

## 1915(i) State plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

**1. Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Applied Behavior Analysis (ABA)

**2. Target Group(s).** *(If applicable, specify the target population(s) that the State plans to include):*

The target group is children, ages 18 months through five years, with a diagnosis of Autistic Spectrum Disorder based upon a medical diagnosis of Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder – Not Otherwise Specified and who have the developmental capacity to clinically participate in the available interventions covered by the benefit.

The diagnosis of autistic spectrum disorder is operationalized using the criteria below.

To be diagnosed with AUTISTIC DISORDER, the child must exhibit:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) Qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) Qualitative impairment in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

- (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
- (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
- (d) persistent preoccupation with parts of objects

To be diagnosed with ASPERGER'S DISORDER, the child must exhibit:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- (1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- (2) failure to develop peer relationships appropriate to developmental level
- (3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- (4) lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- (2) apparently inflexible adherence to specific, nonfunctional routines or rituals
- (3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
- (4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment.

D. There is no clinically significant general delay in language.

E. There is no clinically significant delay in cognitive development (D.Q. or I.Q. > 75) or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment.

To be diagnosed with PERVASIVE DEVELOPMENTAL DISORDER NOS, the child must exhibit:

A. Substantial and prominent impairment in (1) social interaction, (2) language as used in social communication, and (3) symbolic or imaginative play.

B. The impairment is indicated by satisfaction of at least four diagnostic criteria from (1), (2), and (3), including at least one criterion from (1) and one criterion from (2).

(1) Qualitative impairment in social interaction, as manifested by at least two of the following:

- (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- (b) failure to develop peer relationships appropriate to developmental level
- (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- (d) lack of social or emotional reciprocity

(2) Qualitative impairment in communication as manifested by at least one of the

following:

- (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
  - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
  - (c) stereotyped and repetitive use of language or idiosyncratic language
  - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
- (3) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
- (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
  - (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
  - (d) persistent preoccupation with parts of objects

To be eligible for this benefit, a diagnosis of Autism Spectrum Disorders (ASD) must not be attributable to a disorder of sensory impairment (e.g., deafness), to a primary language disorder, to schizophrenia, or to social phobia. The ASD is not associated with a progressive neurodegenerative condition that would preclude anticipated benefits of treatment, as determined by a physician. The ASD is not associated with motor or sensory deficits so severe as to preclude benefit from treatment.

The State will operate this program for a period of five years. At the end of the five-year period, and at least 90 days prior to the end of the current five-year period, the State may request a renewal of this benefit for an additional five-year term in accordance with 1915(i)(7)(C).

**3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select one):**

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program ( <i>select one</i> ):	
	<input type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ):
	<input checked="" type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>
<input type="radio"/>	The State plan HCBS benefit is operated by ( <i>name of agency</i> )	

Behavioral Health & Developmental Disabilities Administration (BHDDA) within the Michigan Department of Community Health (MDCH)

	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

**4. Distribution of State plan HCBS Operational and Administrative Functions.**

■ (By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	■	□	■	□
2 State plan HCBS enrollment managed against approved limits, if any	■	□		□
3 Eligibility evaluation	■	□	■	□
4 Review of participant service plans	■	□	■	□
5 Prior authorization of State plan HCBS	■	□	■	□
6 Utilization management	■	□	■	□
7 Qualified provider enrollment	■	□	■	□
8 Execution of Medicaid provider agreement	■	□	■	□
9 Establishment of a consistent rate methodology for each State plan HCBS	■	□	□	□
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	■	□	□	□
11 Quality assurance and quality improvement activities	■	□	■	□

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

All delegated functions: Prepaid Inpatient Health Plan (PIHP)

(By checking the following boxes the State assures that):

5.  **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
  - financially responsible for the individual
  - empowered to make financial or health-related decisions on behalf of the individual
  - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The §1915(i) State Plan Amendment ABA service will operate within the §1915(b) Managed Specialty Services & Supports Program (MSS&SP), which also includes the concurrent §1915(c) Habilitation Supports Waiver. For more than a decade, the PIHPs have been responsible per the approved §1915(b)/(c) waivers and the MDCH/PIHP contract for 1) determining eligibility for mental health State Plan, additional [(b)(3)] and §1915(c) home and community based services (HCBS); 2) maintaining a provider network of qualified providers; 3) assuring the delivery of all medically necessary mental health State Plan, additional and 1915(c) HCBS to Medicaid beneficiaries; 4) maintaining the mandated organization structure and administrative services for managed care plan, including Customer Service, Grievance & Appeals, Quality Assessment & Performance Improvement Program (QAPIP) and Service & Utilization Management. The PIHPs must comply with all applicable federal and state laws, including the provisions of §1902(a)(4)(D) which mandates safeguards against conflict of interest. The MDCH/PIHP contract also requires “The organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services [Attachment P.3.1.1(VIII)(c)(iii)]. This historical information documents and explains why the PIHPs are the only willing and qualified entities to perform the assessments and plans of care for providing ABA services to children diagnosed with ASD.

ABA is a highly specialized service that requires specific qualified providers that are available within PIHP provider networks and have extensive experience with the diagnosis and treatment of autism. The PIHP will conduct the testing and make the diagnosis of Autism Spectrum Disorder (ASD) when appropriate for each child. The PIHP will submit evidence from diagnostic testing and assessments for each child 18 months through 5 years of age with ASD to the MDCH/BHDDA. Qualified staff at MDCH/BHDDA will review the evidence and complete the Independent Evaluation by determining whether each child meets the needs - based criteria for eligibility for ABA services.-Michigan’s well-established Managed Specialty Services and Supports Program (MSS&SP) utilizes PIHPs as the only willing and qualified providers of specialty mental health and developmental disability services. The MDCH/BHDDA has safeguards in place to assure that the Independent Assessment, development of the Plan of Care and delivery of ABA services by the PIHP provider network are free from conflict of interest through the following:

- 1) The mandated separation required in the MDCH/PIHP contract that assures the assessor(s) will not make determinations about the amount, scope and duration of ABA services;
- 2) All Medicaid beneficiaries are advised about the Medicaid Fair Hearing process in the Customer Services Handbook that is provided by the PIHP to the individual at the onset of services, at least annually at the person-centered planning meeting and upon request of the individual at any time. The Medicaid Fair Hearings process is available to the individual to appeal decisions made related to ABA. This may include beneficiaries who believe they were incorrectly determined ineligible for ABA; beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs; and if ABA services are reduced, suspended or terminated. Adequate Notice of Medicaid Fair Hearing rights is provided at the time the person-centered plan of service is developed and Advanced Notice of Medicaid Fair Hearing rights is provided prior to any reduction, elimination, suspension or termination of services;
- 3) The results of the Independent Assessment, including any test results, may be used as part of the information utilized in developing the individual plan of services (IPOS). However, the professional completing the Independent Assessment is only one of a team of individuals, including the family, involved in person-centered planning process to develop the IPOS. Additionally, oversight/coordination of the IPOS is done by a case manager or supports coordinator or other qualified staff chosen by the family and is not the professional that completes the Independent Assessment;
- 4) The case manager, supports coordinator or other qualified staff or independent facilitator that assists in developing the IPOS is not a provider of any other service for that individual;
- 5) The PIHP or its designated entity performs the utilization management function to authorize the amount, scope and duration of ABA. Utilization management staff are completely separate from the staff performing evaluation, assessment, planning, and delivery of ABA services;
- 6) As part of its QAPIP, each PIHP “has mechanisms to identify and correct under-utilization as well as over-utilization” of services [MDCH/PIHP Contract Attachment P.6.7.1.1 (XIV) (B)]. PIHPs use a number of different mechanisms as part of utilization management to monitor for under- and over-utilization of services. For example, with a new service like ABA for which there will be no historical data, the PIHP may use an independent qualified clinician to review recommended ABA services; UM staff may perform regular reviews to determine if authorizations and service / units utilized are tied to IPOS goals and whether services authorized / used are medically necessary and the level approved is appropriate to meet the goals in the IPOS; or collect utilization data for trending and analysis.

MDCH also monitors through its site review process and the External Quality Review (EQR) to assure that ABA will be determined and delivered appropriate and free from conflict of interest. The site review team completes biennial full reviews at each PIHP to evaluate whether the PIHP has followed MDCH policies and procedures to develop the IPOS using a person-centered planning process; the IPOS identifies the amount, scope and duration of all needed services; and the services have been delivered as specified in the IPOS and by qualified

providers. The EQR includes a standard that evaluates the PIHP's utilization management system to assure there are written criteria and procedures for making utilization decisions, mechanisms for identifying under- and over-utilization, and processes for providing Medicaid Fair Hearing notice if a service is denied, suspended, reduced or terminated. In addition to these existing mechanisms and because this is a new service, MDCH will perform oversight and monitoring through new performance measures. The site review process will look specifically at a conflict of interest performance measures related to the separation of utilization management staff from any provider of another service. Along with the existing required mechanisms that each PIHP must have within its Utilization Management program, MDCH will also monitor for over- or under-utilization of this new service via a performance measure. As part of the Quality Improvement Strategy, MDCH will implement changes as needed with CMS approval if required based on the discovery, analysis and remediation of the performance measures.

6. ■ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ■ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. ■ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.
9. ■ **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
  - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
  - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*



## Number Served

**1. Projected Number of Unduplicated Individuals To Be Served Annually.**

*(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	4/1/2013	3/31/2014	1600
Year 2			
Year 3			
Year 4			
Year 5			

2.  **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

## Financial Eligibility

1. **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

<input type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input checked="" type="radio"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="radio"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input checked="" type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

## Needs-Based Evaluation/Reevaluation

- 1. Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other ( <i>specify State agency or entity with contract with the State Medicaid agency</i> ):
	MDCH/BHDDA will complete the needs-based evaluation and re-evaluation.

- 2. Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

MDCH/BHDDA staff will perform the Independent Evaluation/Re-evaluation. Staff qualifications will be either a Limited License Psychologist or a Child Mental Health Professional who possesses at least a master's degree in a mental health-related field from an accredited school, has at least one year of experience in the examination, evaluation and treatment of children with Autism Spectrum Disorders (ASD), and is able to diagnose within their scope of practice and professional license.

- 3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The processes for completing the Evaluation and Re-evaluation are similar; however, different assessment tools are used. For an Evaluation, the MDCH/BHDDA staff will apply the needs-based criteria described in 4 below to determine whether the child in the targeted group is eligible for the ABA service. There are a number of tests utilized in diagnosing children on the autism spectrum as well as measuring outcomes of the ABA service. The PIHP will provide evidence from diagnosis and assessments to MDCH/BHDDA related to the child's functional abilities in the areas of Social Interaction and Patterns of Behavior. Evidence regarding diagnosis will be based on the Autism Diagnostic Observation Schedule-2 (ADOS-2) an instrument for diagnosing and assessing autism. The protocol consists of a series of structured and semi-structured tasks that involve social interaction between the examiner and the subject. The examiner observes and identifies segments of the subject's behavior and assigns these to predetermined observational categories. Categorized observations are subsequently combined to produce quantitative scores for analysis. Research-determined cut-offs identify the potential diagnosis of autism or related autism spectrum disorders, allowing a standardized assessment of autistic symptoms. The ADOS-2 includes improved algorithms for the Toddler Module and Modules 1 to 3 that facilitate assessment in children ages 12 months of age through adulthood. A developmental family history interview such as the Autism Diagnostic Interview-Revised (ADI-R), or other similar tool, is a structured interview conducted with the parents of the referred individual and covers

the subject’s full developmental history.

Other assessments that may be used to provide evidence to MDCH/BHDDA for making the needs-based eligibility determination include:

An adaptive behavior assessment, the Vineland Adaptive Behavior Scales- Second Edition (VABS-2) Interview must be administered at the time of the cognitive testing. The VABS-2 is an adaptive behavior assessment that is used from birth to 90 years of age and is administered at intake, annually and whenever there is a level of change. Cognitive testing is required during the first quarter of service if not done initially and is accomplished by using one of the following tools.

<u>Cognitive Assessment Tool</u>	<u>Age Range</u>	<u>Purpose of Tool</u>
Mullen Scales of Early Learning	Children from birth to 5 years 8 months of age	Assesses motor, language, spatial processing skills, and global cognitive ability
Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III) or Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV)	Children 2 years 6 months of age through 7 years 6 months of age	Assess processing skills and the child’s global IQ
Differential Ability Scales-II (DAS-II)	Children 2 years 6 months of age through 17 years 11 months of age	Assesses a child’s global cognitive ability

A Re-evaluation is done annually. A formal review of the IPOS will occur no less than annually with the child and family. Neither the ADOS-2, nor the ADI-R (or similar tool) are required for Re-evaluation. The Vineland Adaptive Behavior Scales-Second Edition (VABS-2) is administered annually as part of the IPOS review. In addition, one of the behavioral outcome measurement tools – Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or Assessment of Basic Language and Learning Skills revised (ABLLS-R) is administered every 6 months. MDCH/BHDDA will make the determination of continuing eligibility based on evidence provided by the PIHP that the child meets the needs-based criteria described in 4 below.

**4. ■ Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The child demonstrates substantial functional impairment in Social Interaction (as evidenced by needing ABA to address 2 or more from A.) and significant functional impairment in age-appropriate activities due to the interference by restricted repetitive & stereotyped patterns of behavior, interests and activities (as evidenced by needing ABA to address 1 or more from B.) .

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- (1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- (2) failure to develop peer relationships appropriate to developmental level
- (3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- (4) lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- (2) apparently inflexible adherence to specific, nonfunctional routines or rituals
- (3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
- (4) persistent preoccupation with parts of objects

The child may possess age-appropriate expressive and receptive language skills, learning [defined as cognitive development (D.Q. or I.Q. > 75)], self-care skills, mobility, adaptive behavior (other than in social interaction), and curiosity about the environment.

**5. ■ Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

**Needs-Based/Level of Care (LOC) Criteria**

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The child demonstrates significant functional impairment in Social Interaction (as evidenced by needing ABA to address 2 or more from A.) and significant		Current assessments of the beneficiary reflect evidence of a developmental disability based on either 1 OR 2 AND the beneficiary must also have needs that meet the requirements in 3.	

<p>functional impairment in engaging in age-appropriate activities due to the interference by restricted repetitive &amp; stereotyped patterns of behavior, interests and activities (as evidenced by needing ABA to address 1 or more from B.) for minimum of 2+1 = 3.</p> <p>A. Qualitative impairment in social interaction, as manifested by at least two of the following:</p> <ul style="list-style-type: none"> <li>(1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction</li> <li>(2) failure to develop peer relationships appropriate to developmental level</li> <li>(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)</li> </ul>		<ol style="list-style-type: none"> <li>1. If applied to an beneficiary of any age, the beneficiary has a severe, chronic condition that meets all of the following requirements:             <ol style="list-style-type: none"> <li>a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments</li> <li>b. Is manifested before the beneficiary is 22 years old</li> <li>c. Is likely to continue indefinitely.</li> <li>d. Results in substantial functional limitations in 3 or more of the following areas of major life activity                 <ol style="list-style-type: none"> <li>i. Self-care</li> <li>ii. Receptive and expressive language</li> <li>iii. Learning</li> <li>iv. Mobility</li> <li>v. Self-direction</li> <li>vi. Relative to children age 16 and older[MCL 722.4c(2)(b)]: Capacity for independent living</li> <li>vii. Relative to children age 16 and older[MCL 722.3; 722.4c(2)(b)]: Economic self-sufficiency</li> </ol> </li> <li>e. Reflects the beneficiary’s need for a combination and sequence of special, interdisciplinary, or generic care</li> </ol> </li> </ol> <p>[MCL330.1110a(21)]</p>	
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<p>(4) lack of social or emotional reciprocity</p> <p>B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:</p> <ul style="list-style-type: none"> <li>(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus</li> <li>(2) apparently inflexible adherence to specific, nonfunctional routines or rituals</li> <li>(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)</li> <li>(4) persistent preoccupation with parts of objects</li> </ul> <p>The child does not have to meet ICF/IID requirement #1 as evidenced by demonstrated substantial functional limitations in three or more statutorily defined areas of major life activities nor does the child have to meet</p>		<p>OR</p> <ul style="list-style-type: none"> <li>2. If applied to a beneficiary from birth to age 9, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in 1 above if services are not provided. [42 USC 15002(8)(B)]</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>3. The beneficiary’s intellectual or functional limitations indicate that he would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care [U.S. PL 111-256. “Habilitation services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings” [42 U.S.C. § 1396n(c)(5)(A)]. Per CMS regulation, “Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the</li> </ul>	
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<p>ICF/IID requirement #2 as evidenced by demonstrating delays that indicate a high probability of having a developmental disability later in childhood. The child can be essentially independent in some or all of the statutorily defined areas of major life activities and still meet the needs-based eligibility criteria for the ABA benefit. The child may possess age-appropriate expressive and receptive language skills, learning [defined as cognitive development (D.Q. or I.Q. &gt; 75)], self-care skills, mobility, curiosity about the environment. and adaptive behavior; however, the child can meet needs-based eligibility criteria due to significant functional limitations in social interaction and impairment in engaging in age-appropriate activities due to the interference by restricted repetitive &amp; stereotyped patterns of behavior, interests and activities</p>		<p>acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program” [42 CFR 483.440(a)]. Per CMS regulation, necessary services “Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them [42 CFR 483.440(c)(6)(iii)].” CMS guidelines state, “The receipt of training targeted toward amelioration of these most basic skill deficit areas is a critical component of the active treatment program needed by individuals who are eligible for the ICF/MR (now called ICF/IID) benefit, and therefore, is a required ICF/MR (now called</p>	
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		ICF/IID) service [CMS State Operations Manual, Appendix J, Tag W242 Guidelines]. Therefore, individuals must need and be receiving training in one of the basic skills deficit areas specified in 42 CFR 483.440(c)(6)(iii).”
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\*Long Term Care/Chronic Care Hospital

*(By checking the following boxes the State assures that):*

- 6.  **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
- 7.  **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

## Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1.  There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
  - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
  - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
  - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
  - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
  - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
  - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2.  Based on the independent assessment, the individualized plan of care:
  - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
  - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
  - Prevents the provision of unnecessary or inappropriate care;
  - Identifies the State plan HCBS that the individual is assessed to need;
  - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
  - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
  - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Psychologist: A psychologist who is fully-licensed, limited-licensed or temporary limited-licensed by the State of Michigan (MCL 333.182 *et seq.*) and has one year of experience working with children with Autism Spectrum Disorders (ASD).

- 4. Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

The PIHP is responsible for the development and implementation of the Individual Plan of Services (IPOS). To assist the child and family or authorized representative(s), they may choose to work with a case manager or supports coordinator or other qualified staff. If the child and family or authorized representative(s) prefer an independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of person-centered planning (PCP) independent facilitators [MDCH/PIHP Contract Attachment P.6.3.1.1(11)].

Qualified staff must be able to perform the following functions:

1. Planning and/or facilitating planning using person-centered principles using a family-driven, youth-guided approach for children. This function may be delegated to an independent facilitator chosen by the family or authorized representative(s).
2. Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the request of the family or authorized representative(s) or as changing circumstances may warrant.
3. Linking to, coordinating with, follow-up of, and advocacy with all medically necessary supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.
4. Monitoring of the ABA service and other mental health services the child receives.
5. Brokering of providers of services/supports
6. Assistance with access to entitlements and/or legal representation.

Provider qualifications are as follows:

Supports Coordinator:

1. Chosen by the family or authorized representative(s) of the minor child.
2. Possesses at least a bachelor's degree in human services field and one year of experience with the population the supports coordinator will be serving. If a child with ASD also has a serious emotional disturbance (SED), services must be provided by a child mental health professional.

Case Manager:

1. Chosen by the family or authorized representative(s) of the minor child.
2. Is a QMRP or QMHP or if the case manager has a bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QMRP. If a child with ASD also has a serious emotional disturbance (SED), services must be provided by a child mental health professional.

- 5. Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. (*Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process*):

Each PIHP must have a Customer Services Unit, as required by the MDCH/PIHP contract in boilerplate language (Section 6.3.1) to assist its customers by “orienting new individuals to the services and benefits available including how to access them, [and] helping individuals with all problems and questions regarding benefits.” The Customer Service Handbook is provided to all new beneficiaries initially and at least annually thereafter. The Handbook contains information explaining the PCP process (Template #8 of the MDCH/PIHP Contract Attachment P.6.3.1.1). In addition to the assistance and information provided by the PIHP’s Customer Services Unit, the PIHP will provide each family or authorized representative(s) of the minor child a choice of working with a case manager, supports coordinator or other qualified staff, or an independent facilitator to assist them in being actively engaged in the IPOS development process.

The Person-Centered Planning (PCP) process to develop the Individual Plan of Services (IPOS) is required by the Michigan Mental Health Code (MCL 330.1712). For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The PCP process is an individualized, needs-driven, strengths-based process for children and their families or authorized representative(s). Consistent with Michigan’s strong focus on a family-driven/youth-guided service planning process, all meetings are scheduled at times and locations convenient to the child and family or authorized representative(s). The family or authorized representative(s) of the minor child identify other people to participate in planning, such as extended family members, friends, neighbors and other health and supports professionals.

The strengths, needs, preferences, abilities, interests, goals, and health status of the child are determined through pre-planning and the PCP process. Results from the Independent Assessment and any other medically-necessary assessments by qualified providers, including but not limited to behavioral, psychosocial, speech, occupational and/or physical therapy, social/recreational, and physical and mental health care, are information used in the PCP process. The PCP process considers all life domains of the child, including emotional, psychological and behavioral health; health and welfare; education/ needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains as identified by the family or authorized representative(s), child, or assessors.

The IPOS is developed based on findings of all assessments and input from the child and the family or authorized representative(s). It includes the identification of outcomes based on the child’s stated goals if applicable based on the child’s age, interests, desires and preferences; establishment of meaningful and measurable goals to achieve identified outcomes; determination of the amount, scope, and duration of all medically-necessary services, including ABA, for those supports and services provided through the public mental health system; identification of other services and supports the child and family or authorized representative(s) may require to which the public mental health system will assist with linking the family or authorized representative(s). The IPOS directs the provision of supports and services to be provided through the PIHP in the amount, scope, and duration required to assist the child in achieving the identified outcomes.

The IPOS must specify how ABA will be provided as part of a comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a

private insurance autism benefit or school, and clearly delineates ABA from other mental health services like Community Living Supports, Skill Building, or Respite, or services authorized by another agency, such as Home Help. Per the Michigan Medicaid Provider Manual (MPM), “The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements, and assist the beneficiary to make use of other community resources for non-Medicaid services, or Medicaid services administered by other agencies.”

The IPOS must address the health and welfare of the child. This may include coordination and oversight of any identified medical care needs to ensure health and safety, such as medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or comorbid medical conditions requiring care. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk. For example, a risk factor might be how to ensure consistent staffing in the event a staff did not show up. The backup plan is that the agency has a staff who is already trained in this child’s IPOS and that staff person can be sent in the event a staff does not show up to provide a service.

The MPM requires that all services specified in the IPOS must be “[d]elivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.”

Life Domain planning is always a blend of formal and informal resources, such as natural supports. It uses strategies that are based on strengths, focused on need, are individualized and community-based. The IPOS identifies each of the interventions/responsibilities to be implemented, and who is responsible to implement or monitor the service. MDCH encourages the use of natural supports to assist in meeting the child’s needs to the extent that the family or authorized representative(s) or friends who provide the natural supports are willing and able to provide this assistance. Applied Behavior Analysis services do not substitute for parental care, supervision and responsibility for a child. The use of natural supports must be documented in the child's IPOS.

Per the MPM, “[a] preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release (as required by the Michigan Mental Health Code). Pursuant to state law and in conjunction with the Balanced Budget Act of 1997 [Section 438.10 (f)(6)(v)], each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.”

The IPOS is a dynamic document that is revised based on changing needs, newly-identified or developed strengths and/or the result of periodic reviews and/or assessments. Per the MPM, “[t]he individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary’s health and welfare needs or changes in the beneficiary’s preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.”

- 6. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Each PIHP must maintain a provider network that enables the family or authorized representative(s) of the minor child to choose from among a range of available network providers, and change providers within the PIHP in accordance with the Balanced Budget Act of 1997 and the MDCH/PIHP contract. Each PIHP must have a Customer Services Unit that will provide the family or authorized representative(s) with information about the choice of providers and service array (MDCH/PIHP Contract Attachment P6.3.1.1). Requirements for PIHPs are addressed in the MDCH/PIHP contract.

This §1915(i) State Plan amendment is to run concurrently the §1915(b) Managed Specialty Services & Supports Program (MSS&SP) waiver.

**7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The responsibility for approving the IPOS, which would include ABA services, is delegated to the PIHPs. Each PIHP develops its process by which it approves the IPOS through a Utilization Management function. The State provides oversight through its site review process and tracks compliance through the MSS&SP Quality Improvement Strategy and performance measures required by §1915(i). The site review team completes an on-site visit to each PIHP on a biennial basis to complete record reviews, determining whether the IPOS was developed in accordance with MDCH policies and procedures such as person-centered planning, the IPOS specifies the amount, scope and duration of services needed, and the plan has been implemented as specified and services are delivered by qualified providers. The site review is part of the Quality Improvement Strategy by which the State oversees the IPOS and provision of services to Medicaid beneficiaries through the §1915(b)/(c) concurrent waivers which will also encompass the §1915(i) State Plan amendment. Additional detail related to the site review process is included in the Quality Improvement Strategy and the §1915(c) waivers.

**8. Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ):	The PIHP is responsible for assuring that a written or electronic record of the child’s IPOS is maintained for a minimum of seven years, which exceeds requirements of 45 CFR 92.42. Each PIHP determines the location for storing records and makes these records available for the State to review upon request.			

# Services

**1. State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Applied Behavior Analysis (ABA)
Service Definition (Scope):	
<p>ABA Services are provided to increase developmentally-appropriate skills to facilitate the child’s independence and integration into the community. This service provides-evidenced based techniques or strategies that are targeted to increasing developmental skills of a child with Autism Spectrum Disorders (ASD) in the domains of activities of daily living, communication, higher cognitive functions, interpersonal interaction, learning readiness, motor skills, play and self-regulation. These services must be provided directly to, or on behalf of, the child by training the parents/caregivers, ABA aides, or a Board Certified Assistant Behavior Analyst (BCaBA) to deliver the ABA services. The ABA services, as identified in the individual plan of service (IPOS), are provided in the home or a clinic or may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school. Each child’s plan must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that otherwise are available to the individual through a local education agency.</p> <p>There are two levels of intensity within ABA services: Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Interventions (ABI). The PIHP’s Utilization Management will authorize the intensity of services prior to delivery of services.</p> <p>EIBI is a comprehensive behavior package that is developed for a child between the ages of 18 months through five years to address skill deficits, behavioral issues, and improve overall functioning. This level of intervention is available to any child who has an Autism Diagnostic Observation Schedule (ADOS) score that falls in the Autism range. This intensive treatment involves training the parent/caregivers to continue the behavioral interventions in the home environment. ABI is a less intensive, more focal model of ABA. It is not a comprehensive package. This level of intervention is available to any child with ASD between the ages of 18 months through five years who is not receiving EIBI services and has an ADOS score that falls in the Autism or ASD range.</p> <p><b>1. Early Intensive Behavioral Intervention (EIBI).</b> EIBI is comprehensive applied behavioral program administered in a child’s home or clinic setting that consists of various evidence-based interventions (see National Autism Center’s National Standards Report, 2009, Chapter 4). A comprehensive assessment is utilized to identify goals for intervention. Evidence based interventions include: Discrete Trial Training (DTT) which is part of the Behavioral Package, Antecedent Package, Comprehensive Behavioral Treatment for Young Children, Modeling, Joint Attention Intervention, Naturalistic Teaching Strategies, Peer Training Package, Pivotal Response Treatment, Schedules, Self-Management, Story-based Intervention Package.</p> <p>Discrete Trial Training (DTT) is a method of teaching specific skill acquisition in simplified steps. Instead of teaching an entire skill at one time, the skill is broken down and developed using discrete trials that teach one step at a time. It is one of the techniques from the evidence</p>	

based intervention, Behavioral Package.

**Antecedent Package** - These interventions involve the modification of situational events that typically precede the occurrence of a target behavior. Examples include cueing and prompting/prompt fading procedures, noncontingent reinforcement.

**Behavioral Package** - These interventions are designed to reduce problem behavior and teach functional alternative behaviors or skills through the application of basic principles of behavior change. Examples include chaining, reinforcement, functional communication training and discrete trial training.

**Comprehensive Behavioral Treatment for Young Children** - This treatment reflects research from comprehensive treatment programs that involve a combination of applied behavior analytic procedures. These treatment programs may also be referred to as ABA programs or behavioral inclusive program and early intensive behavioral intervention.

**Joint Attention Intervention** - These interventions involve building foundational skills involved in regulating the behaviors of others. Joint attention often involves teaching a child to respond to the nonverbal social bids of others or to initiate joint attention interactions. Examples include pointing to objects, showing items/activities to another person and following eye gaze.

**Modeling** - These interventions rely on an adult or peer providing a demonstration of the target behavior that should result in an imitation of the target behavior by the individual with ASD. Modeling can include simple and complex behaviors. This intervention is often combined with other strategies such as prompting and reinforcement. Examples include live modeling and video modeling.

**Naturalistic Teaching Strategies** - These interventions involve using primarily child-directed interactions to teach functional skills in the natural environment. These interventions often involve providing a stimulating environment, modeling how to play, encouraging conversation, providing choice and direct/natural reinforcers and rewarding reasonable attempts.

**Peer Training Package** - These interventions involve teaching children without disabilities strategies for facilitation play and social interactions with children on the autism spectrum. Peers may often include classmates or siblings. These interventions may include components of other treatment packages (e.g. self-management for peers, prompting, reinforcement, etc.). Common names for intervention strategies include peer networks, circle of friend, buddy skills package, Integrated Play Group, peer initiation training and peer-mediated social interactions.

**Pivotal Response Treatment** - These interventions focus on targeting “pivotal behavioral areas—such as motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues, with the development of these areas having the goal of very widespread and fluently integrated collateral improvements. Key aspects of Pivotal Response Treatment.

**Schedules** - These interventions involve the presentation of a task list that communicates a series of activities or steps required to complete a specific activity. Schedules are often supplemented by other interventions such as reinforcement. Schedules can take several forms including written words, pictures or photographs, or work stations.



Self-management - These interventions involve promoting independence by teaching individuals with ASD to regulate their behavior by recording the occurrence/non-occurrence of the target behavior, and securing reinforcement for doing so. Initial skills development may involve other strategies and may include the task of setting one's own goals. In addition, reinforcement is a component of this intervention with the individual with ASD independently seeking and/or delivering reinforcers. Examples include the use of checklists (using checks, smiley/frowning faces), wrist counters, visual prompts and tokens.

Story-based Intervention Package - These treatments involve a written description of the situations under which specific behaviors are expected to occur. Stories may be supplemented with additional components (e.g. prompting, reinforcement, discussion, etc.) Social Stories are the most well-known story-based interventions.

Criteria for EIBI includes an ADOS score that falls in the Autism range. The service typically involves an average of 10-20 hours per week (actual hours as determined by a behavior intervention plan and interventions required) and is appropriate for children 18 months through age five as defined by the child's ability to actively engage in the therapeutic treatment process. It is typically provided in the home or in a center, several hours per day, five to seven days per week for two to three years. EIBI is used for reducing intrusive, disruptive behaviors, and/or stereotypic autistic behaviors and improving socially acceptable behaviors, adaptive behaviors and communication skills. Discrete Trial Training and other interventions from The National Standards Report 2009 are utilized over the course of treatment to teach imitation skills, establish play behaviors, integrate the family into treatment, develop early expressive and abstract language, increase peer interactions, social skills, academic skills, and moving toward integrating the family into the community and school system. The comprehensive individualized ABA behavioral intervention plan is part of the child's IPOS and identifies specific targeted behaviors for improvement and includes measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service requires evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of reliable and valid assessment. The IPOS is updated as the child gains new skills and address maintenance of acquired skills in a clear progression over the course of the intervention. The plan will be reviewed at regular intervals, minimally every three months, and if indicated, adjusting service intensity and settings to meet the child's changing needs. This intensive treatment involves training the parents/caregivers to continue the behavioral interventions in the home environment. Coordination with the school and/or early intervention program is also critical.

**2. Applied Behavioral Intervention** - Applied Behavioral Intervention (ABI) includes behavioral interventions provided with a focal approach toward targeted goal(s). Like EIBI, interventions include those from the established treatment list from the National Standards Report (2009) and are directed toward increasing functional communication, independent self-care tasks, receptive language, expressive language, play behaviors, social skills, imitation, and/or any additional behaviors that will enable the child to more readily integrate with typically developing peers. This level of intervention is available to any child with ASD between the ages of 18 months through five years who is not receiving EIBI services and has an ADOS score that falls in the Autism or ASD range. Applied Behavioral Intervention may include Antecedent Package, Joint Attention Intervention, Naturalistic Teaching Strategies, Peer Training Package, Pivotal Response Treatment, Schedules, Self-management, and Story-based Intervention Package that focus on teaching specific adaptive skills. This intervention may include an average of 5-15 hours per week (actual hours as determined by a behavior intervention plan and interventions required). This range may fluctuate considerably over the course of treatment and is closely determined by interventions specified in the

behavioral intervention plan and the child's mastery of skills. As part of the IPOS, there is a comprehensive individualized behavioral treatment plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service (every six months) requires evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of reliable and valid assessment instruments. If indicated, the plan may adjust service intensity and setting(s) to meet the child's changing needs. ABI includes training for parents/caregivers that continue the intervention outside of the ABI professional intervention to extend the treatment into the home.

The ABA service must be provided without the use of punitive, intrusive or restrictive techniques. The use of restraints, seclusion or aversive techniques is prohibited by MDCH in all community settings.

#### Roles and Responsibilities of Qualified Providers:

**Board-Certified Behavior Analyst (BCBA):** Develops and implements EIBI or ABI treatment program. Reviews and monitors data and makes programmatic changes based on the data. Provides skill development training and supervision of BCaBA, Autism Aide and CMHP. Administers one of the behavioral outcome measurement tool.

**Board-Certified Assistant Behavior Analyst (BCaBA):** Works under the supervision of BCBA to provide the technical assistance and implementation of the treatment plan. Provides direct oversight of data collection.

**ABA Aide:** Works under the direction and supervision of BCBA to provide the direct implementation of the treatment plan. Gathers data and makes program adjustments under the direction of the BCBA.

**Licensed Psychologist:** Provides diagnosis of child and treatment within scope of practice which includes psychological testing, evaluations, therapy, administers ADOS and ADI-R, recommends the intensity of the ABA service, administers one of the behavioral outcome measurement tools.

**Limited Licensed Psychologist:** Works within scope of practice and provides psychological testing, psychological evaluations, therapy, administers ADOS and ADI-R, recommends the intensity of the ABA service, administers one of the behavioral outcome measurement tools.

**Child Mental Health Professional (master's degree minimum):** Works under the direction and supervision of the BCBA, works within scope of practice, administers ADOS and ADI-R, participates in treatment team, administers one of the behavioral outcome measurement tools.

**Other Bachelor's degreed Professional:** Works under supervision of BCBA and provides direct implementation of the treatment plan. Gathers data and makes program adjustments under the direction of the BCBA.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

**(ADD SECTION) MDCH Medicaid Autism Benefit**

Specify limits (if any) on the amount, duration, or scope of this service for ( <i>chose each that applies</i> ):			
<input type="checkbox"/>	Categorically needy ( <i>specify limits</i> ):		
<input type="checkbox"/>	Medically needy ( <i>specify limits</i> ):		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
<b>Board Certified Behavior Analyst (BCBA)</b>	Not applicable	Current certification as a BCBA through the Behavior Analyst Certification Board (BACB)	
<b>Board Certified Assistant Behavior Analyst (BCaBA)</b>	Not applicable	Current certification as a BCaBA through the Behavior Analyst Certification Board (BACB)	Works under the supervision of a BCBA
<b>ABA Aide</b>	Not applicable	Not applicable	Must be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien).  Able to perform basic first aid procedures and is trained in the child's plan of service, as applicable.

			<p>Has received training in principles of behavior; behavioral measurement and data collection; functions of behaviors (attention, escape, automatic reinforcement, pain attenuation); basic concepts of ABA; generalization and its importance in sustainability of learned/acquired skills; medical conditions/illness that impact behaviors.</p> <p>Works under the supervision of a BCBA or LP, LLP, or Child Mental Health Professional (Master’s degree minimum) implementing services of the ABA plan.</p>
<p><b>Licensed Psychologist (LP) completing BCBA within four years (by 9/30/16)</b></p>	<p>Licensed psychologist means a doctoral level psychologist licensed under section 18223 (1) of the public health code, 1978 PA 368, MCL 333.18223. Licenses are renewed every two years.</p>	<p>Not applicable</p>	<p>Works within scope of practice and have extensive knowledge and training in applied behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas. Provision of a transcript that documents successful completion in at least three of the six classes with the following content area is required.</p> <ol style="list-style-type: none"> <li>1. Ethical considerations</li> <li>2. Definitions &amp; characteristics and principles, processes &amp; concepts of behavior</li> <li>3. Behavioral assessment and selecting interventions outcomes and strategies</li> <li>4. Experimental evaluation of</li> </ol>

			<p>interventions</p> <p>5. Measurement of behavior and developing and interpreting behavioral data</p> <p>6. Behavioral change procedures and systems supports</p> <p>Provides documentation of a minimum of one year experience in diagnosing and/or treating children with Autism Spectrum Disorders (ASD) based on the principles of applied behavior analysis.</p> <p>Works in consultation with BCBA.</p> <p>Must enroll in a BCBA eligible course sequence within one year of the time they begin providing ABA services.</p> <p>Must complete all coursework and experience requirements and be certified as a BCBA no later than 9/30/16.</p>
<p><b>Limited Licensed Psychologist (LLP) completing BCBA within four years (by 9/30/16)</b></p>	<p>Limited licensed psychologist means a doctoral or master level psychologist licensed under section 18223 (1) of the public health code, 1978 PA 368, MCL 333.18223. Limited psychologist-masters limited license is good</p>	<p>Not applicable</p>	<p>Works within scope of practice and have extensive knowledge and training in applied behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas. Provision of a transcript that documents successful completion in at least three of the six classes with the following content area is required.</p> <ol style="list-style-type: none"> <li>1. Ethical considerations</li> <li>2. Definitions &amp; characteristics and</li> </ol>

	<p>for one two-year period. Limited psychologist-doctoral limited license is renewed annually for a maximum of five years.</p>		<p>principles, processes &amp; concepts of behavior</p> <p>3. Behavioral assessment and selecting interventions outcomes and strategies</p> <p>4. Experimental evaluation of interventions</p> <p>5. Measurement of behavior and developing and interpreting behavioral data</p> <p>6. Behavioral change procedures and systems supports</p> <p>Provides documentation of a minimum of one year experience in diagnosing and/or treating children with Autism Spectrum Disorders (ASD) based on the principles of applied behavior analysis.</p> <p>Works in consultation with BCBA</p> <p>Must enroll in a BCBA eligible course sequence within one year of the time they begin providing ABA services.</p> <p>Must complete all coursework and experience requirements and be certified as a BCBA no later than 9/30/16.</p>
<p><b>Child Mental Health Professional (Master's degree minimum) completing BCBA within four years (by</b></p>	<p>Not applicable</p>	<p>Not applicable</p>	<p>Possesses a minimum of a master's degree from an accredited institution in one of the degree categories approved by the Behavior Analyst Certification Board (BACB) to be eligible to complete BCBA certification by 9/30/16. Specific information about the degree</p>

<p><b>9/30/16)</b></p>			<p>categories is located at the BACB website.</p> <p>Provides documentation of a minimum of one year experience in diagnosing and/or treating children with Autism Spectrum Disorders (ASD) based on the principles of applied behavior analysis.</p> <p>Works under the supervision of a Board Certified Behavior Analyst (BCBA) who provides skill development in ABA.</p> <p>Must enroll in a BCBA eligible course sequence within one year of the time they begin providing ABA services.</p> <p>Must complete all coursework and experience requirements and be certified as a BCBA no later than 9/30/16.</p>
<p><b>Other Bachelor's degree professional completing BCaBA within four years (by 9/30/16)</b></p>	<p>Not applicable</p>	<p>Not applicable</p>	<p>Possesses a bachelor's degree from an accredited institution in one of the degree categories approved by the Behavior Analyst Certification Board (BACB) to be eligible to complete BCaBA certification by 9/30/16. Specific information about the degree categories is located at the BACB website.</p> <p>Provides documentation of a minimum of one year experience in treating children with Autism Spectrum Disorders (ASD) based on the principles of applied behavior analysis.</p> <p>Works under the supervision of a</p>

			<p>Board Certified Behavior Analyst (BCBA) who provides skill development in ABA.</p> <p>Must enroll in a BCaBA eligible course sequence within one year of the time they begin providing ABA services.</p> <p>Must complete all coursework and experience requirements and be certified as a BCaBA no later than 9/30/16.</p>
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**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
<b>BCBA</b>	The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1)	Prior to delivery of services and every two years thereafter
<b>BCaBA</b>	The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1).	Prior to delivery of services and every two years thereafter
<b>ABA Aide</b>	The PIHP is responsible for assuring the provider is qualified as required by the MDCH/PIHP Contract (Attachment and P.6.7.1.1)	Prior to delivery of services and every two years thereafter
<b>LP completing BCBA within four years (by 9/30/16)</b>	The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1)	Prior to delivery of services and every two years thereafter
<b>LLP completing BCBA within four years (by 9/30/16)</b>	The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1)	Prior to delivery of services and every two years thereafter
<b>Child Mental Health Professional (Master's degree)</b>	The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1)	Prior to delivery of services and every two years thereafter



<p><b>minimum) completing BCBA within four years (by 9/30/16)</b></p>		
<p><b>Other Bachelor's degree professional completing BCaBA within four years (by 9/30/16)</b></p>	<p>The PIHP is responsible for assuring the provider is credentialed as required by the MDCH/PIHP Contract (Attachment P.6.4.3.1 and P.6.7.1.1)</p>	<p>Prior to delivery of services and every two years thereafter</p>
<p><b>Service Delivery Method.</b> <i>(Check each that applies):</i></p>		
<p><input type="checkbox"/> Participant-directed</p>	<p><input checked="" type="checkbox"/> Provider managed</p>	

2.  **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) the specific State plan HCBS that can be provided; (c) how the State ensures that the provision of services by such persons is in the best interest of the individual; (d) the State's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

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## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

**1. Election of Participant-Direction.** *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS. <i>(Skip to next section)</i>
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

**2. Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

**3. Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

**4. Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**5. Financial Management.** *(Select one):*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6.  **Participant-Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

**6. Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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**7. Opportunities for Participant-Direction**

**a. Participant–Employer Authority** (individual can hire and supervise staff). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**b. Participant–Budget Authority** (individual directs a budget). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	<b>Participant-Directed Budget.</b> <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	<b>Expenditure Safeguards.</b> <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

## Quality Improvement Strategy

*Describe the State's quality improvement strategy in the tables below):*

Requirement	Discovery Activities			Frequency	Remediation	
	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data &amp; sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>		Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Number & percent of beneficiaries whose IPOS addresses the needs. N: Number of beneficiaries whose IPOS addresses needs. D: All beneficiaries in sample	Source: Site review  Aggregate data from the sample by MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.  Sample size: 310 (based on population = 1600)  Method: Statewide Random Sampling	MDCH BHDDA	Ongoing for data collection  Each PIHP receives a comprehensive on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDCH BHDDA.  MDCH BHDDA reviews and approves the remediation from the PIHP.	Quarterly
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	2. Number and percent of beneficiaries whose IPOS are updated within 365 days of their last plan of service. N: Number of beneficiaries whose IPOS were updated within 365 days of their last plan of service.	Source: web support application  Sample size: 100%  Method: Report compilation & analysis from all beneficiaries	MDCH BHDDA	Ongoing for data collection	PIHPs are responsible for tracking and remediating any identified issues within 30 days. PIHPs can track via web support application report of coming-due and over-due notice to beneficiary regarding choice of providers. Report can be run at any point	Quarterly

	D: All beneficiaries				in time. MDCH BHDDA will run reports quarterly to monitor PIHP remediation activities.	
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	3. Number and percent of beneficiaries whose services and supports are provided as specified in the IPOS, including amount, scope, duration and frequency.  N: Number of beneficiaries whose services and supports are provided as specified in the IPOS, including amount, scope, duration and frequency.  D: All beneficiaries in sample	Source: Site review  Aggregate data from the sample by MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.  Sample size: 310 (based on population = 1600)  Method: Statewide Random Sampling	MDCH BHDDA	Ongoing for data collection  Each PIHP receives a comprehensive on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDCH BHDDA.  MDCH BHDDA reviews and approves the remediation from the PIHP.	Quarterly
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	4. Number and percent of beneficiaries who are informed of their right to choose among providers as evidenced by documentation the Pre-Planning Meeting summary.  N: Number of beneficiaries who are informed of	PRIMARY Source: web support application  Sample size: 100%  Method: Report compilation & analysis from all beneficiaries  SECONDARY Source: Site review	MDCH BHDDA	PRIMARY Source: Ongoing for data collection  SECONDARY Source: Each PIHP receives a comprehensive on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.	PRIMARY: PIHPs are responsible for tracking and remediating any identified issues within 30 days. PIHPs can track via web support application report of coming-due and over-due notice to beneficiary regarding choice of providers. Report can be run at any point in time.	Quarterly

	<p>their right to choose among providers.</p> <p>D: All beneficiaries.</p>	<p>Aggregate data from the sample by MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p>			<p>MDCH BHDDA will run reports quarterly to monitor PIHP remediation activities.</p> <p>SECONDARY: PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDCH BHDDA.</p> <p>MDCH BHDDA reviews and approves the remediation from the PIHP.</p>	
Providers meet required qualifications.	<p>5. Number and percent of beneficiaries whose providers of the ABA services meet credentialing standards.</p> <p>N: Number of beneficiaries whose providers of ABA services meet credentialing standards.</p> <p>D: All beneficiaries in sample</p>	<p>Source: Site review</p> <p>Aggregate data from the sample by MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p>	MDCH BHDDA	<p>Ongoing for data collection</p> <p>Each PIHP receives a comprehensive on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.</p>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDCH BHDDA.</p> <p>MDCH BHDDA reviews and approves the remediation from the PIHP.</p>	Quarterly
The SMA retains authority and responsibility for program operations and	<p>6. Number and percent of beneficiaries whose Independent Assessment</p>	<p>Source: Site review</p> <p>Aggregate data from the sample by</p>	MDCH BHDDA	<p>Ongoing for data collection</p> <p>Each PIHP receives a comprehensive</p>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the</p>	Quarterly



<p>oversight.</p>	<p>and development of IPOS are consistent with MDCH policies and procedures against conflict of interest as evidenced by:                      -the IPOS is developed through a person-centered planning process;                      -the assigned individual overseeing the development of the IPOS does not provide ABA services;                      -the authorization of ABA services is performed by the Utilization Management unit.</p> <p>N: Number of beneficiaries whose Independent Assessment and development of IPOS are consistent with MDCH policies and procedures.</p> <p>D: All beneficiaries in sample.</p>	<p>MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.</p> <p>Scoring this measure will be full compliance or non-compliance (no partial compliance). If any element within the PM is out-if-compliance, remediation is required.</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p>		<p>on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.</p>	<p>approved Plan of Correction has been issued by MDCH BHDDA.</p> <p>MDCH BHDDA reviews and approves the remediation from the PIHP.</p>	
<p>The SMA retains authority and responsibility for program operations and</p>	<p>7. Number and percent of beneficiaries whose ABA service authorization</p>	<p>Source: Site review</p> <p>Aggregate data from the sample by</p>	<p>MDCH BHDDA</p>	<p>Ongoing for data collection</p> <p>Each PIHP receives a comprehensive</p>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the</p>	<p>Quarterly</p>

<p>oversight</p>	<p>was completed by Utilization Management (UM) staff who are free from conflict of interest as evidenced by documentation that the staff does not provide any other service to that beneficiary.</p> <p>N: Number of beneficiaries whose ABA service authorization was completed by UM staff who are free from conflict of interest.</p> <p>D: All beneficiaries in sample.</p>	<p>MDCH across two Fiscal Years to be consistent with §1915(b)/(c) frequency.</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p>		<p>on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.</p>	<p>approved Plan of Correction has been issued by MDCH BHDDA.</p> <p>MDCH BHDDA reviews and approves the remediation from the PIHP.</p>	
<p>The SMA retains authority and responsibility for program operations and oversight</p>	<p>8. Number and percent of administrative hearings related to utilization management Issues (amount, scope, duration of service).</p> <p>N: Number of administrative hearings related to utilization Management</p> <p>D: All beneficiary hearings</p>	<p>Source: Appeals and Grievances Database</p> <p>Sample size: 100%</p> <p>Method: Report compilation &amp; analysis from all beneficiary hearing</p>	<p>MDCH BHDDA</p>	<p>Continuous and Ongoing</p>	<p>PIHPs are responsible for remediating any identified issues required by the Decision and Order of the Administrative Law Judge within the timeframe ordered.</p>	<p>Quarterly</p>
<p>The SMA maintains financial accountability</p>	<p>9. Number and percent of beneficiaries whose average</p>	<p>Source: CHAMPS (Michigan MMIS) data</p>	<p>MDCH/BHDDA  PIHPs</p>	<p>Quarterly</p>	<p>PIHP will submit remediation within 30 days after notification</p>	<p>Quarterly</p>

<p>through payment of claims for services that are authorized and furnished to 1915(i) beneficiaries by qualified providers.</p>	<p>hours of ABA services during a quarter were within the suggested range for the intensity of service plus or minus a variance of 25%.</p> <p>N: Number of beneficiaries whose average hours of services during a fiscal year quarter were within the suggested range for the intensity of services plus or minus a variance of 25%.</p> <p>D: All beneficiaries in the sample</p>	<p>warehouse</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p> <p>Range plus/minus Variance:</p> <p>EIBI quarterly range for a 12 week period is 90 to 300 hrs/quarter</p> <p>ABI quarterly range for a 12 week period is 45 to 225 hrs/quarter</p>			<p>from MDCH/BHDDA for any beneficiary identified</p>	
<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) beneficiaries by qualified providers</p>	<p>10. Number and percent of cost- settlement payments and recoveries made in accordance with MDCH policies and procedures as evidenced by:</p> <ul style="list-style-type: none"> <li>- valid encounters reported in the data warehouse for ABA services delivered</li> <li>- PIHP</li> </ul>	<p>Source: CHAMPS (Michigan MMIS) data warehouse</p> <p>sample size: 100%</p> <p>Method: Report compilation &amp; analysis from all Autism service encounters, amounts of interim payments, and</p>	<p>MDCH/BHDDA</p>	<p>Annually following the end of the fiscal</p>	<p>MDCH BHDDA; remediation within 30 days</p>	<p>Annually</p>

	<p>reporting on Medicaid Contract Settlement Worksheet specifying difference between interim payments received and actual expenditures</p> <p>N: Number of cost-settlement payments and recoveries made in accordance with MDCH policies and procedures</p> <p>D: Number of cost-settlement payments and recoveries</p>	<p>comparison with end-of-year contract settlement report</p>				
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>11. Number and percent of beneficiaries who receive information on how to report abuse, neglect &amp; exploitation on an annual basis as evidenced by documentation the Pre-Planning Meeting summary.</p> <p>N: Number of beneficiaries who receive information</p> <p>D: All beneficiaries</p>	<p>PRIMARY Source: web support application</p> <p>Sample size: 100% review of beneficiaries</p> <p>Method: Report compilation &amp; analysis from all beneficiaries</p> <p>SECONDAR Y Source: Site review</p> <p>Aggregate data from the sample by MDCH across two Fiscal</p>	<p>MDCH BHDDA</p>	<p>PRIMARY Source: Ongoing for data collection</p> <p>SECONDARY Source: Each PIHP receives a comprehensive on-site review biennially and has a follow-up review for remediation of identified issues on alternating years.</p>	<p>PRIMARY: PIHPs are responsible for tracking and remediating any identified issues within 30 days. PIHPs can track via web support application report of coming-due and over-due notice to beneficiary regarding abuse, neglect and exploitation. Report can be run at any point in time.</p> <p>MDCH BHDDA will run reports quarterly to monitor PIHP remediation activities.</p>	<p>Quarterly</p>

		<p>Years to be consistent with §1915(b)/(c) frequency.</p> <p>Sample size: 310 (based on population = 1600)</p> <p>Method: Statewide Random Sampling</p>			<p>SECONDARY: PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDCH BHDDA.</p> <p>MDCH BHDDA reviews and approves the remediation from the PIHP.</p>	
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>12. Number and percent of beneficiaries requiring hospitalization due to injury related to the use of physical management</p> <p>N: Number of beneficiaries requiring hospitalization due to injury related to the use of physical management</p> <p>D: all beneficiaries with reported incidents of hospitalization due to injuries</p>	<p>Source: Event Reporting System</p> <p>Sample size: 100%</p> <p>Method: Report compilation &amp; analysis from all beneficiaries with reported incidents.</p>	MDCH BHDDA	Continuous and ongoing	<p>PIHPs are responsible for reporting hospitalization d/t use of physical intervention within 60days after the intervention and remediating any identified issues related to the use of physical management within 90 days.</p>	Quarterly
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the</p>	<p>13. Number and percent of critical incidents reported for beneficiaries into the Event Reporting System in compliance</p>	<p>Source: Event Reporting System</p> <p>Sample Size: 100%</p> <p>Method: Report compilation &amp;</p>	MDCH BHDDA	Ongoing for data collection.	<p>PIHPs are responsible for reporting incident into system within 60 days after the incidents and remediating any identified issues related to the</p>	Quarterly

<p>use of restraints.</p>	<p>with MDCH policy and procedures for timeliness.</p> <p>N: Number of critical incidents reported for beneficiaries in the Event Reporting System in compliance with MDCH policy and procedures for timeliness.</p> <p>D: All incidents reported for beneficiaries</p>	<p>analysis from all incidents</p>			<p>critical incidents within 90 days.</p>	
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<p align="center"><b>System Improvement:</b></p>			
<p align="center"><i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i></p>			
<p>Methods for Analyzing Data and Prioritizing Need for System Improvement</p>	<p>Roles and Responsibilities</p>	<p>Frequency</p>	<p>Method for Evaluating Effectiveness of System Changes</p>
<p>Using encounter data, measure penetration rates of children with Autism Spectrum Disorders (ASD) who access services at the PIHP level to determine a baseline, median, and negative statistical outliers.</p> <p>Timeliness of access to face-to-face assessment with a professional, and following that access to first service are now measured and reported quarterly in the aggregate by PIHPs. Children with ASD will</p>	<p>MDCH-Autism Section staff will receive data from various sources within MDCH and analyze data related to children with ASD</p>	<p>Quarterly</p>	<p>MDCH will utilize a number of sources to analyze effectiveness of system changes, including but not limited to site reviews, performance indicators, encounter data, critical incident data and Medicaid Fair Hearing data.</p> <p>If continued problems are noted for individual PIHPs, MDCH employs contract sanctions as listed in the contract with the PIHP.</p> <p>If problems are noted for</p>

<p>be identified in this data.</p> <p>Track and trend critical incidents that involve children with ASD at the PIHP level: baseline, then identify negative statistical outliers.</p> <p>Track and trend requests for Medicaid Fair Hearing by children with ASD, and track and trend by PIHP the Fair Hearing decisions that are found in favor of the child.</p>			<p>the majority (more than 50%) of PIHPs, specific performance measures will be added that will require tracking and remediation to the individual level.</p>
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**Methods and Standards for Establishing Payment Rates**

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. (*Check each that applies, and describe methods and standards to set rates*):

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input type="checkbox"/>	HCBS Respite Care
<input checked="" type="checkbox"/>	Other HCBS ( <i>Specify</i> ): Applied Behavior Analysis (ABA)
	<p>The actuary for Michigan, Milliman, developed rates for different levels of provider credentials based on annual compensation amounts for each provider type. Overhead and other non-labor costs were added to the annual salary to arrive at a total annual cost per full-time employee (FTE). Productivity assumptions were then used to estimate the billable time per year an FTE would generate.</p> <p>The required rates were then applied to utilization and membership estimates for the cohort of children (18 months through age five) in the autism spectrum. The actuary compared prevalence rates for children (18 months through age five) in the TANF population against commercial estimates taken from States with autism insurance mandates, and concluded that the milder form of Autism was underrepresented in the TANF claims data. To accommodate this low implied prevalence rate in the TANF population, the actuary made an adjustment to increase the estimated prevalence of Asperger’s in the population by 50%.</p> <p>Benefit uptake was modeled two different ways. First, the actuary estimated that overall uptake will start at 30% for the TANF population and 70% for the DAB population. Uptakes were estimated to increase to 40% and 80% for the TANF and DAB populations, respectively, in Year 2. The actuary assumed long-term uptake rates will be consistent with Year 2 experience. Next, the actuary assumed an operational ramp up during Year 1 of the program where children (18 months through age 5) with the more severe classic Autism will move on to the benefit over a 6 month time frame and the children (18 months through age 5) with the milder Asperger’s will ramp up program enrollment over the first 12 months.</p> <p>There are two benefits that make up Michigan’s ABA service.</p> <ul style="list-style-type: none"> <li>• The Early Intensive Behavioral Intervention (EIBI) benefit is assumed to average 10-20 hours per week and is only available to children ages 18 months through age five in</li> </ul>



the Classic Autism (299.00) cohort.

- The Applied Behavioral Intervention (ABI) benefit is assumed to average 5-15 hours a week and will be utilized by children in the target group who are not receiving EIBI.

The actuary further assumed that because of vacations and other holidays, there will be 48 benefit weeks a year for each case.

The actuary used a ground up approach when building the rates for the ABA benefit to best capture the unique design and local costs in the State of Michigan. In developing the rates, the actuary started with salary assumptions for each credentialing level of staff and built the cost incrementally based on the salary. The following assumptions were used in the development and results are illustrated:

- A benefit and payroll tax load of 35% was applied to salary costs. The load is based on our experience as well as a survey of some of the PIHPs.
- A 30% load to salaries and benefits was applied to cover other overhead costs such as rent, supplies, equipment, other indirect functions, and margin.
- Billable time per employee was based on a 40 hour work week, five weeks of paid time off (PTO) a year, and a 25% daily allotment for non-billable time.
- In Year 1 and Year 2, a “supply premium” was applied to the rates to accommodate network build up. Because this service has not been covered in Michigan, there is currently an insufficient network. The PIHPs will need to compete with commercial payers, employees will have bargaining leverage, and it may be necessary to pay more employees on a contract basis. The premium for Year 1 is 20% and 10% for Year 2.
- 2% annualized general inflation after SFY 2013 was applied to all estimated costs.

For Individuals with Chronic Mental Illness, the following services:

	<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
	<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
	<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)