provider must seek confirmation of the need for the item from the individual's physician. It must be documented in the IICSP that the item is the most cost-effective alternative to meeting the individual's needs. Items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.

Modifications will only be made to vehicles with proper insurance coverage, with the exception of new vehicles coming directly from an automotive factory to the entity performing the modification.

Direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the ICO and/or the three-way contract. Contracted/subcontracted providers must have appropriate state licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

Items like cell phones, internet service, and full-home wiring systems are excluded from this benefit. This service also does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.

5.3.D. CHORE SERVICES

Chore Services include those duties needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver individuals.

Chore services are covered only in cases when neither the individual nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the

responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the IICSP. The ICO must deem the chosen provider capable of performing the required tasks. Pest control suppliers must be properly licensed.

5.3.E. COMMUNITY TRANSITION SERVICES

For the definition of Community Transition Services (CTS), refer to subsection 5.2.B. in this chapter.

For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning individual requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.

5.3.F. ENVIRONMENTAL MODIFICATIONS

The Environmental Modifications service covers physical adaptations to the home, required in the individual's IICSP, that are necessary to ensure the health and welfare of the individual or that enable the individual to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual. Complex kitchen and bathroom modifications may be completed if medically necessary for the individual. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence. A ramp or lift will be covered for only one exterior door or other entrance.

The modification/adaptation must be for a primary residence, but may include additional residences subject to prior authorization by the ICO. Examples of additional residences might be a family member's cottage or the individual's second home or cottage so the individual can go there to be with family.

The modification/adaptation must be the most cost-effective and reasonable alternative. Any modifications/adaptations shall only be used to modify existing spaces or structures. The existing structure must have the capability to accept and support the proposed changes. Repairs, modifications, or adaptations shall not be performed on a condemned structure. Modifications must comply with local building codes. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.

Environmental modifications/adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an individual's home.

The ICO may use MI Health Link funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.

Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the individual, and the ICO must specify that the ICO and individual are not responsible for any costs to restore the property to the original condition.

Excluded from this service are those adaptations or improvements to the home that:

- Are of general utility;
- Are considered to be standard housing obligations of the individual or homeowner; and
- Are not of direct medical or remedial benefit to the individual. For example, kitchen modifications must be required for the individual to prepare his or her own meals.
- Modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.
- Are used for upgrades to the home or for additions to homes (adding square footage, etc.).
- Are improvements exclusively required to meet local building codes and not directly related to an individual's medical or physical condition.

Some examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The ICO shall not cover general construction costs in a new home or additions to a home purchased after the individual is enrolled in the waiver. If an individual or the individual's family purchases or builds a home while receiving waiver services, it is the individual's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the individual has mobility limitations. However, MI Health Link funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening of doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the ICO may fund the difference between the standard fixture and the modification required to accommodate the individual's need.

Contracted providers (such as licensed building contractors) must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3). Verification of certification, licensure, or

other provider qualifications must be done prior to execution of the contract related to the modification project to be done.

5.3.G. EXPANDED COMMUNITY LIVING SUPPORTS

To receive Expanded Community Living Supports (ECLS), individuals MUST need prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete activities of daily living (ADLs). ECLS does not include hands on assistance for ADLs unless something occurs incidental to this service. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.

Expanded Community Living Supports (ECLS) include:

- Assisting, reminding, cueing, observing, guiding and/or training in the following activities:
  - Meal preparation
  - Laundry
  - Routine, seasonal, and heavy household care and maintenance
  - ADLs such as bathing, eating, dressing, and personal hygiene
  - Shopping for food and other necessities of daily living
- Assistance, support, and/or guidance with such activities as:
  - Money management
  - Non-medical care (not requiring nursing or physician intervention)
  - Social participation, relationship maintenance, and building community connections to reduce personal isolation
  - Transportation (excluding to and from medical appointments) from the individual's residence to community activities, among community activities, and from the community activities back to the individual'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
- Reminding, cueing, observing, and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
- Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
- Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the individual as identified in the individual's IICSP.

- Observing and reporting to the ICO Care Coordinator any changes in the individual's condition and the home environment.

Individual providers chosen by the individual must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation related to this service, the provider must possess a valid Michigan driver's license.
- Providers of ECLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained on the individual's specific needs as identified in the IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.
- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.
- Must be deemed capable of performing the required tasks by ICO.

Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal history review.
- A registered nurse (RN) licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
- The ICO and/or provider agency must train each worker to properly perform each task required for each individual the worker serves before delivering the service to that individual. The supervisor must ensure that each worker can competently and confidently perform every task assigned for each individual served. MDHHS strongly recommends each worker delivering ECLS services complete a certified nursing assistance training course.
- ECLS providers may prompt, cue, or supervise the individual to perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each individual who requires such care. The supervising RN

must ensure each workers confidence and competence in the performance of each task required.

- ECLS service providers must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.
- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.

When the ECLS services include transportation, the following standards apply:

- The ICO may not use MI Health Link funds to purchase or lease vehicles for providing transportation services to waiver individuals.
- The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MI Health Link funds. The provider must cover all vehicles used with liability insurance.
- All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
- The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Health Link funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
- Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Each direct service provider who chooses to allow staff to assist individuals with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall include, at a minimum:

- The provider staff authorized to assist individuals with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the individual takes and its impact upon the individual.
- Verification of prescription medications and their dosages. The individual shall maintain all medications in their original, labeled containers.
- Instructions for entering medication information in individual files.
- A clear statement of the individual's and his or her legal representative's responsibility regarding medications taken by the individual and the provision for informing the individual and his or her legal representative of the provider's procedures and responsibilities regarding assisted self-administration of medications.

ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:

- A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
- A provider shall ensure that medication use conforms to federal standards and the standards of the medical community.
- A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
- A provider shall review the administration of a psychotropic medication periodically as set forth in the individual's IICSP and based upon the individual's clinical status.
- If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
- A provider shall record the administration of all medication in the individual's record. The ICO may do this electronically or via paper format, but the records must be readily available if requested by MDHHS.
- A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the individual's record.

ECLS cannot be provided in circumstances where they would be a duplication of services available through MI Health Link. The distinction must be apparent by unique hours and units in the approved IICSP.

ECLS may be furnished outside the individual's home.

The individual oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the IICSP. When transportation incidental to the provision of ECLS is included, the ICO shall not also authorize transportation as a separate waiver service for the individual.

Members of an individual's family may provide ECLS to the individual. However, the ICO shall not directly authorize funds to pay for services furnished to an individual by that person's spouse or legal guardian or other financially responsible person. Family members who provide this service must meet the same standards as providers who are unrelated to the individual. Roommates or other individuals who live with the individual may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e. meal preparation, laundry, housecleaning, etc.). Paid ECLS services are only for the benefit of the individual receiving the services.

In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need

not be pro-rated. Providers must be trained to perform each required task prior to service delivery. The supervisor must ensure the provider can competently and confidently perform each assigned task.

With the assistance of the individual and/or individual's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each individual, pursuant to each visit for emergencies and provider no-shows or late arrivals.

ECLS does not include the cost associated with room and board. ECLS also excludes nursing and skilled therapy services.

ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting. Documentation in the individual's record must clearly identify the individual's need for additional supports and services not covered by licensure. The IICSP must clearly identify the portion of the individual's supports and services covered by ECLS. The setting must comply with the requirements of the Home and Community-Based Services (HCBS) Final Rule as described in subsection 9.3 of this chapter.

5.3.H. FISCAL INTERMEDIARY

Fiscal Intermediary (FI) services assist the individual to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the individual to manage and distribute funds contained in the individual budget. The individual uses funds to purchase home and community based services authorized in the IICSP. FI services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring individual-directed budget expenditures and identify potential over and under expenditures; ensuring compliance with documentation requirements related to management of public funds. The FI helps the individual manage and distribute funds contained in the individual budget. The FI also assists with training the individual and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

FI services are available only to individuals participating in arrangements that support self-determination. Additionally, FI services may not be provided by the individual's family, guardian, or providers of other services for the same individual. The ICO and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements provided by MDHHS. FI services through the MI Health Link HCBS waiver must only be used for MI Health Link HCBS services as identified in the CMS-approved 1915(c) waiver application.

Each FI must:

- Be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.

- Demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
- Demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
- Provide four basic areas of performance:
  - Function as the employer agency for individuals directly employing workers to ensure compliance with payroll tax and insurance requirements;
  - Ensure compliance with requirements related to management of public funds, the direct employment of workers by individuals, and contracting for other authorized supports and services;
  - Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each individual and ICO; and
  - Offer supportive services to enable individuals to self-determine and direct the supports and services they need.

5.3.I. HOME DELIVERED MEALS

This service is the provision of one to two nutritious meals per day to individuals who are unable to care for their nutritional needs. This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law. Meal options must meet individual preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences. ICOs must follow the minimum operating standards for this service as provided by MDHHS.

Each ICO must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:

- The individual must be unable to obtain food or prepare complete meals.
- The individual does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
- The individual does not have a paid caregiver that is able and willing to prepare meals for the individual.
- The provider can appropriately meet the individual's special dietary needs and the meals available would not jeopardize the health of the individual.
- The individual must agree to be home when meals are delivered. For any unavoidable absence, the provider or ICO must be contacted. If the ICO is contacted, they must contact the provider.

5.3.J. NON-MEDICAL TRANSPORTATION

This service is offered to enable individuals to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP). Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. Need for this service and details as to whom and how it will be provided should be discussed in the person-centered planning meeting and documented in the IICSP.

Direct service providers shall be a centrally organized transportation company or agency. Transportation may be provided by any of the following methods:

- Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
  - Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the individual.
  - Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.
- Public Transit: Characterized by partial or full payment of the cost for an individual to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.
- Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals who transport individuals in their private vehicles. The provider may include a passenger assistance component.
- Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance. MI Health Link funds may not be used to purchase or lease vehicles for providing transportation services to waiver individuals. All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

MI Health Link funds shall not be used to reimburse caregivers (paid or informal) to run errands for individuals when the individual does not accompany the driver of the vehicle.

5.3.K. PERSONAL EMERGENCY RESPONSE SYSTEM

For the definition of the Personal Emergency Response System (PERS) definition, refer to section 5.2.C. of this Chapter.

5.3.L. PREVENTIVE NURSING SERVICES

Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an individual who generally requires nursing services for the management of a chronic illness or physical disorder in the individual's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for individuals who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the individual such as hospitalizations and nursing facility admissions. An individual using this service must demonstrate a need for observation and evaluation.

When the individual's condition is unstable, could easily deteriorate, or when significant changes occur, the ICO covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the individual's condition and report findings to the individual's physician or other appropriate health care professional such as the ICO Care Coordinator to prevent additional decline, illness, or injury to the individual. The ICO Care Coordinator shall communicate with both the nurse providing this service and the individual's health care professional to ensure the nursing needs of the individual are being addressed.

Individuals must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including individual-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
- Require professional assessment of the individual's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
- Require professional evaluation of the individual's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary.
- Require professional evaluation of the individual's physical status to encourage optimal functioning and discourage adverse outcomes.
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the individual's physician or other health care professional.

In addition to observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Complied Law (MCL) 333.7103(1)).
- Setting up medications according to physician orders.
- Monitoring individual adherence to his or her medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the individual or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.

This service is limited to **no more than two hours per visit.**

Individuals receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services

All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical Nurse

5.3.M. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an individual age 21 or older on an individual and continuous basis, **up to a maximum of 16 hours per day**, to meet the individual's health needs directly related to the individual's physical disability.

Medical Criteria

To be eligible for PDN services, the ICO must find the individual meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria below). Regardless of whether the individual meets Medical Criteria I or II, the individual must also meet Medical Criteria III.

- Medical Criteria I – The individual is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
  - Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
  - Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
  - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
  - Total parenteral nutrition (TPN) delivered via a central line, associated with complex medical problems or medical fragility; or

- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for individuals 21 years of age or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

- Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions:

  - "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
  - "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
  - "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
  - "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
  - "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more activities of daily living.
  - "Substantiated" means documented in the clinical or medical record, including the nursing notes.

- Medical Criteria III – The individual requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. Definitions:
  - "Continuous" means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
  - "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
    - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
    - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the individual four or more hours per day;
    - Deep oral (past the tonsils) or tracheostomy suctioning;
    - Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
    - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, or is associated with complex medical problems or medical fragility;
    - Total parenteral nutrition delivered via a central line and care of the central line;
    - Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;
    - Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

All nurses providing PDN to waiver individuals must maintain a current State of Michigan nursing license, and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242. PDN may include medication administration according to MCL 333.7103(1).

This service must be ordered by a physician, physician's assistant, or nurse practitioner. The ICO is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for ensuring the PDN provider has a copy of these orders and delivers PDN services according to the orders. The ICO shall maintain a copy of the physician orders in the Care Bridge Record. The individual's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to ensure services are delivered according to that order.

Through a person-centered planning process, the ICO shall determine the amount, scope and duration of services provided. The direct service provider shall maintain close contact with the authorizing ICO to promptly report changes in each individual's condition and/or treatment needs upon observation of such changes. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the individual.

Individuals receiving Preventive Nursing Services are not eligible to receive PDN services.

All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.

5.3.N. RESPITE

5.3.N.1 RESPITE PROVIDED AT THE INDIVIDUAL'S HOME OR IN THE HOME OF ANOTHER PERSON

Respite services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Respite services include:

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

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who

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

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in payment for respite services.

5.3.N.2. RESPITE PROVIDED OUTSIDE OF THE HOME

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.

Respite services include:

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

Out of home respite may be scheduled for several days in a row, depending upon the needs of the individual and the individual's caregivers.

SECTION 6 – CONTINUITY OF CARE

Individuals enrolled in the MI Health Link program must maintain their current Medicare and Medicaid providers, supports and services for the following timeframes after enrollment: Individuals have the right to continue to see providers who are not in the ICO's network during the Continuity of Care period. Communication between the individual, providers, and the ICO is essential to ensure providers are identified so services can be provided and covered by the ICO. The ICO must work to bring individuals' current providers into the plan's network.

ICO Transition Requirement for Individuals receiving services through the HAB waiver and Managed Specialty Services and Supports Program through the PIHPs	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for one hundred and eighty (180) calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred and eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for one hundred eighty (180) calendar days. The Individual Integrated Care and Supports Plan (IICSP) must be reviewed and updated and providers secured within one hundred eighty (180) calendar days of Enrollment.

ICO Transition Requirements for All Other Individuals	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for ninety (90) calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of Enrollment for ninety (90) calendar days
Medicaid Nursing Facility Services	Individual may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the Individual chooses to relocate.
Waiver Services	MI Choice HCBS waiver individuals: Maintain current providers and level of services at the time of Enrollment for ninety (90) calendar days unless changed during the Person-Centered Planning Process. Not applicable to other Individuals
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for ninety (90) calendar days. The Individual Integrated Care and Supports Plan (IICSP) must be reviewed and updated and providers secured within ninety (90) calendar days of Enrollment. Not applicable for individuals transitioning from the MI Choice program.

The ICO is required to review Medicare and Medicaid utilization data provided by the Centers for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) to determine which providers have existing relationships with individuals. Continuity of care protection is automatic for providers which are verified through utilization data to meet the prior relationship requirement.

The individual must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

Specialists: The individual must have seen the specialist at least once within the twelve months prior to enrollment into a ICO for a nonemergency visit.

Primary Care Provider: The individual must have seen the primary care provider at least twice within the twelve months prior to enrollment into a ICO for a non-emergency visit.

Other Covered Providers: The individual must have received services from other providers within the past twelve months prior to enrollment into a ICO.

If the ICO cannot determine if a relationship exists based on the available data, the ICO shall ask the provider and individual to provide documentation of the visit from the medical record or proof of payment to establish the relationship. An attestation that a relationship exists is not sufficient.

The ICO must ask the individual about any upcoming appointments to ensure agreements are in place with out-of- network providers. If data is not available to establish relationship with the individual's provider, the individual or his or her appointed/legal representative may request continuity of care. The individual's out-of-network provider may also request continuity of care on behalf of the individual. Requests for continuity of care should be made by contacting the ICO's member services department or the individual's ICO Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the ICO.

Generally, ICOs must start processing a request for continuity of care within five working days after the request is received. The ICO has a maximum of 30 days to complete the request. However, if the individual's medical condition requires more immediate attention (e.g., an upcoming appointment); the ICO must complete the request within 15 days. If there is a risk of harm to the individual or rescheduling of the appointment would be required, the request must be completed within three days of the request. The ICO may verbally convey Continuity of Care approval with the requester and record such approval in the individual's record.

If the criteria for the prior relationship as outlined above are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within 30 days of the first date of service.

The ICO must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would cause the ICO to exclude the provider based on state or federal requirements.

Pharmacy

ICOs are required to maintain current prescriptions for medications for 180 days if medications are not on the ICO's formulary unless otherwise directed by CMS and MDHHS. The individual can ask the ICO to make an exception to cover a drug that is not on the ICO's formulary.

Nursing Facilities

Out-of-network nursing facilities must be offered Single Case Agreements by the ICO to continue to care for the individual through the life of the program if the nursing facility does not participate in the ICO's network and the individual: 1) resides in the nursing facility at the time of enrollment; 2) has a family member or spouse that resides in the nursing facility; or 3) requires nursing facility care and resides in a retirement community that includes a nursing facility. This continuity of care protection is available as long as the individual resides in the nursing facility. Continuity of care in a nursing facility is automatic. The individual does not have to make a request for continuity of care. The ICO must refill prescriptions for individuals in a nursing facility for a minimum of 91 days and the ICO must refill the drug multiple times during the first 90 days of enrollment, as needed. This allows the prescriber time to change the drugs to those on the drug list or ask for an exception.

Personal Care Providers:

The ICO must allow choice of personal care service providers including non-financially responsible family members or friends to provide the service if they meet the criteria to enroll in the ICO's network.

The ICO may enter into an agreement for non-agency personal care providers when a permissible exclusion is identified through a background check. The ICO may allow for this exclusion if the individual is informed of the details of the permissible exclusion and agrees, in writing, to allow the person to provide personal care to the individual during the continuity of care period. During this time period, the individual can seek alternatives to receiving personal care services if the ICO does not continue the agreement beyond the required continuity of care period.

Under no circumstance must the ICO enter into an agreement if it is discovered the personal care services provider falls under the policy for mandatory exclusion from providing personal care services.

Other Providers

Continuity of care does not extend to durable medical equipment (DME) providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to these types of providers, the ICO must still provide continuity of care for services and the ICO is responsible for finding an in-network provider to deliver services without disruption.

SECTION 7 – CARE COORDINATION, ASSESSMENT AND PERSON-CENTERED PLANNING

The MI Health Link program requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, behavioral health (BH), substance use disorder (SUD) and/or intellectual/developmental disabilities (I/DD), pharmacy, and long term supports and services (LTSS). This requires coordination between the Integrated Care Organization (ICO) and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable. The ICO shall contract with the PIHP to deliver Medicare BH, SUD and/or I/DD services to individuals. This contract and any other downstream contracts related to care coordination activities will be monitored by the CMS and MDHHS contract management team to ensure all delivery system requirements of MI Health Link are met and all individuals receive the appropriate care coordination services. To accomplish this, the ICO must:

- Develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative claims data, and other available information to help prioritize and determine the care coordination needs of each individual.
- Focus on providing services in the most integrated and least restrictive setting.
- Maintain flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.
- Exhaust the use of community-based services before utilizing institutional settings for LTSS.
- Wherever possible, include a person familiar with the needs, circumstances and preferences of the individual when the individual is unable to participate fully in or report accurately to the Integrated Care Team (ICT).
- Ensure that the individual has a primary care provider (PCP) appropriate to meet his or her needs and assist the individual in accessing services.

7.1 THE CARE BRIDGE

The care coordination model for MI Health Link is the Care Bridge, which includes both technology and people through the person-centered planning process. The ICO is required to utilize a care coordination platform supported by web-based technology that is discussed in this section and referred to as the Care Bridge.

The Care Bridge allows secure access to information and enables all individuals and members of the ICT to use and (where appropriate) update information. Through the electronic Care Bridge, the members of the individual's ICT facilitate access to formal and informal supports and services identified in the individual's Individual Integrated Care and Supports Plan (IICSP) developed through a Person-Centered Planning process.

The Care Bridge includes an electronic care coordination platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the ICT. The electronic Care Coordination platform will include a mechanism to alert ICT members of emergency department use or inpatient admissions. The ICBR will allow ICO Care Coordinators, PIHP and LTSS coordinators, where applicable, and providers to post key updates and notify ICT members of changes.

This platform will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other relevant laws, and provide for the exchange of data in a standard format.

The approved electronic care coordination platform will generate and maintain an individualized individual record referred to as ICBR including:

- Current integrated condition list;
- Contact information for the ICO Care Coordinator and ICT members;
- Current medications list;
- The date of service and the name of the provider for the most recently provided services;
- Historical and current utilization and claims information;
- Historic Medicaid and Medicare utilization data: MDHHS will provide the ICO with access to the CareConnect360 (CC360) system to view and extract historic utilization data.
- MDHHS will initially provide the ICO with extract files containing historical data for all individuals for the previous 24 months. Updates thereafter are available on a monthly basis or by the frequency identified by the ICO.
- Initial screening, Assessments (Level I and Level II), nursing facility LOCD and Personal Care Assessment results
- Service outcomes, including specialty provider reports, lab results, and emergency room visits;
- IICSP; and
- Notes and correspondence across provider settings.

7.2 Health Promotion and Wellness Activities

The ICO must provide a range of health promotion and wellness informational activities for individuals, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavior in the Medicare-Medicaid population. Interpreter services must be available for individuals who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to the following:

- Chronic condition self-management;
- Smoking cessation;
- Nutrition; and,
- Prevention and treatment of alcohol and substance abuse.

7.3 Integrated Care Team (ICT)

Every individual shall have access to and input in the development of an ICT to ensure the integration of all the individual's supports and services including medical, behavioral, psychosocial, and LTSS. The ICT will be person-centered, respecting and incorporating the individual's specific preferences and needs. The ICT will deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The ICT will honor the individual's choice about his or her level of

participation and interaction with the ICT. This choice will be periodically revisited with the individual by the ICO Care Coordinator.

7.3.A. Integrated Care Team Members

The ICO Care Coordinator will lead the ICT. It will be the responsibility of the ICO Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between ICOs, PIHPs and other providers. While the ICO Care Coordinator will be the ICT lead, the individual may request the LTSS or PIHP Supports Coordinator remain his or her main point of contact regarding the ICT.

ICT membership will include the individual and the individual's chosen allies, ICO Care Coordinator, primary care physician, and LTSS Supports Coordinator or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary depending on the changing needs of the individual. The ICT may also include the following persons as needed and available:

- Family caregivers and natural supports
- Primary care nurse care manager
- Specialty providers
- Personal care providers
- Hospital discharge planner
- Nursing facility representative
- Others as appropriate

7.3.B. Integrated Care Team Responsibilities

The role of ICT is to work collaboratively with the individual to meet goals identified in the IICSP and ensure the best possible health care outcomes. The ICO Care Coordinator is responsible to ensure the completion of tasks listed below for the ICT. ICT members will

- Ensure the IICSP is developed, implemented, and revised according to the person-centered planning process and the individual's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.
- Participate in the Person-Centered Planning process at the individual's discretion to develop the IICSP;
- Collaborate with other ICT members to ensure the Person-Centered Planning process is maintained;
- Assist the individual in meeting his/her goals;

- Monitor and ensure that their part of the IICSP is implemented in order to meet the individual's goals;
- Update the ICBR as needed pertinent to the ICT member's role on the ICT;
- Review assessment, test results and other pertinent information in the ICBR;
- Address transitions of care when a change between care settings occur;
- Ensure continuity of care requirements are met; and
- Monitor for issues related to quality of care and quality of life.

The operations of ICTs will vary depending on the needs and preferences of the individual. An individual with extensive service needs may warrant periodic meetings with all ICT members. An individual with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with ICT members.

The ICT will adhere to an individual's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and other laws, and for individuals in SUD treatment, 42 C.F.R. Part 2.

7.4 ICO CARE COORDINATOR

ICO Care Coordinators must have the experience, qualifications and training including MDHHS required training appropriate to the needs of the individual, and the ICO must establish policies for appropriate assignment of ICO Care Coordinators.

ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

The ICO Care Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or
- Licensed Master's prepared social worker.

ICO Care Coordinator Training

The ICO Care Coordinator will participate in train-the-trainer Person-Centered Planning and Self-Determination educational opportunities offered by MDHHS. The ICO will be responsible for training any new ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDHHS and ICO trainings as required.

The ICO will participate, train and report on any other training required or offered by MDHHS or its designee.

ICO Care Coordinator Responsibilities

The ICO Care Coordinator will be responsible for care coordination for each individual. The ICO Care Coordinator will conduct the Level I Assessment, ensure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT.

The ICO Care Coordinator will be responsible to:

- Support an on-going person-centered planning process;
- Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and completion of or referral for a Level II Assessment (as appropriate);
- Facilitate timely access to primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the individual, including referrals to address any physical or cognitive barriers or referrals to the PIHP;
- Create and maintain an ICBR for each individual to manage communication and information regarding referrals, transitions, and care delivery;
- Facilitate communication among the individual's providers through the use of the care coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;
- Notify the ICT of the individual's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;
- Facilitate face-to-face meetings, conference calls, and other activities of the ICT as needed or requested by the individual;
- Facilitate direct communication between the provider and the individual or the individual's authorized representative and/or family or informal supports as appropriate;
- Facilitate individual and family education;
- Coordinate and communicate, as applicable, with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;
- Develop, with the individual and ICT, following the person-centered planning process, an IICSP specific to individual needs and preferences, and monitor and update the IICSP at least annually or following a significant change in needs or other factors;
- Coordinate and make referrals to community resources (e.g., housing, home delivered meals, energy assistance programs) to meet IICSP goals;

- Perform ongoing care coordination;
- Monitor the implementation of the IICSP with the individual, including facilitating the individual's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;
- Advocate with or on behalf of the individual as needed, to ensure successful implementation of the IICSP;
- Support transitions in care when the individual moves between care settings including:
  - The ICO Care Coordinator will contact the individual once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community;
  - The ICO Care Coordinator will ensure immediate and continuous discharge planning including electronic and verbal communication with the individual and ICT members following an individual's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the individual when discharged. This includes scheduling an outpatient appointment, ensuring the individual has all necessary medications or prescriptions upon discharge, and conducting follow-up with the individual and/or caregiver.
  - The Care Coordinator shall make every effort to ensure that home and community based services are in place upon hospital discharge to avoid unnecessary nursing facility placements. The ICO Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to ensure prompt initiation of appropriate HCBS. If the individual is being discharged from a Nursing Facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.
  - Evaluating Section Q of the Minimum Data Set (MDS) for individuals currently in a nursing facility and discussing options for returning to the community, revising the IICSP and transitioning the individual to the most integrated setting.
  - The ICO Care Coordinator will inform the individual of his or her right to live in the most integrated setting, inform the individual of the availability of services necessary to support his or her choices, and record the home and community-based options and settings considered by the individual.
  - Engage in other activities or services needed to assist the individual in optimizing his or her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status;
  - Ensure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits; and
  - If the individual is receiving services that require meeting the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) standards, ensure through required Level I and/or Level II assessments that the individual continues to meet the criteria or transitions to services that do not require LOCD standards. The ICO Care Coordinator is required to conduct the LOCD assessment for individuals with

identified long term care needs, and MDHHS will make final eligibility determinations, unless otherwise directed by the State and CMS.

Individual ICO Care Coordinator Assignments and Change Requests

- The ICO shall allow the individual or his or her authorized representative choice in ICO Care Coordinator.
- The ICO shall ensure every individual has an ICO Care Coordinator with the appropriate experience and qualifications based on the individual's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).
- The ICO must have a process to ensure that an individual or his or her authorized representative is able to request a change in his or her ICO Care Coordinator at any time including a process for the transition from one ICO Care Coordinator to another.
- The ICO must establish policies for appropriate assignment of ICO Care Coordinators to align with the individual's known or expressed cultural, religious and ethnic preferences by considering the knowledge and experience of the ICO Care Coordinator.

7.5 Coordination with PIHP and LTSS Supports Coordinators

The ICO Care Coordinator must collaborate with the applicable PIHP Supports Coordinator or identified behavioral health representative as defined in the contract between the ICO and the PIHP when:

- The individual has received services through a PIHP within the last 12 months, or
- A new individual requests or is identified as having potential need for BH, I/DD, or SUD services.

If the individual has need of LTSS, the ICO Care Coordinator will collaborate with the individual's chosen LTSS Supports Coordinator when:

- The individual has received LTSS within the last 12 months, or
- A new individual requests or is identified as having potential need for LTSS.

7.5.A. LTSS Supports Coordinator

LTSS Supports Coordinator will be offered to all individuals who have needs for long term supports and services. The LTSS Supports Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or
- Licensed Master's prepared social worker.

The LTSS Supports Coordinator must:

- Have knowledge of HCBS;
- Have completed a person-centered planning and person-centered direction training;
- Be culturally competent;
- Be able to provide information regarding the quality ratings and licensure status, if applicable, of available options;
- Be knowledgeable about risk factors and indicators of, and resources to respond to, abuse and neglect;
- Be familiar with applicable long term care facility licensing requirements and resources such as the long term care ombudsman program; and
- Have experience conducting LTSS needs assessments.

LTSS Supports Coordinator Responsibilities

The ICO will be responsible to provide, directly or contractually, the following LTSS Supports Coordination services:

- Support an on-going person-centered planning process;
- Assist the individual to take a lead role in the person-centered planning process;
- Provide information to the individual and ICT;
- Communicate and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment;
- Participate in the assessment process as needed, including conducting the Level II Assessment specific to the individual's needs;
- Participate on the individual's ICT;
- Develop, with the individual and the ICT, an IICSP;
- Ensure optimal utilization of information and community supports;
- Arrange services as identified in the IICSP;
- Update the ICBR with current individual status information to manage communication and information flow regarding referrals, transitions, and care delivery;
- Monitor service implementation, service outcomes, and the individual's satisfaction;
- Collaborate with the ICO Care Coordinator to assist the individual during transitions between care settings, including full consideration of all community options; and
- Advocate for the individual and support self-advocacy by the individual.

The ICO Care Coordinator may serve as the LTSS Supports Coordinator and complete the required functions of both roles.

7.6 Assessment Tools and Process

7.6.A. Individual Stratification

The ICO will develop and implement a strategy that uses a combination of initial screenings, assessments, assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of Care Coordination needed by each individual.

The ICO must review program level data through CHAMPS and CareConnect360 or through file exacts provided by MDHHS as part of the initial screening process. CareConnect360 contains past Medicare and Medicaid utilization data from the MDHHS Data Warehouse. The ICO must review program level data and utilization data within fifteen (15) calendar days of enrollment.

Levels of stratification should be based on:

- Individual demographics, medical conditions, functional status, care patterns, resource utilization data; and
- The individual's risk for long term care institutionalization or avoidable hospitalization.
- Individuals receiving services in the Habilitation and Supports Waiver or an individual transitioning to MI Health Link from the MI Choice waiver are automatically stratified as high risk.
- The ICO will determine the parameters and definitions for other individuals defined as high risk as well as definitions for low or moderate risk individuals.

The ICO may also choose to use existing predictive modeling software to support the screening and assessment requirements are not be required to do so.

7.6.B. Initial Screening

The purpose of the initial screening is to identify individuals with immediate needs in order to prioritize in-person Level I Assessments. The initial screening is a series of individual reported yes/no questions related to historical and current service usage. This screening is conducted via telephone when individuals call the enrollment broker to enroll in MI Health Link.

For those individuals passively enrolled into the ICO or those not completing the screen during the enrollment call, the ICO must make its best efforts to administer the initial screening within 15 calendar days of enrollment.

The ICO must document attempts in the ICBR to contact the individual for the purpose of scheduling or conducting the initial screening on different days of the week and at different times during the day, including times outside of standard work hours. If the initial contact is not made within 15 calendar days of enrollment, the ICO must continue efforts to contact the individual and document such in the ICBR.

The ICO will review the individual's responses to the initial screening questions to identify current utilization of PIHP services, nursing facility care, community-based supports and services, and hospital care (inpatient or emergency room treatment).

The ICO must document the individual's responses to the initial screening questions in the ICBR.

7.6.C. LEVEL I ASSESSMENTS

Each individual must receive, and be an active participant in (to the extent they desire), a timely Level I Assessment of medical, behavioral health, psychosocial, and LTSS needs completed by the ICO Care Coordinator, unless one of the following circumstances applies:

- An individual declines an assessment. Should that occur, the ICO will honor the individual's decision and will only contact the individual regarding an assessment if the individual requests one or a new assessment is needed according to the reassessment requirements.
- An individual is not reachable through the contact information provided by the State or CMS. The ICO must document its attempts to reach the individual and what means of communication were used.
  - The ICO shall attempt to contact the individual at least five times within the first 45 days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.
  - ICO shall use community resources where possible to identify and engage individuals.

- The ICO Care Coordinator will identify, through the Level I Assessment, individuals who may require institutional level of care or personal care services.
- The ICO will perform the Level I Assessment using its tool approved by MDHHS to assess each individual's current health, welfare, functional needs and risks.
- The ICO will use the DSM V screening tool as part of or in addition to its Level I Assessment tool to identify Individuals with BH, SUD, and/or I/DD needs.

The ICO Care Coordinator may complete the Level I Assessment in lieu of the initial screening if the Level I Assessment is completed within 15 calendar days of enrollment.

Level I Domains

Level I Assessment domains must include, but not be limited to, the following:

- Individual preferences, strengths, and goals including Self-Determination arrangements;
- Natural supports, including family and community caregiver capacity, and social strengths and needs;
- Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and individual health literacy;

- Current services, including those covered by Medicare and Medicaid, community supports, and care transition needs;
- Medical health risk, status, and history, including but not limited to medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections;
- BH and SUD risk status; BH, SUD, and I/DD history and needs, including medications;
- Nutritional strengths and needs;
- Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs;
- Cognitive strengths and needs;
- LTSS;
- Quality of life including physical, mental, and psycho-social well-being;
- Discussion and education related to abuse, neglect, and exploitation; and
- Advance Directives

The ICO may include State-approved domains as appropriate. Additional domains should be included in the ICO's Level I Assessment tool when submitting the tool for approval by MDHHS.

Involvement in the Level I Assessment

The Level I Assessment will be completed by the ICO Care Coordinator (see qualifications above) employed or contracted with the ICO who is accountable for providing Care Coordination services. The ICO may delegate through contract with entities or individuals meeting the Care Coordinator qualifications for performance of Initial Screenings, Level I Assessments and LTSS Level II Assessments, as well as Care Coordination functions. The ICO retains responsibility and accountability for utilization management functions, appeals, and approval of services. The Care Coordinator role cannot be delegated through contract or other means to Long Term Supports and Services providers who are otherwise responsible for providing services to individuals, such as nursing facilities.

- The ICO will include the appropriate PIHP or LTSS Supports Coordinator or nursing facility staff in conducting the Level I Assessment if the individual has been active in the PIHP or LTSS system during the previous twelve (12) months or is currently residing in a nursing facility.
- Family members or other individuals may also be included in the Level I Assessment process to the extent desired by the individual.

Level I Results and Referral

The ICO will use the results of the Level I Assessment to confirm the appropriate acuity or risk stratification level for individual Care Coordinator assignments. The Level I Assessment and the DSM-V screening tool for BH, SUD, I/DD, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.

The ICO will make referrals according to the process identified in ICO/PIHP contract to the PIHP/BH system for individuals identified as having BH, SUD, and/or I/DD needs.

The PIHP will conduct in person or adopt current Level II Assessments for individuals identified as receiving services from the Habilitation Supports Waiver and/or the Specialty Services and Supports Program. The PIHP will conduct a telephonic screen using the MDHHS approved tool to determine:

- If the individual has mild to moderate needs that can be met through referral for additional services; or
- If the individual has needs that require the Level II Assessment.

The PIHP will coordinate service referrals to ICO or PIHP network providers or conduct further assessment as needed. The PIHP will document the results from the telephonic screen and referral in the ICBR.

The ICO Care Coordinator is responsible for ensuring completion of further assessment for individuals with medically complex conditions. The ICO will coordinate with the primary care provider to ensure that further follow-up relevant to these needs is provided to the individual.

The individual will continue to receive any services in any existing care plan prior to the Level I Assessment. The ICO will adhere to all transition requirements for services, as outlined in the Continuity of Care Section of this chapter and any other documentation provided by CMS or MDHHS.

Level I Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

Timing of Level I Assessments

Level I Assessments will be completed within 45 calendar days of enrollment. ICOs approved by CMS and MDHHS to conduct early Level I Assessment may start the assessment no earlier than 20 days before the enrollment effective date. Early assessment does not impact the time frames for completing other assessments. Other Assessments cannot be completed before the enrollment effective date. Individuals identified with immediate needs or as having high risk should have Level I Assessments completed earlier than 45 calendar days from enrollment, as appropriate.

In-person Level I Assessments

The ICO Care Coordinator is encouraged to conduct the Level I Assessment in person. Individuals identified with immediate needs or as having high risk will have assessments completed in person.

Locating Individuals

The ICO shall identify individuals through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and ICO personnel. The ICO shall notify the primary

care provider (PCP) of an individual who has not completed a Level I Assessment within the time period set forth above and whom the ICO has been unable to contact. The ICO shall encourage the PCPs to conduct outreach to these individuals and to schedule visits. The ICO shall collaborate with clinics, hospitals, or urgent care centers to identify individual contact information for individuals the ICO has not been able to contact.

7.6.D. Triggers from the Level I Assessment

Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

The Michigan Medicaid Nursing Facility Level of Care Determination tool must be conducted for all individuals according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in the Medicaid policy and additional guidance provided by MDHHS. For the MI Health Link program only, the Nursing Facility Level of Care Exception Review criteria will be applied at the time the LOCD is conducted for the individual if the individual does not meet LOCD criteria under Doors one through seven.

PIHP Telephonic Screen

The ICO shall refer individuals identified in the Level I screen as having BH, SUD or I/DD needs to the PIHP for additional assessment. Of this population, those individuals without a known history of PIHP services will receive a telephonic screen to determine service needs. The PIHP will determine if the individual has mild to moderate needs which can be addressed through additional assessment or referral to providers (PIHP or ICO). For all other individuals, the PIHP will complete the appropriate Level II assessment. The PIHP has flexibility to perform the telephonic screening function within the current intake system as long as identification of needs is completed using the prescribed tool.

7.6.E. Level II Assessment

The ICO Care Coordinator will collaborate with the PIHP to ensure that the Level II Assessment is conducted for individuals identified through the telephonic screen as needing referral to the PIHP for Level II Assessment. The ICO Care Coordinator will ensure that the Level II Assessment is conducted for individuals demonstrating LTSS needs identified in the Level I Assessment.

Level II assessments must be completed using the tools approved by MDHHS.

Qualifications for Completing Level II Assessment

Level II Assessments will be conducted by professionally knowledgeable and trained LTSS Supports Coordinators or PIHP Supports Coordinators or behavioral health case managers, who have experience working with the population. Each Level II Assessment tool has specific qualifications for the person completing the tool.

Timing of Level II Assessments

Any Level II Assessment completed prior to enrollment by the PIHP Supports Coordinator, a trained LTSS Supports Coordinator or a behavioral health case manager

may be adopted if it is not past the reassessment date. The Level II Assessment should be reviewed to determine if it is complete, accurate and appropriate for the individual's current status. Level II Assessments will be conducted in person within 15 calendar days of completion of the Level I Assessment. Level II Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.6.F. REASSESSMENTS

7.6.F.1. LEVEL I REASSESSMENTS

The ICO is responsible to ensure that an annual Level I reassessment for each individual (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within 12 months of the last Level I Assessment. If prior to the annual reassessment, the individual experiences a major change impacting health status, the ICO is required to reassess the individual and review and revise the IICSP with members of the ICT as needed. The ICO must ensure that a reassessment and an IICSP update are performed:

- As warranted by the individual's condition but at least every 12 months after the Level I Assessment completion date;
- When there is a change in the individual's health status or needs;
- As requested by the individual, his or her caregiver or authorized representative, or his or her provider; and
- Upon any of the following trigger events:
  - A hospital admission;
  - Transition between care settings;
  - Change in functional status;
  - Loss or change in circumstances of a caregiver so that the individual supports or services are affected;
  - Change in diagnosis; and
  - As requested by a member of the ICT who observes a change that requires further investigation.

The ICO will analyze utilization data of all individuals monthly to identify acuity and risk level changes. As acuity and risk levels change, reassessments will be completed as necessary and IICSP and interventions updated and documented in the ICBR.

The ICO is responsible to complete a reassessment as often as desired by the individual and update the IICSP with members of the ICT as needed. The ICO is encouraged to conduct reassessments in person.

7.6.F.2. LEVEL II REASSESSMENTS

Level II reassessments will be completed according to the reassessment timeframe of each assessment tool utilized. For assessments adopted at the time of enrollment, the next assessment date with follow the annual scheduled described above for each tool

unless the individual has a significant change of conditioning requiring a new assessment.

For individuals receiving nursing facility level of care services, the reassessment must confirm that the individual continues to meet the Michigan Medicaid Nursing Facility LOCD standards. If the standards are not met, a new LOCD tool must be completed to allow the individual rights to an appeal. The ICO will initiate planning for transitioning the individual to more appropriate supports and services. Reassessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.7 CARE PLANNING

Individual Integrated Care and Supports Plan (IICSP)

The ICO Care Coordinator, individual, providers, and other ICT members develop a comprehensive, person-centered, written IICSP for each individual. The person-centered planning process must be conducted in-person unless the individual chooses otherwise. The individual may choose to participate in person-centered planning to the extent he or she desires.

Every individual must have an IICSP. The IICSP should be developed based on the outcome of the person-centered planning meeting unless the individual chooses not to participate and the refusal to participate is documented in the IICSP and ICBR. At a minimum the ICO Care Coordinator or Supports Coordinator must provide his or her contact information to the individual and re-visit the opportunity to participate in person-centered planning and development of the IICSP at the time of reassessment, a change of condition, or upon the individual's request.

The ICO must complete the initial IICSP within 90 calendar days of enrollment. Existing person-centered service plans or plans of care may be incorporated into the IICSP. The ICO must review the adopted plan with the individual to determine if revisions are necessary to address the individual's goals and meet the individual's needs. The IICSP must be contained in the ICBR and shared with the individual and the ICT.

The ICO must discuss advance directives with the individual including the choice to execute a directive, its incorporation in the IICSP, and assurance of provider knowledge of the individual's directive.

The IICSP must:

- Focus on supporting the individual to achieve personally defined goals in the most integrated setting;
- Be developed following MDHHS principles for person-centered planning;
- Include the individual's preferences for care, services, and supports;
- Include the individual's prioritized list of concerns, goals and objectives, and strengths;
- Include specific providers, supports and services including amount, scope, and duration;
- Include a summary of the individual's health status;
- Include the plan for addressing concerns or goals and measures for achieving the goals;

- Include person(s) responsible for specific interventions, monitoring, and reassessment; and
- Include the due date for the interventions and reassessment.

IICSP Monitoring

The ICO will review the individual's IICSP to ensure the IICSP continues to meet the individual's needs and is updated accordingly.

- The ICO must review IICSPs of high-risk individuals least every 30 calendar days.
- The ICO must review IICSPs of moderate-risk individuals at least every 90 calendar days.
- The ICO must review IICSPs of low-risk individuals at least every one hundred and 180 calendar days.

The ICO will make contact with the individual to inquire if the IICSP continues to meet the individual's needs. This contact may be telephonic, unless in-person contact is requested by the individual. The ICO must update the individual's IICSP at least annually and more frequently if conditions warrant, or if an individual requests a change.

SECTION 8 – CRITICAL INCIDENT REPORTING

The ICO must report critical incidents to MDHHS and other authorities as required by CMS and the State.

8.1 TYPES OF CRITICAL INCIDENTS THAT NEED TO BE REPORTED

ICOs must report the following:

- Exploitation
- Illegal activity in the home
- Medication Errors
- Neglect
- Physical Abuse
- Provider no shows
- Restraints, Seclusion, or restrictive interventions
- Sexual Abuse
- Suspicious or Unexpected Death
- Theft
- Verbal Abuse
- Worker consuming drugs or alcohol on the job

SECTION 9 – MI HEALTH LINK HCBS WAIVER

The MI Health Link HCBS waiver offers home and community-based services to allow MI Health Link individuals to remain in the community instead of an institution. MI Health Link individuals who require services through this waiver must apply to MDHHS and be approved for enrollment. ICOs or their subcontractors, according to a contractual agreement, must submit an application to MDHHS for review and approval. Waiver eligibility must be re-determined on an annual basis.

Waiver enrollment is limited to a certain number of individuals that has been approved by CMS.

9.1 APPLICATION PROCESS

When a MI Health Link individual is interested in participating in the MI Health Link HCBS waiver, the ICO must submit an application packet to MDHHS for review and approval prior to an individual participating in the waiver. Applications may be submitted to MDHHS electronically via the Waiver Support Application system or via hard copy paper format using U.S. Mail, United Postal Service, FedEx, or fax as directed by MDHHS.

The ICO will be notified by MDHHS of the outcome of the application review, approval, or rejection via telephone, email, U.S. Mail, or the electronic Waiver Support Application system.

9.2 PERSON-CENTERED PLANNING

The person-centered planning process and IICSP for MI Health Link HCBS waiver individuals must be compliant with the Home and Community-Based (HCBS) Final Rule (CMS-2249F; CMS- 2296-F) that was released by CMS on January 16, 2014. At a minimum, the IICSP must include the following components:

- The ICO must develop the Individual Integrated Care and Supports Plan (IICSP) before providing services.
- The individual must approve of all services in the service plan.
- The ICO must document individual approval and participation on the IICSP, including.
  - Individual's preferences for care, services, supports, residential settings, and non-residential settings
  - Supports and services options that were discussed with the individual, and his or her (or legal representative's) choice of those services and providers
  - When the individual selects controlled residential settings such as licensed Adult Foster Care or Homes for the Aged, or others, the following must be included in the IICSP
    - The chosen setting
    - The individual's resources
    - Whether or not the individual chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, etc.
    - Preference for engaging in community activities outside the home, and whether or not the individual needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen

- Personal safety risks, and any interventions, that may affect the individual's ability to engage in community activities outside the home without supervision
- Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an individual's assessed needs; indicate established timeframes for periodic review of these modifications

- Individual's health and safety risks
- Individual's prioritized list of concerns, goals and objectives, strengths
- Summary of the individual's health status
- The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services including amount, scope and duration

- The individual's (or legal representative's) rights and choices of specific providers (and alternative providers, if necessary)
- A contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies

- Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes
- Individual's informed consent
- Due date for interventions and reassessment

The IICSP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The amount (units), frequency, and duration of each waiver service to be provided are included in the IICSP. The individual chooses the supports and services that best meet his or her needs and whether to use the option to self-direct applicable services or rely on a ICO Care Coordinator and/or LTSS Supports Coordinator to ensure the services are implemented and provided according to the IICSP. When an individual chooses to participate in arrangements that support self-determination, information, support and training are provided by the ICO Care Coordinator and/or LTSS Supports Coordinator and others identified in the IICSP and according to the Self-Determination Implementation Technical Advisory. When an individual chooses not to participate in self-determination, the ICO Care Coordinator or LTSS Supports Coordinator ensures that supports and services are implemented as planned. The ICO Care Coordinator and/or LTSS Supports Coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the IICSP. This oversight ensures that waiver services in the IICSP are not duplicative of similar State Plan services available to or received by the individual.

9.3 Home and Community-Based Residential and Non-Residential Settings

The HCBS Final Rule (CMS-2249F; CMS- 2296-F) applies to 1915(c) waiver programs. The ICO has been provided with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. The ICO, and its subcontractors as appropriate, must be familiar with all aspects of the HCBS Final Rule as it applies to the MI Health Link HCBS waiver. All residential settings in which MI Health Link HCBS waiver individuals live must comply with the requirements of the HCBS Final Rule. Similarly, non-residential settings, such as Adult Day Program settings, must comply with the HCBS Final Rule. Residential and non-residential settings must be immediately compliant with the HCBS Final Rule for the

MI Health Link program. This compliance will be assessed prior to the individual's enrollment in the waiver. The ICO must utilize the standard statewide Provider Survey tool produced by MDHHS, and this survey must be conducted in-person with the provider and as directed otherwise by MDHHS. Licensed settings used for the Respite service do not need to be assessed unless the individual stays in the setting for more than 30 days.

9.4 SELF-DETERMINATION

Self-Determination provides MI Health Link HCBS waiver individuals the option to direct and control their own waiver services. For those MI Health Link HCBS waiver individuals who choose to participate in arrangements that support self-determination, the individual (or chosen representative(s)) has decision-making authority over providers of waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring
- Hiring staff
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the individual's needs and preferences so long as such qualifications comply with those described in the 1915(c) waiver application approved by CMS, and any additional guidance provided by MDHHS
- Specifying how services are to be provided and determining staff duties consistent with the service guidelines as indicated in the CMS-approved waiver application and additional guidance provided by MDHHS
- Determining staff wages and benefits, subject to State and federal limits if applicable
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff from providing services
- Reallocating funds among services included in the individual's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Budget development for individuals using arrangements that support self-determination occurs during the person-centered planning process and is intended to involve any persons chosen by the individual. Planning for the individual's IICSP precedes the development of the individual's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. An individual's budget is not authorized until the individual and the ICO have agreed to

the amount and its use. In the event that the individual is not satisfied with the authorized budget, he/she may reconvene the person-centered planning process. Fiscal Intermediary services are available through the waiver to help individuals more fully exercise control over their services.

At any time, the individual may modify or terminate the arrangements that support self-determination.

The individual, his or her chosen allies, the ICO Care Coordinator and LTSS Supports Coordinator must all work together to identify challenges and address problems that may be a barrier to a successful self-determination arrangement. The decision of an individual to terminate participation in self-determination does not alter the supports and services identified in the IICSP. When the individual no longer wishes to participate in self-determination, the ICO must assume responsibility for ensuring the provision of those services through its network of contracted provider agencies while still maintaining and honoring the individual's choice of providers to extent possible.

An ICO may terminate self-determination for an individual when problems arise due to the individual's inability to effectively direct supports and services. Prior to terminating a self-determination agreement (unless it is not feasible), the ICO informs the individual in writing of the issues that have led to the decision to terminate the arrangement. The ICO will continue efforts to resolve the issues that led to the termination.

9.5 Waiver Support Application System

The ICO must utilize the waiver management database in the Waiver Support Application (WSA) system for anything related to MI Health Link HCBS Waiver enrollments, application submission, slot management, and disenrollments. The ICO is required to submit a list of users for this system, and the ICO must keep the list updated on a regular basis as staff come onboard or leave. When approved users leave the organization, the organization must notify the appropriate person as directed by MDHHS.

SECTION 10 – CRIMINAL HISTORY REVIEWS

Each ICO and direct provider of home-based services must conduct a criminal history review through the Michigan State Police (ICHAT), at a minimum, for any paid or volunteer individuals who will be entering the individual's residence. The ICO and direct provider must have completed reference and criminal history reviews before authorizing the person providing services in an individual's residence. At a minimum, the scope of the reference and criminal history investigation is statewide.

ICOs and MDHHS will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.

SECTION 11 – USE OF RESTRAINTS, SECLUSION, AND RESTRICTIVE INTERVENTIONS

Providers are prohibited from using methods of seclusion, restraint, and/or other restrictive interventions. MDHHS will conduct site reviews to ensure these methods are not used. ICO Care Coordinators and LTSS Supports Coordinators, as applicable, have the primary responsibility for identifying and addressing the use of seclusion, restraints, and/or restrictive interventions.

SECTION 12 – PROVIDER PARTICIPATION

Providers have the opportunity to participate in MI Health Link by joining the provider networks of the ICOs. ICOs are encouraged to contract with existing service providers for individuals eligible for and enrolling in the program to ensure continuity of care. Likewise, service providers are encouraged to participate in ICO networks to provide choice, continuity of care and high quality service. The ICO will be responsible for authorizing and paying for Medicare and Medicaid services. Additional information regarding how providers may participate in MI Health Link can be found on the MI Health Link website at http://michigan.gov/mihealthlink on the linked provider page.

SECTION 13 – MEDICAID POLICY

Current and future Medicaid policies are applicable to the Medicaid portion of the MI Health Link benefit package unless otherwise specified in this chapter or other policies or guidance.

SECTION 14 – QUALITY ASSURANCE

ICOs and PIHPs, as applicable, must comply with requirements set forth in the three-way contract, MI Health Link waiver applications approved by CMS, any other supporting documentation, and the contracts between the ICOs and PIHPs.

SECTION 15 – APPEALS

The three-way contract establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the ICO or contracted entities that would fall under the grievance or appeals processes available to individuals through Medicare and Medicaid guidelines.

SECTION 16 – OMBUDSMAN

ICOs and providers must work with the MI Health Link Ombudsman to resolve enrollment and service issues. ICOs must provide the Ombudsman contact information in their member materials.