DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

September 17, 2020

Kate Massey, Medicaid Director
Medical Services Administration
Michigan Department of Health & Human Services
400 South Pine Street
Lansing, MI 48933

RE: MI 0233.R05.03 MI Choice Waiver Amendment

Dear Ms. Massey:

The Centers for Medicare and Medicaid Services is approving the state's request to amend the MI Choice waiver for elderly individuals ages 65 and older, as well as disabled individuals ages 18 and older, who meet a nursing facility level of care. The CMS Control Number for the amendment is MI 0233.R05.03. Please use this number in future correspondence relevant to this waiver action.

With this amendment, the state increases the number of participants for the any point in time limit under B-3-b. The effective date of the amendment is March 1, 2020.

This approval is subject to your agreement to serve no more individuals than those indicated in "C Factor Estimates" in the approved amendment. If the state wishes to serve more individuals or make any other alterations to this waiver, an amendment must be submitted for approval.

It is important to note that CMS' approval of this waiver amendment solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Thank you for your cooperation during the review process. If you have any questions concerning this information, please contact me at (206) 615-2356, or your staff may contact Justyna Redlinski at Justyna.Redlinski@cms.hhs.gov or (312) 353-7370.

Sincerely,

David L. Meacham, Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Lynell Sanderson, CMCS
Cynthia Nanes, CMCS

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
MI Choice Waiver

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

D. Amendment Number:MI.0233.R05.03

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

03/01/20

Approved Effective Date: 03/01/20
Approved Effective Date of Waiver being Amended: 10/01/18

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment increases the number of participants for the Any Point in Time number under B-3-b due to federal guidance restricting Medicaid program disenrollments and eligibility for the COVID-19 pandemic. Due to not being able to disenroll participants, the Michigan Department of Health and Human Services (MDHHS) is expecting to exceed the Any Point in Time number indicated in the current waiver at some points since March 2020.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A	

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

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

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

Specify:

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

MI Choice Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.0233
Waiver Number:MI.0233.R05.03
Draft ID: MI.003.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/18
Approved Effective Date of Waiver being Amended: 10/01/18

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

MI Choice is limited to serving older adults (age 65 and over) and persons with disabilities (age 18 and older).

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

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

A 1915(b) waiver application will be submitted concurrently with this 1915(c) waiver renewal application. The Control Number for the 1915(b) waiver is MI.0018.R01.00

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

☒ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

MI Choice is a § 1915(c) waiver used to deliver home and community based services to elderly and disabled individuals meeting Michigan's nursing facility level of care who, but for the provision of such services, would require nursing facility services. The goal is to provide home and community based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. The waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Medical Services Administration (MSA), which is the Single State Medicaid Agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations.

MI Choice is a Medicaid managed care program. MI Choice participants receive services from entities classified as Prepaid Ambulatory Health Plans (PAHPs), herein referred to as waiver agencies. MDHHS contracts with waiver agencies to carry out its waiver obligations. Each waiver agency must sign a provider agreement with MDHHS assuring that it meets all program requirements.

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

MI Choice operates concurrently with the §1915(b)(1)/(b)(4) waiver, Control Number MI.0018.R01.00. Participants enrolled in MI Choice may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

MDHHS initiated the public input process by issuing official communication in February 2019.

MDHHS sent a Tribal notice February 2019 to provide an opportunity for Tribal members to review the waiver applications and submit comments. The period of Tribal comment was February 7, 2019 through March 25, 2019.

The general public notice/comment period was February 11- March 15, 2019. A letter was sent electronically to stakeholders to notify them of the review and comment opportunity and how to submit comments or receive information.

Non-electronic public notice:
Public notice was released via several of the major newspapers statewide. The newspaper notice included the website where the applications were posted as well as the email address and mailing address where comments and requests could be submitted.

The website where the waiver applications were posted for review and comment is:

https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42549_42592-151693--,00.html

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the

Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

Agency: Medical Services Administration, Actuarial Division

Address: P.O. Box 30479

Address 2: 400 S. Pine, 7th Floor

City: Lansing

State: **Michigan**

Zip: 48909-7979

Phone: (517) 284-1190 **Ext:** ☐ **TTY**

Fax: (517) 241-5112

E-mail: ColemanJ@Michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Kate Massey

State Medicaid Director or Designee

Submission Date: Sep 14, 2020

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Massey

First Name: Kate

Title: Medicaid Director

Agency: Michigan Department of Health and Human Services

Address: 400 S. Pine St

Address 2:

City: Lansing

State: **Michigan**

Zip: 48933

Phone: (517) 241-7882 **Ext:** ☐ **TTY**

Fax: (517) 335-5007

E-mail: masseyk4@michigan.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☒ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The state intends to continue providing community transition services to those receiving them, BUT THROUGH A NEW 1915i STATE PLAN BENEFIT. We plan to continue allowing current providers to furnish transition services which will not significantly change how services are delivered to participants. The biggest change will be how services are billed, which should not affect the participants. Participants would continue to have the right to a State Fair Hearing.

Michigan has health and welfare protections in place for the MI Choice Waiver. These will continue to apply for all MI Choice Waiver participants. There are also health and welfare protections identified in the approved 1915i State Plan Transition Services benefit that would apply to any individuals receiving the community transition services under this benefit. Michigan will ensure that health and welfare is protected.

This Amendment is only related to Community Transition Services and does not affect any other services available to MI Choice participants enabling them to remain in a community setting. When an individual is enrolled in MI Choice after the nursing facility discharge, any Community Transition Services that were needed for the transition to the community would have already been provided prior to facility discharge. There would be no loss in Community Transition Service coverage once the individual becomes enrolled in MI Choice. The same transition services are still available to any qualified Medicaid eligible individual who wishes to choose to transition from a nursing facility to a community setting. The criteria are less restrictive for the 19195i State Plan benefit than for MI Choice.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

As of 07/01/2018, there have been 777 total residential settings assessed and submitted to MDHHS. MDHHS completed reviews of all 777 of these settings. Of these 777, 393 were found in compliance, 360 do not meet requirements but could come into compliance, and 24 have been identified as possible heightened scrutiny.

As of 07/01/2018, there have been 73 total non-residential settings assessed and submitted to MDHHS. MDHHS completed reviews of all 73 of these settings. Of the 73 settings, 29 were found in compliance, 29 do not meet requirements but could come into compliance with HCBS guidance, and 15 have been identified as possible heightened scrutiny.

MDHHS and the waiver agencies have been working with the settings on CAP to bring these settings into compliance. All MI Choice assessments have been submitted. As of October 1, 2018, all new settings must be immediately compliant.

MDHHS Continues to work with LARA to incorporate policy language into the Medicaid Provider Manual regarding Emergency and Non-Emergency Involuntary Discharge. Regulations and policy will be promulgated.

MDHHS will change the dates as the original dates were not met as projected. Compliance will be determined by 01/01/2017. CAPs started in January 2016 for settings that have been determined out of compliance and notified of such. Once these settings indicate they are in compliance, they will be reassessed to verify compliance.

MDHHS has updated the corrective action process for MI Choice waiver agencies. As stated in the Contract, Attachment H, the corrective action process will be as follows:

1) MDHHS will notify both the provider and the MI Choice waiver agency regarding the providers compliance based upon the completed survey tool that was submitted to
MDHHS.
2) For providers who are non-compliant, the provider will have 90 days to correct all issues that cause the noncompliance.
3) Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
4) The waiver agency will have 90 days to complete another on-site survey and submit the survey to MDHHS for review.
5) If a provider does not notify the waiver agency within 90 days, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
6) If the provider has not satisfactorily resolved the compliance issues, the waiver agency will suspend the provider from receiving new MI Choice participants until such time as the provider comes into compliance.
7) Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than September 30, 2018.
8) Waiver agencies will start transition plans with individuals being served by non-compliant providers as of October 1, 2018. This planning will be person-centered and will focus on meeting the wishes of each participant regarding their preference of a qualified provider and enrollment in the MI Choice program.
9) By March 17, 2019, no MI Choice participants will be served by non-compliant providers.

The State assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

MDHHS received no comments from the public or Tribes.

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Michigan Department of Health and Human Services, Medical Services Administration

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the

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

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

The Michigan Department of Health and Human Services (MDHHS) contracts with 20 waiver agencies to perform
administrative and case management functions. They are responsible for disseminating waiver information to potential enrollees, assisting individuals in waiver enrollment (which includes assisting applicants with completion of the Medicaid eligibility application to secure financial eligibility), managing waiver enrollment against approved limits, conducting assessments and level of care evaluations, developing and reviewing participant service plans to ensure waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

Appendix A: Waiver Administration and Operation

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

The Home and Community Based Services Section (HCBSS), organizationally situated in the Long Term Care Services Division, Bureau of Medicaid Long Term Care Services and Supports, Medical Services Administration, Michigan Department of Health and Human Services, is responsible for assessing the performance of each waiver agency.

Appendix A: Waiver Administration and Operation

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

MDHHS uses several methods to assess the performance of waiver agencies and assure assigned operational and administrative functions are completed in accordance with waiver requirements. MDHHS biennially examines administrative elements during the on-site Administrative Quality Assurance Reviews (AQAR). MDHHS contracts with an External Quality Review Organization (EQRO) to examine the case record elements during the Clinical Quality Assurance Reviews (CQARs). MDHHS contracts with a third party vendor to conduct participant satisfaction surveys and provide analysis of the results.

The AQAR process includes an examination of policy and procedure manuals, peer review reports, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, quality management plans (QMPs) and verification of required provider licensure to assure that each waiver agency meets all requirements. The AQAR also verifies the waiver agency meets administrative, program policy, and procedural requirements by ensuring maintenance of program records for ten years, controlled access to program records according to HIPAA requirements, waiver agency employee access to program policies and procedures, and proper accounting procedures. MDHHS reviews waiver agency agreements with subcontracted providers, performs provider reviews, and may conduct interviews with both supports coordinators and MI Choice participants.

The second element is the CQAR. The EQRO employs qualified reviewers to complete the CQAR for every waiver agency each fiscal year. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each participant. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and Federal requirements. Identified discrepancies are reviewed and addressed.

MDHHS monitors implementation of the concurrent §1915(b)/(c) MI Choice waivers and monitors the following waiver agency delegated responsibilities:

Participant Waiver Enrollment – MI Choice has three requirements for program eligibility: 1) medical/functional (nursing facility level of care), 2) financial (Medicaid eligible), and 3) the need for at least one MI Choice service in addition to Supports Coordination. Waiver agencies assess medical/functional eligibility during an in-person interview using the Nursing Facility Level of Care (NFLOC) determination. MDHHS requires waiver agencies to put NFLOC results for all enrollments in the State's NFLOC system. The State's MMIS system will not approve MI Choice capitation payments for persons who do not have a valid, passing NFLOC in the system. MDHHS requires the EQRO to monitor compliance with NFLOC policy during annual CQARs by reviewing NFLOC determinations against completed iHC assessments and making home visits to participants. The CQAR process assures participants continually meet NFLOC criteria throughout MI Choice enrollment. MDHHS uses additional methods for all long term services and supports providers to validate the level of care determinations in the NFLOC system.

MDHHS local office staff determines financial eligibility for potential MI Choice participants. When the MDHHS local office affirms program financial eligibility, the waiver agency enters an enrollment record into the State's MMIS system. A Benefit Plan and Program Enrollment Type for MI Choice will be automatically assigned in the MMIS system. The system contains payment edits that will generate MI Choice capitation payments only when the beneficiary’s record contains both the MI Choice Benefit Plan and Program Enrollment Type.

MDHHS requires waiver agencies to monitor their caseload for participants who have not received services for 30 days. This is a quality measure required in the Quality Management Plan. Persons who do not require a MI Choice service are removed from the program following established policies and procedures.

Waiver Enrollment Management Against Approved Limits - Waiver agencies manage applicant enrollment into MI Choice and must develop written procedures for enrollment activities that are consistent with MDHHS policy. MDHHS reviews these policies and procedures during their biennial AQAR, or when waiver agencies propose changes to their policies and procedures. MDHHS monitors enrollment counts on a monthly basis. MDHHS monitors nursing facility transition requests and activities as they occur.

Waiver Expenditures Managed Against Approved Levels – Waiver agencies maintain administrative and financial accountability and manage expenditures against approved levels. The waiver agencies must take full advantage of services in the community that are paid for by other sources before authorizing MI Choice services for a participant. MDHHS routinely monitors encounters, expenditures, and administrative data from the Medicaid data warehouse. MDHHS also conducts reviews of expenditures and financial policies and procedures during the biennial AQAR.

Level of Care Evaluation – Waiver agencies determine medical/functional eligibility during an in-person interview using the NFLOC determination. MDHHS reviews all determinations and provides final approval for enrollment into the MI Choice Program. During the CQAR, the EQRO reviews a statistically significant sample of cases to compare level of care determinations (LOCDs) with actual assessments and verify that enrolled participants are eligible, LOCD items match comparable assessment responses, and supports coordinators reevaluate enrollees at least annually or upon a significant change in status. MDHHS also reviews LOCD administrative hearing decision summaries regularly, provides technical assistance and training, and initiates corrective actions as needed. MDHHS reviews all determinations and provides final approval as well as final decisions on denials and terminations for the MI Choice program.

Reviews of Participant Person-Centered Service Plans – Waiver agencies work with each participant and their allies to develop a written person-centered service plan. During the CQAR process, the EQRO conducts annual service plan and case record reviews on a statistically significant random sample of participants to ensure adherence to MDHHS contract requirements. Reviews include ensuring services are provided as planned, person-centered planning is used, and services and supports are consistent with identified needs and preferences.

Prior Authorization of Waiver Services – Waiver agencies use person-centered planning (PCP) principles to develop a person-centered service plan with the participant. The participant must approve of all services in the person-centered service plan before the waiver agency may authorize the participant's chosen qualified provider to start furnishing the services. During the CQAR review process, the EQRO confirms participant approval and assures the approval occurred before services started. As part of the AQAR process, MDHHS verifies the waiver agency has policies and procedures related to the person-centered service plan development and that those policies and procedures are consistent with MDHHS and Federal requirements.

Utilization Management – Waiver agencies determine the appropriateness and efficacy of services provided. As part of the AQAR process, MDHHS conducts financial reviews by evaluating a sample of participants' claims to the services included on the person-centered service plan over a three month period. This process includes reviewing the service record from inception through approved Medicaid encounter data to verify records match by date of service, amount, duration, and type of service. During CQAR reviews, the person-centered service plan is compared to iHC data and other information available in the record to assure the service plan meets the participants identified needs.

Qualified Provider Enrollment - Waiver agencies approve and enroll qualified service providers in their provider network to furnish MI Choice services. MDHHS requires each waiver agency to have an open bid process and to enroll willing and qualified providers in their provider network. MDHHS reviews and approves the contracting process and bid packet used by each waiver agency. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of their expected utilization for each MI Choice service and at least two providers for each MI Choice service. This assures network capacity as well as choice of providers. When waiver agencies cannot assure this choice within 30 miles or 30 minutes of travel time for each participant, they may request a rural area exception from MDHHS.

MDHHS reviews and approves all waiver agency bid packets prior to implementation. Waiver agencies must have policies and procedures that describe the frequency and method of verifying and monitoring staff qualifications. MDHHS reviews these policies and procedures during the AQAR process, or sooner if the waiver agency makes changes. MDHHS requires waiver agencies to submit provider network reports within 60 days of the start of the fiscal year that list all of their contracted providers, the services offered by each, and their capacity to serve MI Choice participants. Updates to this listing must be sent within 30 days of any changes. In addition to monitoring qualifications during the annual contracting process, MDHHS requires waiver agencies to complete a more comprehensive provider monitoring on 20% of providers annually (with a gradual increase in percent reviewed, reaching 20% in 4 years). Waiver agencies use a monitoring tool created by MDHHS during their provider monitoring. At the beginning of the fiscal year, MDHHS requires waiver agencies to send provider monitoring schedules to MDHHS. The waiver agency submits provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. MDHHS reviews and evaluates these reports for completeness and integrity of the process and may request additional information if there are any concerns. MDHHS will contact other waiver agencies using a provider if significant deficiencies are found. MDHHS also reviews provider files during the biennial AQAR.

Execution of Medicaid Provider Agreements – Waiver agencies use the Medicaid Provider Enrollment Agreement to complete enrollment into the waiver agency's provider network. The waiver agencies maintain signed and executed agreements on file. MDHHS reviews waiver agency agreements with subcontracted providers during the biennial AQAR

and as described above. MDHHS requires that all providers must be enrolled in the MMIS system (CHAMPS) to ensure appropriate background screening is completed. Once CHAMPS is ready to accept provider enrollment for atypical providers, they must all be enrolled in CHAMPS in order to receive payment for services. Until CHAMPS is ready to accept atypical provider enrollment, the waiver agencies retain the responsibility to assure criminal history screenings are conducted for their service providers.

Quality Assurance and Quality Improvement Activities – Waiver agencies develop their own Quality Management Plan (QMPs) every other year that address CMS and MDHHS quality requirements. MDHHS reviews and analyzes waiver agency QMPs and the associated yearly update reports. These reports provide detail regarding progress in quality assurance and quality improvement activities. MDHHS also compiles and compares individual waiver agency quality indicators and statewide averages. MDHHS has the capacity to run data on quality indicators and examine it at any time to monitor each waiver agency's performance as needed.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS. Numerator: Number of service plans for participants that were completed in specified time frame. Denominator: Number of service plans reviewed for participants.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures. Numerator: Number of qualified participants enrolled consistent with policies and procedures. Denominator: All participant files reviewed.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP. Numerator: Number of waiver agencies who submit annual QMP activity and outcome reports. Denominator: All waiver agencies.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: waiver agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of appropriate LOC determinations found after MDHHS review.
Numerator: Number of appropriate LOC determinations found after MDHHS review.
Denominator: Number of LOC determinations reviewed by MDHHS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's NFLOC system

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by MDHHS or EQRO. Numerator: Number of corrective action plans that were provided by waiver agencies according to requirements set by MDHHS or EQRO. Denominator: Number of corrective action plans submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDHHS, AQAR or EQRO reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MDHHS or EQRO	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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

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

1. Routinely monitors encounter and capitation data from the Medicaid data warehouse.
2. Verifies active licensure via a public website for each registered nurse and social worker employed at the waiver agency annually or sooner if the waiver agency provides an updated personnel list.
3. Routinely reviews, analyzes, and compiles all MI Choice administrative hearings and appeals decisions and takes corrective action when a waiver agency is non-compliant with a decision and order resulting from an administrative hearing.
4. As needed, investigates and monitors through resolution complaints received regarding operations of the MI Choice waiver program. This process might involve discussion with the waiver agency, participants or their representatives, the Michigan Department of Health and Human Services (MDHHS), or any other entity that might be helpful in producing a resolution.
6. Routinely monitors, reviews, and evaluates the Critical Incident Reporting System.

In addition, MDHHS performs the following functions:

a. MDHHS verifies sub-contracted providers have active licenses as required and meet provider qualifications.

MDHHS approves the contracting process used by each waiver agency. This includes confirming providers have active licenses (all licensing information is available online) and meet all qualification requirements. MDHHS reviews and approves the bid packet as necessary. MDHHS reviews each agency's policies and procedures and contractor files during the AQAR. When MDHHS has concerns about any provider, it may look up provider licenses online at any time. MDHHS requires the following providers of MI Choice services to be licensed: supports coordinators, which include a registered nurse (RN) or social worker (SW); nurses (RN or LPN) furnishing private duty nursing or nursing services; adult foster care homes, and homes for the aged. MDHHS conducts a 100% license verification process for all supports coordinators annually, and as additional staff are reported to MDHHS.

b. MDHHS provides administrative oversight of provider approvals, sanctions, suspensions, and terminations by the waiver agencies.

As part of the contract between MDHHS and the waiver agencies, MDHHS outlines steps waiver agencies can require as part of provider corrective action plans. As stated previously, waiver agencies send all provider monitoring reports, including corrective action plans, to MDHHS. MDHHS reviews these reports and may request additional information.

b. Methods for Remediation/Fixing Individual Problems

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

If any participant is found to be enrolled and is being served but does not qualify for the program, the waiver agency must help the participant find alternative services in the community. The waiver agency must start disenrollment procedures with the participant within seven days of notification of the finding and must also inform the participant of appeal rights. MDHHS will recover all Medicaid capitation payments made during the period of ineligibility.

If any service plans for participants are not completed in the required time frame, the waiver agency must develop a service plan within seven business days of the finding.

If any service plans do not support paid services, the waiver agency either must immediately (within seven business days) update the service plan as necessary and have the participant review and provide approval, or arrange for the appropriate level of services to be provided as specified in the service plan.

If any waiver agency submits an annual QMP Activity and Outcome report that does not illustrate that it is adhering to its QMP, the waiver agency must submit a revised Activity and Outcome report that addresses all of the plans in the approved QMP. The waiver agency may be required to revise and resubmit its QMP within two weeks of the finding.

If any NFLOCs are found to have been conducted inappropriately after MDHHS review, a new NFLOC tool will need to be conducted and entered into the NFLOC system. If the participant no longer meets NFLOC, the waiver agency must start disenrollment procedures with the participant, including notification of the individual's right to appeal.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: waiver agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	18	64	
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

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

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	16856
Year 2	17402
Year 3	18056
Year 4	18854
Year 5	19796

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

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	12000
Year 2	12500
Year 3	13000
Year 4	13200
Year 5	13400

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

(a) Michigan operates its waiver through waiver agencies.

(b) The methodology used to allocate capacity is based on several factors:

1. Original allocation was determined by demand for services when the waiver began operation.
2. Annual allocations are determined by the funds approved in the final State budget.
3. Waiver agencies are allocated additional slots based upon the following factors (in no particular order of importance):
   a. Each waiver agency's previous percentage of the statewide allocation
   b. The number of participants currently enrolled at the waiver agency
   c. The number of individuals on the waiting list in a provider service area relative to the number of waiver participants in the provider service area
   d. The number of unused slots in the previous fiscal year for each waiver agency
   e. The average number of days individuals are on the waiting list for each provider service area (i.e. wait time)

MDHHS uses an algorithm for reallocating slots each fiscal year. The algorithm accounts for the available funding, the current number of slots filled (i.e. carry over from one fiscal year to the next), each waiver agency's capacity to fill slots, the number of individuals on the waiting list, and the average length of time on the waiting list before enrollment. Agencies that have used previously allocated slots and have a high number of individuals on the waiting list, and a longer wait time are allocated more slots each year than other agencies.

(c) There is currently no excess capacity in any of the waiver agencies. MDHHS may not use all requested slots per year, but it does deplete allocated program funding each fiscal year. The Michigan Legislature allocates a specific amount of funding each year for the MI Choice program. MDHHS can only allocate slots up to the amount determined to deplete that funding. There is a waiting list for MI Choice services.

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

All applicants for MI Choice must meet nursing facility level of care requirements as determined by a qualified professional through an evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). After this evaluation, MDHHS requires that individuals receive information on all programs for which they qualify. Individuals then indicate the program of their choice and document the receipt of information regarding their options by completing the Michigan Freedom of Choice form. This form must be signed and dated by the applicant seeking services or their legal representative, indicate the individual chooses to receive services through the MI Choice program, and is maintained in the applicant's case record.

When the number of program participants receiving and applying for MI Choice services exceeds program capacity, a procedure is implemented giving priority in descending order to the following groups for enrollment in the program:

1. Young adults who are no longer eligible for State Plan Private Duty Nursing Services because of age restrictions on this benefit who continue to demonstrate a need for Private Duty Nursing services;

2. Nursing facility residents who meet program requirements, and express a desire to return to a home and community based setting;

3. Qualified applicants diverted from an imminent nursing facility admission including any applicant with an active Adult Protective Services (APS) case who qualifies for and could benefit from MI Choice services;

4. All other qualified applicants in chronological order by date of inquiry.

Category 1 has the highest priority and individuals on the waiting list in this category are enrolled first. Then, applicants in Category 2 followed by applicants in Category 3 followed by applicants in Category 4 are enrolled. Within each category applicants are prioritized in chronological order by date of inquiry. However, because of unique circumstances pertaining to each applicant, actual enrollment may vary from the waiting list ranking of an individual. For instance, some applicants in category 2 may need to wait to enroll in MI Choice until they secure affordable housing. This would not prevent an applicant who was lower on the waiting list and ready to enroll from doing so, as long as there are slots available. All waiting list priority categories are established and further defined in state Medicaid policy.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☒ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☒ **Aged and disabled individuals who have income at:**

Select one:

◉ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

  Specify the entity:

  Waiver agency

- ○ **Other**

  Specify:

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

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

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

Enrollment into the MI Choice waiver requires the applicant to meet the State Medicaid Agency's specified medical/functional eligibility criteria for nursing facility level of care within a seven (7) and fourteen (14) calendar day look-back period, using the Nursing Facility Level of Care Determination (LOCD) Tool. Waiver agencies conduct the evaluations, but the State provides the final approval or denial for all LOCDs. Nursing facility level of care criteria consists of seven medical/functional domains that are outlined in the LOCD Tool. These domains, or doors, are: Door 1: Activities of Daily Living, Door 2: Cognitive Performance, Door 3: Physician Involvement, Door 4: Treatments and Conditions, Door 5: Skilled Rehabilitation Therapies, Door 6: Behavioral Challenges, Door 7: Service Dependency, and Door 8: Frailty Criteria. The applicant must meet, and continue to meet, the LOCD criteria on an on-going basis to remain eligible for the program. The online LOCD is completed every 365 days for each participant, unless the participant has a significant change of condition which may change their current eligibility status. The online NFLOC/LOCD system determines whether the applicant/participant meets or does not meet level of care.

Door 1 - Activities of Daily Living (ADL) Dependency

Self-ability in (A) Bed (sleeping surface) Mobility, (B) Transfers, and (C) Toilet Use in the last seven (7) calendar days from the date the LOCD was conducted online:

Independent or Supervision = 1
Limited Assistance = 3
Extensive Assistance or Total Dependence = 4
Activity Did Not Occur during the entire 7-day period regardless of ability (applicant was not mobile, did not transfer, did not toilet) = 8

Self-ability in (D) Eating in the last seven calendar days from the date the LOCD was conducted online:

Independent or Supervision = 1
Limited Assistance = 2
Extensive Assistance or Total Dependence = 3
Activity Did Not Occur during the entire 7-day period regardless of ability (applicant did not eat) = 8

Door 1 Eligibility Requirement: The applicant must score at least six points in Door 1 to qualify.

Door 2 - Cognitive Performance

The Cognitive Performance Scale is used to identify cognitive difficulties with short-term memory and daily decision-making.
A. Short Term Memory: determine the applicant's functional capacity to remember recent events (i.e., short term memory).

Memory Okay is selected when applicant appears to recall after five (5) minutes.
Memory Problem is selected when the applicant does not recall after five (5) minutes.

B. Cognitive Skills for Daily Decision Making. Review events of the last seven (7) calendar days from the date the LOCD was conducted online and score how the applicant made decisions regarding tasks of daily life.

Independent: decisions were consistent, reasonable; applicant organized daily routine consistently and reasonably in an organized fashion.
Modified Independent: applicant organized daily routines, made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations.
Moderately Impaired: applicant's decisions were poor, required reminders, cues and supervision in planning, organizing and correcting daily routines.
Severely Impaired: applicant's decision-making was severely impaired;
Applicant never or rarely made decisions.

C. Making Self Understood. Within the last seven (7) calendar days from the date the LOCD was conducted online, document the applicant's ability to express or communicate requests, needs, opinions, urgent problems and social

conversation.

Understood: applicant expresses ideas clearly and without difficulty.
Usually Understood: applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses; little or no prompting is required.
Sometimes Understood: applicant has limited ability, but is able to express concrete requests regarding basic needs (food, drink, sleep, toilet).
Rarely/Never Understood: at best, understanding is limited to interpretation of highly individual, applicant-specific sounds or body language.

Door 2 Eligibility Requirement: The applicant must score under one of the following three options:

1. ‘Severely Impaired‘ in Decision Making.
2. ‘Yes’ for Memory Problem, and Decision Making is ‘Moderately Impaired’ or ‘Severely Impaired.’
3. ‘Yes’ for Memory Problem, and Making Self Understood is ‘Sometimes Understood’ or ‘Rarely/Never Understood.’

Door 3 - Physician Involvement

The number of days in which the physician or authorized assistant/practitioner examined the applicant or changed orders in the last fourteen (14) calendar days from the date the LOCD was conducted online.

A. Physician Visits/Exams: in the last 14 calendar days, count the number of days the applicant was examined. For example, if three physicians examined the applicant on the same day over the last 14 calendar days, count that as one exam. Do not count emergency room examinations. Do not count visits/exams made while the applicant was hospitalized. Do not count examinations prior to the last 14 calendar days.
B. Physician Orders: in the last 14 calendar days, count the number of days the physician changed the applicant’s orders. For example, if three physicians changed orders on the same day over the last 14 calendar days, count that as one order change. Do not count drug or treatment order renewals without change. Do not count sliding-scale order changes. Do not count emergency room orders. Do not count orders prior to the last 14 calendar days.

Door 3 Eligibility Requirement:

1. Over the last 14 calendar days, at least one day in which the Physician visited and examined the applicant AND at least four days in which the Physician changed orders, OR
2. Over the last 14 calendar days, at least two days in which the Physician visited and examined the applicant AND at least two days in which the Physician changed orders.

Door 4 - Treatments and Conditions

Nine Treatments/Conditions require a physician-documented diagnosis in the medical record. The treatments/conditions must be evidenced within the last fourteen (14) calendar days from the date the LOCD was conducted online. Applicants will no longer qualify under the treatment/condition once it has been resolved OR no longer affects functioning OR no longer requires the need for care. Applicants who are determined eligible require ongoing assessment and follow-up monitoring. Care planning and the focus for treatment for these applicants must involve active restorative nursing and discharge planning.

Treatment/Condition: Stage 3-4 pressure sores; Intravenous or Parenteral Feedings; Intravenous Medications, End-stage care; Daily Tracheostomy care, Daily Respiratory care, Daily Suctioning; Pneumonia within the last 14 days; Daily Oxygen Therapy (not Per Resident Need); Daily insulin with two order changes in last 14 days; Peritoneal or Hemodialysis.

Door 4 Eligibility Requirement: The applicant must score ‘Yes’ in at least one of the nine categories AND have a continuing need.

Door 5 - Skilled Rehabilitation Therapies

Skilled rehabilitation interventions is based on ordered AND scheduled therapy services within the last seven (7) calendar days from the date the LOCD was conducted online.

A. Speech Therapy in the last seven (7) calendar days
B. Occupational Therapy in the last seven (7) calendar days
C. Physical Therapy in the last seven (7) calendar days

Minutes: record the total minutes speech, occupational and physical therapy was administered for at least 15 minutes a day. Do not include evaluation minutes. Zero minutes are recorded if less than 15.
Scheduled Therapies: record the estimated total number of speech, occupational and physical therapy minutes the applicant was scheduled for, but did not receive. Do not include evaluation minutes in the estimation. Zero minutes are recorded if less than 15.

Door 5 Eligibility Requirements: The applicant must have required at least 45 minutes of active speech therapy, occupational therapy, or physical therapy (scheduled or delivered) in the last seven (7) calendar days AND continue to require skilled rehabilitation therapies to qualify.

Door 6 – Behavior

The repetitive display of behavioral challenges, OR the experience of delusions or hallucinations, both of which are supported by the Preadmission Screen Annual Resident Review (PASARR) requirement for nursing facility admission if the applicant chooses a residential setting for care, that impact the applicant's ability to live independently in the community and are identified in Door 6. Behavioral challenges, hallucinations and delusions must have occurred within seven (7) calendar days prior to the date the LOCD was conducted online. The challenging behaviors are:

1. Wandering: moving about with no discernible, rational purpose; oblivious to physical or safety needs.
2. Verbal Abuse: threatening, screaming at or cursing at others.
3. Physical Abuse: hitting, shoving, scratching or sexually abusing others.
4. Socially Inappropriate/Disruptive: disruptive sounds, noisiness, screaming, performing self-abusive acts, inappropriate sexual behavior or disrobing in public, smearing or throwing food or feces, or hoarding or rummaging through others' belongings.
5. Resists Care: verbal or physical resistance of care (i.e., physically refusing care, pushing caregiver away, scratching caregiver). This category does not include the applicants informed choice to not follow a course of care or the right to refuse treatment; do not include episodes where the applicant reacts negatively as others try to re-institute treatment that the applicant has the right to refuse.

Door 6 Eligibility Requirement: The applicant must have exhibited any one of the above behavioral symptoms in at least four of the last seven (7) calendar days (including daily) from the date the LOCD was conducted online OR the applicant exhibited delusional thinking or clearly demonstrated having experienced hallucinations within seven (7) calendar days from the date the LOCD was conducted online AND met the PASARR requirement for nursing facility admission if they choose a residential setting of care.

Door 7 - Service Dependency

Service dependency applies to current beneficiaries only who are enrolled in and receiving services from a Medicaid-certified nursing facility, MI Choice program or the Program of All Inclusive Care for the Elderly (PACE). All three of the following criteria must be met to demonstrate service dependency:

1. Applicant has been served by a Medicaid reimbursed nursing facility, MI Choice or PACE for at least one year; consecutive time across the programs (no break in service) may be combined
AND
2. Applicant requires ongoing services to maintain current functional status
AND
3. No other community, residential or informal services are available to meet the applicant's needs (only the current

provider can provide those services/needs)

Door 7 Eligibility Requirement: The applicant must meet all three of the above criteria to be determined service dependent.

Door 8: Frailty Criteria, must meet one of the criteria for eligibility.
Frailty: 6 criteria
1. performs late loss ADLs independently but requires unreasonable amount of time
2. performance in activities impacted by shortness of breath, pain or weakness
3. at least two falls in the past month
4. difficulty managing medications
5. poor nutrition despite meal preparation services
6. ER visits for unstable conditions

Behaviors:
1. wandering
2. verbal/physical abuse
3. socially inappropriate behavior
4. resists care

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

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

An LOCD must be conducted according to MDHHS policy prior to MI Choice enrollment for every MI Choice participant. The LOCD must be entered in the online system no more than fourteen (14) calendar days from the MI Choice enrollment date. The LOCD may be entered at any time prior to enrollment as long as it remains valid upon enrollment. A valid LOCD is an LOCD that has been entered into the NFLOC/LOCD system and demonstrates the individual meets the nursing facility level of care. Annual LOCD reevaluations are conducted by qualified individuals according to MDHHS policy and are entered into the State's online NFLOC/LOCD system. The LOCD is required to be conducted every 365 days or sooner if there is a significant change in condition. The online NFLOC/LOCD system determines whether the applicant/participant meets or does not meet nursing facility level of care.

The criteria is the same for evaluations and reevaluations.

The LOCD assessment is comprised of several different “doors” which are different medical/functional conditions or categories through which an individual may meet LOCD. Waiver agencies are responsible for conducting the assessments and gathering the appropriate information to support the Door through which they think the individual may meet. The criteria are selected in the CHAMPS LOCD system, and CHAMPS makes the level of care determination. A random sample of the records in CHAMPS is pulled for MDHHS review, at which time the waiver agency that conducted the assessment must submit supporting documentation to MDHHS for review and approval.

MDHHS uses a two-tiered quality assurance strategy to verify the quality of all level of care determinations conducted within the state. The first tier is a statewide process used for nursing facilities, MI Health Link, PACE, and MI Choice. MDHHS requires ALL nursing facility level of care determinations conducted for individuals who are either applying or currently served by a long-term care program to be put in a secure web-based system that is located within the Community Health Automated Medicaid Payments System (CHAMPS), Michigan’s Medicaid Management Information System. Licensed, qualified health professionals conduct the nursing facility level of care determination using the statewide tool (available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-103102--,00.html) and input their findings into the software application within CHAMPS. CHAMPS then runs the data through the nursing facility level of care algorithm to determine whether an individual meets the nursing facility level of care.

The quality assurance for this first tier is to randomly select at least 400 records that meet the nursing facility level of care and 400 records that do not meet the nursing facility level of care for additional review. MDHHS contracts with the Michigan Peer Review Organization (MPRO) to conduct reviews of the selected records to verify the level of care determination was properly conducted by the health professional.

Because the number of level of care determinations that are conducted per year will vary, MDHHS applied the following formula for determining a statistically significant sample size of an unknown population:
Necessary Sample Size = (Z-score)2 * StdDev*(1-StdDev) / (margin of error)2
Where: Margin of Error equals 95%
Z-score equals 1.96 (95% confidence)
Standard Deviation (StdDev) equals .5
((1.96)2 * .5(.5)) / (.05)2 = 384.16, or 385 if rounding up.

Therefore, the minimum number of cases that should be reviewed on ALL level of care determinations statewide only needs to be 385. MDHHS rounded that number up to 400 to assure the sample size remains statistically significant. Additionally, because of the adverse effects to the beneficiary of improperly determining that they do not meet the nursing facility level of care, MDHHS felt it important to assure that we are reviewing a statistically significant sample of both eligible and non-eligible determinations. Therefore, MDHHS will be reviewing at least 800 level of care determinations each year, 400 that meet level of care criteria, and 400 that do not meet level of care criteria.

For this first tier of quality assurance, MDHHS uses the simple random sampling technique. This technique is needed for several reasons. First, the nursing facility level of care determination is required to be completed BEFORE the individual is enrolled in a HCBS program. Second, individuals often require this determination BEFORE they can become eligible for Medicaid-funded LTSS. Lastly, individuals commonly transfer between HCBS programs and nursing facilities. Therefore, stratification of this sample based upon the program utilized by the individual at the time of the determination is impossible.

The second tier of quality assurance for the MI Choice program is the Clinical Quality Assurance Review (CQAR) process. This process randomly selects a statistically significant sample of MI Choice case records to review. The

population includes participants who have been enrolled in MI Choice for at least 90 days in the review year. The process for making this selection is to use an online sample size calculator, using 95% confidence level and a standard deviation of .5. Once the sample size is determined, the EQRO uses the probability proportional to size (PPS) sampling method to determine the number of records to review at each waiver agency. This is employed by determining the percentage of the MI Choice population served by each waiver agency, then applying that percentage to the number of records required for a statistically significant result. For example, if the total number of records to review was 300, and an agency served 10% of the total statewide participants, that agency would have 30 records reviewed. The only exception to this methodology is that the EQRO selects a minimum of 10 records to review at each waiver agency. The specific records reviewed for each agency are randomly selected using the systemic sampling method.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

A reevaluation is required every 365 days or with significant change in condition.

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

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

Specify the qualifications:

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

The state requires supports coordinators to reevaluate each MI Choice participant's level of care at each in-person reassessment visit. The supports coordinators document that the participant continues to meet the nursing facility level of care within the case record, usually specifying the appropriate "door" through which the participant meets level of care criteria. Reassessments are conducted in person 90 days after the initial assessment, with a reassessment annually, or upon a significant change in the participant's condition. Supports coordinators track reassessment dates within the waiver agencies' information systems. When a supports coordinator suspects the participant no longer meets the nursing facility level of care, the supports coordinator conducts a new LOCD and enters the information in the State's NFLOC/LOCD system, which makes the level of care eligibility determination. When the system confirms the participant no longer meets nursing facility level of care, the supports coordinator initiates program discharge procedures and provides the participant with the adverse benefit determination and information on appeal rights.

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

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

The NFLOC/LOCD system maintains all level of care determinations for a minimum of seven years. Waiver agency case records must confirm participants continue to meet LOCD criteria during MI Choice enrollments. This may be accomplished by verifying online LOCD records for participants, maintaining paper copies of LOCDs for participants, or identifying assessment data that supports LOCD eligibility within the record.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment. Numerator: Number of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment. Denominator: All new MI Choice waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of level of care determinations made by a qualified evaluator.
Numerator: Number of level of care determinations made by a qualified evaluator.
Denominator: All level of care determination files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

EQRO		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied. Numerator: Number of participants who had level of care initial determinations where the level of care criteria was accurately applied. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
EQRO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of MI Choice disenrollments based upon no longer meeting LOCD criteria that were determined correctly. Numerator: MI Choice Disenrollments based on the enrollee no longer meeting LOCD criteria that were determined correctly Denominator: All MI Choice disenrollments based on the enrollee no longer meeting the LOCD criteria

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOCD data in CHAMPS for MI Choice enrollees

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

1) MDHHS contacts with an EQRO that employs qualified reviewers to conduct case record reviews on a sample of cases to compare level of care determinations (LOCDs) with actual assessments. Qualified reviewers analyze findings and verify that enrolled participants are eligible, LOCD items match comparable assessment responses, and supports coordinators reevaluate enrollees at least annually. The EQRO compiles results into the final written review report provided to the waiver agency. When qualified reviewers identify non-compliance, immediate remediation is required and pursued. Additionally, qualified reviewers may provide instructions for assuring compliance on-site and MDHHS staff provides training as needed. MDHHS disseminates and discusses final review results at the Quality Management Collaboration that meets quarterly, and at monthly Waiver Directors' meetings.

2) MDHHS or its designee conducts retrospective reviews monthly and as requested to validate the accuracy of the LOCDs completed by waiver agencies. The waiver agency must submit all supporting documentation requested by MDHHS or its designee.

3) MDHHS uses an edit process within the Medicaid Management Information System (CHAMPS) to prohibit generation of a capitation payment for participants who do not have a valid LOCD.

4) MDHHS reviews LOCD appeal and decision summaries regularly, provides technical assistance and training, and initiates corrective actions as needed.

5) MDHHS policy requires each waiver agency to use the established LOCD process and forms. Waiver agencies have first line responsibility for ensuring on a continual basis that supports coordinators determine participants eligible by using this process and MDHHS requires them to monitor determinations for errors and omissions. MDHHS requires the waiver agencies to have written procedures that follow MDHHS policy. As part of the retrospective review process, MDHHS or its designee ensures that the waiver agency uses the LOCD process and instruments described in the waiver application to determine level of care.

6) The new strategy for reviewing LOCDs will be in addition to the existing quality assurance and monitoring efforts. It provides additional program integrity. The statistically significant random sample for the new LOCD review process will be a different sample from that pulled for the clinical quality assurance review conducted by the EQRO for the existing quality assurance process, though some cases may overlap based on the nature of a random sample.

7) As part of the clinical quality assurance review conducted by the EQRO, a statistically significant random sample of MI Choice participants is reviewed for accuracy of the LOCDs conducted and whether the individual meets ongoing program eligibility. The LOCD record is compared to other clinical documentation such as assessments, physician orders, etc., in the participant’s record to ensure the information is consistent. Please see attached document (within the response for Request for Additional Information) for review protocol standards. There is also the new process for LOCDs in addition to the performance measure listed in this section. The MDHHS designee will review a statistically significant random sample of all LOCDs entered into the CHAMPS MMIS system for all LTSS programs including nursing facilities, MI Choice Waiver, PACE, and MI Health Link HCBS Waiver. The random sample calculator website by Raosoft is used to determine an appropriate statistically significant random sample. For the review, providers will submit documentation supporting the criteria they entered in CHAMPS from which CHAMPS made the level of care determination.

b. Methods for Remediation/Fixing Individual Problems

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

During reviews conducted to validate the LOCD, if an applicant is found to be ineligible for the nursing facility level of care, the waiver agency must help the participant find alternative services in the community. Then the participant must be disenrolled from the MI Choice program and given their appeals rights. MDHHS will recover all Medicaid capitation payments made during the period of ineligibility. LOCDs resulting from such reviews may be appealed by the waiver agency through procedures established by MDHHS.

If during the CQAR, any waiver participant is found to not have an eligibility redetermination within 12 months of the participant's last evaluation, the waiver agency must conduct a level of care evaluation within two weeks of notification of finding, if one has not already been conducted.

During the LOCD review or the CQAR, if any LOCDs were incorrectly applied, the waiver agency must conduct a new LOCD within two weeks of notification of the finding. If the participant originally was found ineligible for the waiver program, but the LOCD finds the participant eligible, the participant must be enrolled with the program as soon as possible. If the LOCD was done incorrectly but eligibility does not change, the waiver agency must conduct a new NFLOC review of the participant with supervisory oversight.

If during the CQAR, any level of care determinations are found to be conducted by someone unqualified, the waiver agency must conduct a new LOCD by someone who is a qualified evaluator. If a new LOCD is performed by a qualified evaluator and an applicant is found to be ineligible for MI Choice, MDHHS must disenroll the participant from the program, offer them appeal rights, and recover all Medicaid capitation payments made during the period of ineligibility.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: waiver agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any individual applying for Medicaid long term care services, including nursing facility services, MI Choice, MI Health Link HCBS Waiver, or PACE must meet functional eligibility through the Michigan Medicaid Nursing Facility Level of Care. Once an applicant has qualified for services under the nursing facility level of care criteria, the applicant must be informed of benefit options and elect, in writing, to receive services in a specific program. This election must take place before initiating Medicaid funded long term care services in the specified program.

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

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

Applicants must indicate their choice of program in writing by signing the Freedom of Choice (FOC) form. A completed copy of this form must be retained for a period of seven years. The completed form must be kept in the case record if the participant chooses MI Choice. The FOC form must also be witnessed by an applicants representative when available. MDHHS ensures that waiver agencies inform participants of long term care choice through the review of LOCDs, which is performed by a peer review organization contracted with MDHHS and the CQAR process. The peer review organization and qualified reviewers verify that waiver agencies have signed FOC forms in the participants records indicating that choice has been offered and discussed.

The waiver agency is responsible for providing the information about various program options to the individuals. There is a Freedom of Choice form the individual signs indicating information about various programs was provided and he/she chose MI Choice.

The waiver agency is responsible for providing the information about various program options to the individuals. There is a Freedom of Choice form the individual signs indicating information about various programs was provided and he/she chose MI Choice.

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

The FOC form must be signed and dated by the applicant (or their legal representative) seeking services, indicate the participant's preference for the MI Choice program, completed according to established policies and procedures, and must be maintained in the applicant's case record.

Appendix B: Participant Access and Eligibility

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

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

Waiver agencies are required to provide language and culturally sensitive information to all applicants for MI Choice. Depending on the local community, brochures are printed in Spanish, French, Arabic, Polish, and Chinese. In meeting with individual waiver applicants or participants, waiver agencies may employ bilingual staff, or use translation services. The MI Choice Participant Handbook is available on the MDHHS website in English, Spanish, and Russian.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Respite**		
Statutory Service	**Supports Coordination**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Supports for Participant Direction	**Fiscal Intermediary**		
Supports for Participant Direction	**Goods and Services**		
Other Service	**Chore Services**		
Other Service	**Community Health Worker**		
Other Service	**Community Living Supports**		
Other Service	**Community Transition Services (termination effective 7/1/2019)**		
Other Service	**Community Transportation**		
Other Service	**Counseling**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Nursing Services**		
Other Service	**Personal Emergency Response System**		
Other Service	**Private Duty Nursing/Respiratory Care**		
Other Service	**Training**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services must not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health Centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation, or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health Center separately.

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

Participants cannot receive Community Living Supports while at the Adult Day Health facility. Payment for Adult Day Health Services includes all services provided while at the facility. Community Living Supports may be used in conjunction with Adult Day Health services, but cannot be provided at the exact same time.

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

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

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

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

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

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

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

6. Each day health center must have the following furnishings:

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

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

7. Each day health center must document that it is in compliance with:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. Services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, a licensed Adult Foster Care or Home for the Aged facility, a Medicaid-certified nursing facility, or another State approved facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence.

Services include:

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

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

There is a 30-days-per-calendar-year-limit on respite services provided outside the home. The costs of room and board are not included except when respite is provided in a facility approved by the State that is not a private residence. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Agency	Long Term Care Facility
Individual	Individuals chosen by the participant who meet the qualification standards

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Home Care Agency

Provider Qualifications
License *(specify):*

Respite services provided in licensed care settings must meet the standards set forth in MCL 333.21511.

Certificate *(specify):*

N/A

Other Standard *(specify):*

When providing care in the home of the participant:

1. When Chore or Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

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

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

b. Verification of prescription medications and their dosages.

c. Instructions for entering medication information in participant files.

d. A clear statement of the participants and participants familys responsibility regarding medications taken by the participant and the provision for informing the participant and the participants family of the providers procedures and responsibilities regarding assisted self administration of medications.

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

When providing respite in a licensed setting:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Long Term Care Facility

Provider Qualifications
License *(specify):*

Nursing facilities: sections 2226(d), 2233, 20115, 20145, 20171, 21741, and 21795 of 1978 PA 368, MCL 333.2226(d), 333.2233, 333.20115, 333.20145, 333.20171, 333.21741, and 333.21795; section 9 of 1965 PA 380, MCL 16.109.

Administrative Rules 325.20101-325-22004.

Certificate *(specify):*

Must meet any applicable federal laws or rules for certification and/or licensure.

Other Standard *(specify):*

Other State-approved facilities that meet specific needs of Waiver enrollees.

Verification of Provider Qualifications
Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. When Chore or Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Supports Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's person-centered service plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.

Functions performed by a supports coordinator include the following:

1. Conducting the initial and subsequent Nursing Facility Level of Care Determinations per state policy.
2. Conducting the initial assessment and periodic reassessments.
3. Facilitating a person-centered planning process that is focused on the participant's preferences , includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports.
4. Developing a service plan using the person-centered planning process, including revisions to the service plan at the participant's initiation or as changes in the participant's circumstances may warrant.
5. Referral to and coordination with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.
6. Monitoring of MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
7. Providing social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.
8. Providing advocacy in support of the participant's access to benefits, assuring the participant's rights as a program beneficiary, and supporting the participant's decisions.
9. Maintaining documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other relevant policies, and meet the performance requirements delineated in the waiver agency's contract with the Michigan Department of Health and Human Services (MDHHS).

Communication is a required intervention and must be incorporated into the person-centered service plan.

Additional guidance for Supports Coordination can be found in the contract between MDHHS and MI Choice waiver agencies.

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

Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supports Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:

Agency

Provider Type:

Supports Coordinator

Provider Qualifications

License *(specify):*

MCL 133.18501 ... 333.18518 (Social Work), MCL 133.17201 ... 333.17242 (Registered Nurse)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements as specified in the MI Choice contract. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. Qualified staff includes a Registered Nurse (RN) and a Social Worker (SW), both with valid Michigan licenses to practice their profession as defined in the MI Choice contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies waiver agency qualifications. The waiver agency is responsible for assuring its employees and contracted providers meet provider qualifications for the service being delivered as specified in the MI Choice contract.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items.

This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's person-centered service plan.

All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items that are not of direct medical or remedial benefit to the participant.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid or Medicare DME Provider
Agency	Retail Stores

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Enrolled Medicaid or Medicare DME Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Items purchased from retail stores must meet the Specialized Medical Equipment and Supplies service definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Fiscal Intermediary

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's plan of service, controlling a participant's budget, and choosing staff authorized by the waiver agency. The fiscal intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's plan of service. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures, and assuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history reviews, and assisting the participant to understand billing and documentation requirements.

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

Fiscal Intermediary services are available only to participants choosing the self-determination option.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Intermediary Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:

Fiscal Intermediary Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Provider must be bonded and insured.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to execution and annual renewal of contract.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Goods and Services are services, equipment or supplies not otherwise provided through either MI Choice or the Medicaid State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would:

Decrease the need for other Medicaid services,
Promote inclusion in the community, and
Increase the participant's safety in the home environment.

These goods and services are only available if the participant does not have the funds to purchase the item or service and it is not available through another source.

Goods and Services are only approved by CMS for self-direction participants. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Stores
Individual	Contract Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Items purchased from retail stores must meet the Goods and Services definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Contract Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The service or item must be designed to meet the participant's functional, medical or social needs and advances the desired outcomes in the individual plan of service.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to contract execution.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third
party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Individuals chosen by the participant who meet the qualification standards

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/a

Other Standard *(specify):*

1. Only properly licensed suppliers may provide pest control services.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal history review conducted by the waiver agency.

2. Previous relevant experience and training to meet MDHHS operating standards.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:

Community Health Worker

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The Community Health Worker (CHW) works with individuals who are re-enrolling in the MI Choice Waiver, or are enrolled in the MI Choice waiver after nursing facility or hospital discharge. The CHW visits the participant at home within 3 days of hospital or facility discharge to review the discharge paperwork and any other documentation, reviews any medications received or orders that need to be filled, reminds the participant of the importance of filling the medications, and talks with the participant about the importance of following up with the physician. If needed, the CHW may make calls for medication to be filled, or to arrange for the follow-up appointment with the physician. The CHW also trains the participant about anything to be aware of and what to do if his/her condition worsens. The CHW does another follow-up visit in 30 days to determine if the participant did follow up with the physician, take the prescribed medications, and follow any other discharge recommendations.

The CHW must thoroughly document what was discussed and discovered during the contacts with the participant so the Supports Coordinator is aware of what occurred. If there are medication discrepancies, the CHW will follow up with the RN Supports Coordinator to get those issues addressed.

The CHW may also visit the individual in the hospital or nursing facility to ensure the hospital or nursing facility knows who to contact to coordinate the discharge home. The CHW ensures the hospital or nursing facility staff has the contact of the Supports Coordinator with whom the discharge should be coordinated.

If the Supports Coordinator wishes, the CHW will be in contact with the nursing facility if a participant goes from a hospital to a nursing facility for temporary rehab before returning to the Waiver. The CHW may assist with coordinating any supplies, services, etc., the participant requires at home after rehab.

The CHW service is not limited to nursing facility or hospital transitions. The service is applicable to any participant who needs it.

The CHW may also perform the duties of a supports broker. They may provide assistance throughout the planning and implementation of the service plan and individual budget (as applicable), assist the participant in making informed decisions about what works best for the participant, assist the participant to explore the availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports. CHW services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting, hiring and managing workers, effective communication skills, and problem solving.

The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist the participants with completion of applications for programs for which they may be eligible.

Community Health Workers must work in close collaboration with the participant's Supports Coordinator as the Supports Coordinator has ultimate responsibility for the participant's case.

Most of the functions of the Community Health Worker (CHW) are separate, but may seem similar. The waiver agency must ensure there is no duplication. If medication administration is provided by the CHW, it shouldn't be provided in the same way at the same time by the Community Living Supports provider. Similarly, some functions may seem similar between the CHW and Supports Coordinator, but if the CHW is performing the duty, the supports coordinator would just be coordinating with the CHW to ensure things are done for the participant and would not duplicate the work of the CHW.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organization or Entity Other Than an Individual Provider
Individual	Individuals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Health Worker

Provider Category:

Agency

Provider Type:

Organization or Entity Other Than an Individual Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Trained in duties of the job.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Health Worker

Provider Category:

Individual

Provider Type:

Individuals

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Unlicensed, but trained in the duties of the job

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08050 homemaker
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it must not also be authorized as a separate waiver service for the beneficiary.
Community Living Supports includes:

1. Assisting, reminding, cueing, observing, guiding and/or training in household activities, activities of daily living or routine household care and maintenance.
2. Reminding, cueing, observing and/or monitoring of medication administration.
3. Assistance, support and/or guidance with such activities as:
a. non-medical care (not requiring nurse or physician intervention) - assistance with eating, bathing, dressing, personal hygiene, and activities of daily living;
b. meal preparation, but does not include the cost of the meals themselves;
c. money management;
d. shopping for food and other necessities of daily living;
e. social participation, relationship maintenance and building community connections to reduce personal isolation;
f. training and/or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work;
g. transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence;
h. routine household cleaning and maintenance;
4. Dementia care, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan;
5. Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
6. Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.

These service needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from any services in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

Community Living Support services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals chosen by the participant who meet the qualification standards
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Individual
Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

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

3. Previous relevant experience and training to meet MDHHS operating standards. Refer to the MI Choice contract for more details.

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

5. Trained in how to perform ventilator CPR, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Workers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal history review.

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services (termination effective 7/1/2019)

HCBS Taxonomy:

Category 1: 16 Community Transition Services

Sub-Category 1: 16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

This service will be terminated effective 7/1/2019.

Community Transition Services (CTS)) are non-recurrent expenses for participants transitioning from a nursing facility to a community setting. Allowable transition costs include the following:

- Housing or security deposits: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are not included).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are not included).
- Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of participant to a community setting.
- Other: Services deemed necessary and documented within the participant's plan of service to accomplish the transition into a community setting. Costs for Community Transition Services are billable upon enrollment into the MI Choice program.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

Community Transition Services do not include monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional and recreational purposes. Additional limitations on the amount, frequency, or duration of services are identified in the contract between the PAHP and MDHHS.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Agency
Agency	Retail Stores
Agency	Center for Independent Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (termination effective 7/1/2019)

Provider Category:
Agency
Provider Type:

Waiver Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The waiver agency or contracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the waiver agencies.
Verification of Provider Qualifications
Entity Responsible for Verification:

The contracting waiver agency.
Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (termination effective 7/1/2019)

Provider Category:
Agency
Provider Type:

Retail Stores
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Items purchased from retail stores must meet the Community Transition Services definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (termination effective 7/1/2019)

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The contracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the waiver agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transportation (CT) services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual plan of services.

The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants.

Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT services through the MI Choice program.

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

Waiver agencies must not use this service to authorize MI Choice funds to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver of the vehicle. The purpose of Community Transportation is for the participant to gain access to the community.

Whenever possible, family, neighbors, friends, or community agencies who can provide transportation services without charge must be utilized before MI Choice provides transportation services.

When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or Community Living Supports), there must be mechanisms to prevent duplicative billing for transportation.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The vehicle owner must have automobile insurance required by Michigan Law.

2. All drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. Drivers must also be physically capable and willing to provide assistance to get from the pick-up location to the vehicle and from the vehicle to the drop-off location.

3. Each driver and passenger must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Contracted provider

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must have vehicle insurance required by Michigan Law.

2. All drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. Drivers must also be physically capable and willing to provide assistance to get from the pick-up location to the vehicle and from the vehicle to the drop-off location. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

3. The provider shall train all drivers to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4. Each driver and passenger must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.

Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral health needs.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant’s preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Counselor
Individual	Psychologist

Provider Category	Provider Type Title
Individual	Social Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Individual
Provider Type:

Counselor

Provider Qualifications

License *(specify):*

MCL 333.18101 ... 333.18117

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in social work, psychology, psychiatric nursing, or counseling or

b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Individual
Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

MCL 333.18201 ... 333.18237

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in social work, psychology, psychiatric nursing, or counseling or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

MCL 333.18501 ... 333.18518

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in social work, psychology, psychiatric nursing, or counseling or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

MI Choice Environmental Accessibility Adaptations Service Definition:

Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's plan of service that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include:

- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Modification of kitchen facilities;
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and
- Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service.

The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing.

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

The PAHP must assure there is a signed contract or bid proposal with the builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the PAHP to work with the participant and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. All services must be provided in accordance with applicable state or local building codes.

The existing structure must have the capability to accept and support the proposed changes.

The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The participant, with the direct assistance of the PAHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. The participant's record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MI Choice waiver is a funding source of last resort.

Adaptations may be made to rental properties when the lease or rental agreement does not indicate the landowner is responsible for such adaptations, and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the PAHP must specify any requirements for restoration of the property to its original condition if the occupant moves.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

Excluded are those adaptations or improvements to the home that:

- Are of general utility;
- Are considered to be standard housing obligations of the participant or homeowner; and
- Are not of direct medical or remedial benefit.

Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

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

The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations must exclude costs for improvements exclusively required to meet local building codes.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contracted Provider
Agency	Retail Stores
Agency	Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:

Contracted Provider

Provider Qualifications

License *(specify):*

MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to service execution.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Items purchased from retail stores must meet the Environmental Accessibility Adaptation service definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contracted provider

Provider Qualifications

License *(specify):*

MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2404(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to contract execution.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the participant's service plan. A Home Delivered Meal cannot constitute a full nutritional regimen.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

The meals authorized under this service must not constitute a full nutritional regimen.

Limitations on who can get a meal:

a. The participant must be unable to obtain food or prepare complete meals.
b. The participant does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
c. The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.
d. The provider can appropriately meet the participant's special dietary needs and the meals available would not jeopardize the health of the individual.
e. The participant must be able to feed himself/herself.
f. The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meal Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meal Provider

Provider Qualifications

License *(specify):*

Health Code Standards (PA 368 of 1978)

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Each home delivered meals provider must have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

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

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

4. The provider must deliver food at safe temperatures as defined in Home Delivered Meals service standards. Meals that are delivered in a frozen state must include directions on how to reheat the meals to a safe temperature.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to the delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services must not duplicate services available through the Medicaid State Plan or third payer resources.

When the participant's condition is unstable, could easily deteriorate, or when significant changes occur, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the participant. The supports coordinator must communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

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

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

Other Services

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

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

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

This service is limited to no more than two hours per visit. Participants receiving Private Duty Nursing services are not eligible to receive MI Choice Nursing Services.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201-17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing nursing services to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agents and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

3. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

4. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided. PERS does not cover monthly telephone charges associated with phone service.

The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The participant must reside in an area where the cellular or mobile coverage is reliable. When the participant uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

PERS does not cover monthly telephone charges associated with phone service.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PERS Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing/Respiratory Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11110 respitory therapy
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Private Duty Nursing (PDN) services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's plan of service.

This service also includes Respiratory Care (RC) for participants who are ventilator dependent. The RC service includes provision of respiratory and ventilator assessment, treatment and observation by a licensed Respiratory Therapist.

To be eligible for PDN or RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's plan of service must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance.

PDN and RC for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

• Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or

• Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or

• Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

• Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or

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

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

Definitions:
• "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.

• "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

• "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

• "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

• "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.

• "Substantiated" means documented in the clinical or medical record, including the nursing notes.

Medical Criteria III – The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:
• "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.

• Equipment needs alone do not create the need for skilled nursing services.

• "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

o Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;

o Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

o Deep oral (past the tonsils) or tracheostomy suctioning;

o Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

o Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

o Total parenteral nutrition delivered via a central line and care of the central line;

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

o Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

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

• Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing/Respiratory Care (PDN/RC) services.

• Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

• The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

• PDN/RC is limited to persons aged 21 or older. PDN/RC is a Medicaid State Plan benefit for persons under the age of 21 who qualify for the service.

• It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24 hours per day, 7 days per week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDHHS.

• 24/7 PDN/RC services cannot be authorized for persons who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These persons must have informal caregivers actively involved in providing some level of direct services to the participant on a routine basis.

• All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this application.

• The participant's physician, physician's assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency, Nurse
Individual	Nurse
Individual	Respiratory Therapist
Agency	Home Care Agency, Respiratory Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:
Agency
Provider Type:

Home Care Agency, Nurse

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 - 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license. If the nurse is an LPN, they need to demonstrate how an RN provides supervision.

2. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Individual

Provider Type:

Nurse

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 - 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license. If the nurse is an LPN, they need to demonstrate how an RN provides supervision.

2. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Individual

Provider Type:

Respiratory Therapist

Provider Qualifications

License *(specify):*

State of Michigan Respiratory Therapist license under MCL 333.18701-333.18713

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All Respiratory Therapist providing Respiratory Care to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.18701-333.18713, and maintain a current State of Michigan Respiratory Therapist license.

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

3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:
Agency
Provider Type:

Home Care Agency, Respiratory Therapist

Provider Qualifications

License *(specify):*

State of Michigan Respiratory Therapist license under MCL 333.18701-333.18713

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All Respiratory Therapist providing Respiratory Care to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.18701-333.18713, and maintain a current State of Michigan Respiratory Therapist license.

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

3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist

Provider Category	Provider Type Title
Individual	Physical Therapist
Individual	Social Worker
Individual	Registered Nurse
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:

Occupational Therapist
Provider Qualifications
License *(specify):*

MCL 333.18301 ... 333.18311
Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18301 ... 333.18311 (Occupational Therapist).
Verification of Provider Qualifications
Entity Responsible for Verification:

The contracting waiver agency.
Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:

Physical Therapist
Provider Qualifications
License *(specify):*

MCL 333.17801 ... 333.17831

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

MCL 333.18501 ... 333.18518

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18501 ... 333.18518 (social work).

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Individual
Provider Type:

Registered Nurse
Provider Qualifications
License *(specify):*

MCL 333.17201 ... 333.17242
Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 133.17201 ... 333.17242 (nursing).
Verification of Provider Qualifications
Entity Responsible for Verification:

The contracting waiver agency.
Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:
Agency
Provider Type:

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

MCL 333.17201 ... MCL 333.17242 (Nursing),MCL 133.17801 ... MCL 333.17831 (Physical Therapy), MCL 333.18301 ... MCL 333.18311 (Occupational Therapists), MCL 333.18501 ... MCL 333.18518 (Social Work)
Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

Each waiver agency and direct provider of home-based services must conduct a criminal history review through the Michigan State Police for each paid or volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history reviews before authorizing the employee to furnish services in a participants home.

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

Both waiver agency and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history reviews have been conducted in compliance with operating standards.

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

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

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

Appendix C: Participant Services

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

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

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

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

Facility Type	
Home For the Aged	
Long Term Care Facility	
Adult Foster Care Home	

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

The State of Michigan licenses five types of Adult Foster Care (AFC) homes that are used in MI Choice. Capacity limit for Family Homes are 1 - 6; Small Group Homes are 1-12; Medium Group Homes are 7-12; Large Group Homes are 13-20; and Congregate Homes are larger than 21 residents. Michigan is phasing out the licensing of Congregate Homes, but existing homes continue to operate.

Homes For The Aged (HFA)are supervised personal care facilities (other than a hotel, adult foster care facility, hospital, nursing facility, or county medical care facility) that provide room, board, and supervised personal care to unrelated, nontransient individuals 60 years of age or older. Each HFA is licensed for a specific number and cannot exceed that capacity. If an HFA is connected to a nursing facility, it can only be licensed for 20 or fewer individuals. If it is not connected to a nursing facility, an HFA can be licensed for 21 or more individuals.

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

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

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

All AFCs and HFAs have full kitchens, and snacks and beverages must be available to all residents. Michigan requires that residents be allowed privacy for visitations.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home For the Aged

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Fiscal Intermediary	☒
Community Transportation	☒
Supports Coordination	☒
Goods and Services	☒
Counseling	☒
Specialized Medical Equipment and Supplies	☒
Personal Emergency Response System	☐
Community Transition Services (termination effective 7/1/2019)	☐
Home Delivered Meals	☐
Private Duty Nursing/Respiratory Care	☒
Environmental Accessibility Adaptations	☐
Community Health Worker	☐
Adult Day Health	☐
Nursing Services	☒
Respite	☒
Chore Services	☐
Training	☒
Community Living Supports	☒

Facility Capacity Limit:

100+

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒

Standard	Topic Addressed
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Long Term Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Fiscal Intermediary	☐
Community Transportation	☐
Supports Coordination	☐
Goods and Services	☐
Counseling	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Community Transition Services (termination effective 7/1/2019)	☐
Home Delivered Meals	☐
Private Duty Nursing/Respiratory Care	☐
Environmental Accessibility Adaptations	☐
Community Health Worker	☐
Adult Day Health	☐
Nursing Services	☐
Respite	☒
Chore Services	☐
Training	☐
Community Living Supports	☐

Facility Capacity Limit:

Any number of beds

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Foster Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Fiscal Intermediary	☒
Community Transportation	☒
Supports Coordination	☒
Goods and Services	☒
Counseling	☒
Specialized Medical Equipment and Supplies	☒
Personal Emergency Response System	☐
Community Transition Services (termination effective 7/1/2019)	☐

Waiver Service	Provided in Facility
Home Delivered Meals	☐
Private Duty Nursing/Respiratory Care	☒
Environmental Accessibility Adaptations	☐
Community Health Worker	☐
Adult Day Health	☐
Nursing Services	☒
Respite	☒
Chore Services	☐
Training	☒
Community Living Supports	☒

Facility Capacity Limit:

20

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

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

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

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

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

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

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

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

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

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

Legal guardians or other legally responsible individuals cannot also be the worker through self-determination.

- ( ) **Other policy.**

Specify:

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

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

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

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

MDHHS reviews new provider bid packets, contracting processes, provider monitoring, provider network lists, and policies and procedures related to providers to ensure that sufficient and qualified providers are available to serve participants.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.
Numerator: Number of providers continuing to meet applicable licensure &

certification standards following initial enrollment. Denominator: All providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: waiver agencies review 20% of the records, and MDHHS reviews all of those records reviewed by the waiver agency.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services. Numerator: Number of new waiver service provider applications that meet initial licensure/certification standards prior to the provision of waiver services. Denominator: Number of new providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of non-licensed or non-certified waiver providers that initially meet provider qualifications. Numerator: Number of non-licensed or non-certified waiver providers that initially meet provider qualifications. Denominator: All providers.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications. Numerator: Number of non-licensed or non-certified waiver providers that continue to meet provider qualifications. Denominator: All providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: waiver agencies review 20% of the records, and MDHHS reviews 100% of those records reviewed by the waiver agencies.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of providers who meet provider training requirements.
Numerator: Number of providers who meet provider training requirements.
Denominator: All providers.

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

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

		waiver agencies review 20% of their records, and MDHHS reviews 100% of the records reviewed by the waiver agencies
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Waiver agencies enter into annual contracts with qualified providers. During the contract negotiation, waiver agencies review provider documents to assure the provider initially meets provider qualification and training requirements for the delivery of MI Choice services and confirm providers have active licenses and certification (all licensing information is available online). MDHHS approves the contracting process used by each waiver agency. MDHHS reviews and approves the bid packet used by each waiver agency. MDHHS reviews each agency's policies and procedures and contractor files (including bid packets, original applications and contracts) during the Administrative Quality Assurance Review (AQAR).

MDHHS reviews initial and annual provider monitoring reports submitted by waiver agencies to determine compliance with provider licensure and certification standards. MDHHS can request waiver agencies take action with their providers if they are concerned about their performance or interaction with participants. These actions can include required corrective action plans, additional provider monitoring or suspension or termination.

Waiver agencies send their provider network lists and updates to MDHHS. MDHHS reviews these to ensure enough providers are available to meet the needs of the population served. Provider lists and files are also reviewed during the biennial AQAR.

Waiver agency staff reviews each provider file and documentation annually at the time of contract renewals. The providers must assure that they have the capacity to meet the performance standards of the services with qualified, trained and supervised employees. The providers' contractual responsibilities include conducting reference and criminal history reviews, reporting critical incidents, submitting accurate bills, maintaining accurate documentation and maintaining emergency response plans.

In addition, waiver agency staff conducts on-site monitoring reviews for a minimum of 20% of enrolled providers of recurrent services annually. Monitoring reviews use a template developed by MDHHS and includes compliance with MDHHS standards, delivery of services according to the participant's plan of service, adequate staff supervision and training, and adequate participant case record documentation to support provider claims. Waiver agency staff evaluate providers of non-recurrent services at least once every two years to ensure compliance with MDHHS standards, delivery of services according to plans of service, and adequate participant case record documentation to support provider claims. Waiver agencies also conduct home visits that confirm that providers furnish services according to the person-centered service plan and participant preferences and determine participant satisfaction with those services. Waiver agencies send all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process.

Additional Oversight

Description of administrative oversight exercised by MDHHS over the waiver agencies in order to assure that:

i. Providers meet provider qualifications and training requirements; and

MDHHS reviews and approves all contract templates prior to the waiver agency using them, which includes information about required qualifications and training. MDHHS reviews provider monitoring reports as they are submitted by the waiver agencies. MDHHS also reviews provider files, including the waiver agency bid packets, original applications and contracts and all provider related policies and procedures during the biennial AQAR.

ii. Waiver agencies maintain a sufficient network of providers
MDHHS reviews annual provider network lists and any updates submitted by the waiver agencies to ensure enough providers are available to meet the needs of the population served. Provider lists and files are also reviewed during the biennial AQAR.

b. Methods for Remediation/Fixing Individual Problems

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

Waiver agencies work with providers to meet MI Choice service standards and become qualified providers. If at any time the provider agency no longer meets requirements, the waiver agencies notify the provider of non-compliance and provide an opportunity for improvement and may need to recover all Medicaid payments made for the services rendered during the period of provider ineligibility. If after working with the waiver agency the provider still does not meet required standards, the waiver agency must first find alternate providers for any participants currently being served by the provider not meeting standards. Then the waiver agency will end their contract with the provider until they can provide proof of meeting standards. The waiver agency will need to recover all Medicaid payments made for the services rendered during the period of ineligibility. If the provider does not make the necessary improvements, the waiver agency terminates its contract with the provider and works with participants to find a new provider of service.

Providers also have requirements related to training. If it is discovered a provider is not meeting training requirements, the provider must make up those trainings within 30 days to continue providing services. Depending on the type of training needed, the provider may need to stop providing services until training can be secured. In this case, all participants affected must be assigned to different providers who can meet their needs.

Waiver agencies are required to conduct an in-depth monitoring of a sample of their providers annually. Within 30 days following completion of the review written findings and corrective action requirements are sent from the waiver agency to the provider. The waiver agency also sends all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process.

When results of the initial monitoring indicate any irregularities, the waiver agency must conduct further review of provider case records. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and is sent to the provider and MDHHS within 30 working days following completion of the review. Waiver agency staff must schedule a follow-up review within a three (3) to six (6) month timeframe for providers deficient in any part of the review to assure that the provider initiates corrective action.

If during the review of these written reports MDHHS has outstanding concerns, MDHHS can ask for additional documentation, reports, meetings, or may conduct site visits to assure issues are addressed. If necessary, depending on the provider’s deficiency, the waiver agency may suspend new referrals to the provider agency or transfer participants to another provider, adjust provider billings, or suspend or terminate the provider until the waiver agency can verify that the provider corrected deficiencies and changed procedural practices as required.

If a waiver agency has concerns or takes actions against a provider that may serve other waiver agencies, they contact the other waiver agencies to notify them of problems with the provider. MDHHS also reviews provider monitoring reports when submitted and during AQAR then notifies other waiver agencies if issues are identified. (See more detail on the AQAR in Appendix H)

MDHHS ensures that waiver agencies are appropriately remediating issues with qualified providers using the following procedures:

Written findings and corrective action requirements (as necessary) are sent from the waiver agency to the provider within 30 days following completion of the provider review. The waiver agency also must send all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. The written review includes citations of both positive findings and areas needing corrective action.

When results of the initial case record and bill review indicate any irregularities, the waiver agency must conduct further review of provider case records. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and is sent to the provider and MDHHS within 30 working days following completion of the review. Waiver agency staff must schedule a follow-up review within a three (3) to six (6) month timeframe for providers deficient in any part of the review to assure the provider initiates corrective action.

If during the review of these written reports MDHHS has outstanding concerns, MDHHS can ask for additional documentation, reports, meetings or may conduct site visits to assure issues are addressed.

MDHHS requires waiver agencies to submit the results of additional monitoring to MDHHS upon completion. MDHHS reviews this additional follow-up and contacts the agency if additional questions or concerns remain. MDHHS confirms waiver agency follow-up during annual CQARs and biennial AQARs.

If a waiver agency has concerns or takes actions against a provider that may serve other waiver agencies, it contacts the other waiver agencies to notify them of problems with the provider. MDHHS also reviews provider monitoring reports when submitted and during AQAR, then notifies other waiver agencies if issues are identified with a provider also used by another waiver agency.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: waiver agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix

C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. MI Choice participants who reside in their own home or in the home of their relative (non-provider controlled) and receive home and community-based services comply with the federal HCB Settings requirements. These settings allow the participants to be in control of their life and be fully integrated in the community.

2. MDHHS will use an HCB Settings assessment tool, developed using guidance from CMS and stakeholders, to determine adherence to the requirements. Waiver agencies are required to use this tool, in conjunction with the Provider Monitoring Tool (in the MI Choice contract, Attachment J) to assess residential and non-residential MI Choice providers to ascertain that they meet federal HCB Setting requirements prior to service provision. Waiver agencies must continue to use the HCB Settings assessment tool as part of their provider monitoring activities, outlined in Appendix A. MDHHS will review this provider monitoring as part of the Administrative Quality Assurance Review process.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☒ **Other**
  Specify the individuals and their qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Waiver agencies may directly employ registered nurses (RNs) and social workers as supports coordinators. However, waiver agencies may also contract with other qualified RNs and social workers to provide supports coordination. Each waiver participant may use the qualified supports coordinator of their choice. Additionally, participants who choose the self-determination option can use an independent supports broker to assist in implementing, managing, and monitoring the plan and budget. When a participant uses an independent supports broker, the participant limits the supports coordinator's role in assisting the participant in planning, implementing, and managing service arrangements to avoid duplication of efforts. The supports coordinator retains the role of authorizing and monitoring the plan of service and individual budget.

Waiver agencies assign the responsibility for service plan development to supports coordinators. In some agencies, supports coordinators provide Community Transition Services as one of their responsibilities. Supports coordinators do not provide other waiver services, such as nursing or counseling.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a) Waiver agencies provide the MI Choice Participant Handbook to all applicants during the enrollment process. The information packet explains the MI Choice services, the person-centered planning process, rights and appeals information, information on elder abuse, and other information relevant to the service area. Waiver agencies solicit participant preferences for date, time, and place of the assessment meeting before finalizing schedules. The participant, the participant's chosen allies, and family or legal representatives are provided with written information about the right to participate in the person-centered planning process and the self-determination option upon enrollment in MI Choice, during assessment, reassessment, or upon request. The participant has the right to directly choose an independent supports broker to participate in development of the individual plan. The supports coordinator provides additional information and support and directly addresses issues and concerns the participant may have either over the phone or in a face-to-face meeting. Continued assistance from a supports coordinator is available throughout the person-centered service planning process. A participant who chooses the self-determination option may directly choose an independent supports broker. As a result, the participant may choose to:

1. start enrollment and services with a preliminary service plan that is put in place before the supports broker is engaged, or
2. delay enrollment until such time as a supports broker is secured and able to fully assist with person-centered planning and the service plan development process.

Participants choosing option 1. agree to a preliminary person-centered service plan that will allow the waiver agency to provide services to the participant until a full person-centered planning meeting can be arranged with the chosen supports broker, supports coordinator, and participant. Upon completion of the full person-centered service plan, the preliminary service plan will be modified to the person-centered service plan developed during the meeting with the supports broker.

b) The participant has authority to determine who will be involved in the person-centered planning process and may choose allies, such as family members, friends, community advocates, service providers and independent advocates to participate. A participant who chooses the self-determination option may also include an independent supports broker, if the participant desires. Participants are informed of the availability of supports brokers during the enrollment process through the MI Choice Participant Handbook. Each waiver agency has a listing of qualified persons willing to perform this role for the participant. A participant may directly choose a supports broker to participate in development of the person-centered service plan. If preferred by the participant, a pre-planning conference may occur before the person-centered planning meeting. In this pre-planning conference, the participant and the supports coordinator discuss who the participant wants to involve in the planning process, goals and dreams that will be addressed, topics that will be discussed at the meeting and topics that will not be addressed. The time and location for the planning meeting is also determined at the pre-planning session.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Who develops the plan, who participates in the process, and the timing of the plan:
After completing the eligibility determination and initial assessment, the supports coordinators work with the participant and their representatives to develop the initial person-centered service plan. The team of supports coordinators includes an RN and a social worker. If the participant is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim service plan may be developed by the supports coordinator(s) and approved by the participant. Interim service plans are authorized for no more than 90 days without a follow-up visit to determine the participant's status. The first person-centered planning meeting is conducted when the participant is not in crisis and at a time of the participant's choice.

A pre-planning session may occur before the first person-centered planning meeting. During pre-planning, the participant chooses dreams, goals and any topics to be discussed, who to invite, who will facilitate and record the meeting, as well as a time and location that meets the needs of all individuals involved in the process. The participant and selected allies design the agenda for the person-centered planning meeting. The person-centered service plan is based on the expressed needs and desires of the participant and is updated upon request of the participant. Regular updates to the service plan also occur when the need for services or participant circumstances change, but at least once every year.

(b) The types of assessments that are conducted to support the person-centered service plan development process, including securing information about participant needs, preferences and goals, and health status:
MI Choice uses the interRAI Home Care (iHC) assessment. Supports coordinators perform a comprehensive evaluation including assessment of the individual's unique preferences, physical, social and emotional functioning, medication, physical environment, natural supports, and financial status. The supports coordinator must fully engage the individual in the interview to the extent of the individual's abilities and tolerance. The participant must be reassessed 90 days after enrollment and annually thereafter.

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

The participant is informed of services available by the supports coordinator. This occurs through direct communication with the supports coordinator as well as through written information provided to the participant regarding waiver services and other available community services and supports. The participant is offered information on all possible service providers. The participant specifies how he/she wishes to receive services and this is included in the person-centered service plan. An independent supports broker may be used by participants who choose the self-determination option to access the identified needed services, locate providers and ensure implementation of services.

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

MDHHS has developed a person-centered planning practice guide for MI Choice waiver agencies. The document is included as an attachment to waiver agency contracts to assist supports coordinators in ensuring that the person-centered service plan clearly identifies the participant's needs, goals and preferences with the services specified to meet them.

The supports coordinator and participant base the person-centered service plan upon participant preferences, goals, and needs identified through the person-centered planning process. A written person-centered service plan is developed with each participant and includes the individual's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services provided to or needed by the participant and is finalized within 90 days of enrollment. Supports coordinators arrange formal services based upon participant choice and approval. The participant and the supports coordinator explore other funding options and intervention opportunities when personal goals include things beyond the scope of MI Choice services.

(e) How waiver and other services are coordinated and by whom:

The plan of service clearly identifies the types of services needed from both paid and non-paid providers of services and supports. The amount (units), frequency, and duration of each waiver service to be provided are included in the person-centered service plan. The participant chooses the services that best meet their needs and whether to use the option to self-direct applicable services or rely on a supports coordinator to ensure the services are implemented and provided according to the person-centered service plan. When a participant chooses to participate in self-determination, information, support and training are provided by the supports coordinator and others identified in the person-centered service plan. When a participant chooses not to participate in self-determination, the supports coordinator ensures that

services and supports are implemented according to the person-centered service plan. Supports coordinators oversee the coordination of State Plan and waiver services included in the person-centered service plans. This oversight ensures that waiver services in the person-centered service plans are not duplicative of similar State Plan services available to or received by the participant.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The assignment of responsibilities to implement the service plan are determined through person-centered planning and may be delegated to the participant, a supports coordinator, an independent supports broker, or others designated by the participant. The supports coordinator and the participant, to the extent the participant chooses, are responsible for monitoring the person-centered service plan. This occurs through periodic case reviews, monthly contacts, participant request, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the participant.

(g)How and when the plan is updated:

Waiver agencies are required to contact participants monthly. Reassessments are conducted in person 90 days after the initial assessment, with an annual reassessment thereafter, or upon a significant change in the participant's condition. Supports coordinators conduct an in person reassessment of the participant for the purpose of identifying changes that may have occurred since the initial assessment or previous reassessment and to measure progress toward meeting specific goals outlined in the participant's person-centered service plan. The participant may choose to have additional face to face meetings to specifically focus on the person-centered service plan at any time. The service plan is also reviewed and updated during this process, based upon reassessment findings and participant preferences. The service plan is also updated after changes in status and upon participant request.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Supports coordinators identify and discuss potential risks to the participant during the assessment and reassessments. The person-centered planning process specifies risks and methods of monitoring their potential impact in conjunction with the participant. The supports coordinators, or other qualified individuals, fully discuss strategies to mitigate risks with the participant and allies, family, and relevant others during person-centered planning. Participant approved risk strategies are documented and written into the person-centered service plan. Participants may be required to acknowledge situations in which their choices pose risks for their health and welfare. The waiver agency is not obligated to authorize services believed to be harmful to the participant. Negotiations of such issues are initiated in the person-centered planning process. Supports coordinators assess and inform participants of their identified potential risk(s) to assist participants in making informed choices with regard to these risks. Service providers are informed of a participant's risk status when services are ordered. Service providers, including waiver agencies, are required to have contingency plans in place in the event of emergencies that pose a serious threat to the participant's health and welfare (i.e., inclement weather, natural disasters, and unavailable caregiver).

Each person-centered service plan describes back-up plans that are to be implemented when selected service providers are unable to furnish services as scheduled. Additionally, emergency plans that clearly describe a course of action when an emergency situation occurs are developed for each participant. Plans for emergencies are discussed and incorporated into the participant's service plan as a result of the person-centered planning process.

Qualified reviewers examine a random sample of back-up and emergency plans during the CQAR to assure plans are properly documented, meet participant needs, and include risk management procedures.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The supports coordinator provides participants with information and training on selecting qualified service providers. Information may also be provided by the participants trusted support network. Service providers must meet the minimum standards established by MDHHS for each service. Participants choose among qualified providers or employ providers who meet the minimum standards. Participants may receive assistance as needed to identify and select qualified providers at any time from supports coordinators or relevant others. A brochure on how to find and hire workers has been developed by MDHHS and is distributed to participants via the waiver agency.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Qualified supports coordinators are responsible for conducting, securing and verifying level of care (LOC) eligibility, conducting participant assessments and reassessments, initiating interim service planning and the person-centered planning process with participants, and specifying approval of plans of service. MDHHS contracts with an EQRO which uses the CQAR process to meet CMS requirements for the review of service plan authorizations and case record reviews. The CQAR team uses a sample size program from www.raosoft.com/samplesize.html using a 95% confidence level and +/- 5% margin of error to determine total number of records to review for each waiver agency each fiscal year. Records reviewed are a completely random sample of MI Choice participants. In addition, for each waiver agency, MDHHS interviews at least five MI Choice participants in their homes. Qualified reviewers examine participant enrollment, assessment data, nursing facility level of care eligibility, the person-centered service plan and care planning process, and reassessment data to assure compliance with program standards and requirements.

Every self-determination budget is reviewed by at least two entities: waiver agencies and fiscal intermediaries. Fiscal intermediaries submit monthly reports for each participant directed budget. An additional sampling component is part of the service
plan approval and authorization review for cases involving individual budgeting. This has been included to assure compliance with policies and guidelines associated with self-determination.

The EQRO conducts a random review of a representative sample of all MI Choice participants during the CQAR and if a self-determined individual falls into the random sample, the participant's file is reviewed as part of that sample. The reviewers are well-versed in the requirements of self-determination and assure all requirements are met within the case record. When requirements are not met, corrective action is required.

MDHHS requires the fiscal intermediary to send monthly monitoring reports to both the participant and the waiver agency. These reports identify the planned services and budget, the paid services, and a comparison of each. When budgets have more than a 10% discrepancy, MDHHS requires the waiver agency to discuss this discrepancy with the self-determination participant to determine the root cause and identify methods of remediation as necessary.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

The Waiver Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a) Entities responsible for implementation and monitoring are the waiver agency, supports coordinator, the independent supports broker, where applicable, the participant to the extent chosen by them, and the participant's support network, as appropriate. MDHHS contracts with and EQRO that employs qualified reviewers who conduct CQAR activities to ensure waiver agencies meet CMS and MDHHS requirements.
b) and c) Within two weeks of service implementation for newly enrolled participants, MDHHS requires waiver agencies to contact each participant to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies implement corrective actions to resolve problems and issues. MDHHS requires waiver agencies to contact each participant according to the frequency identified by the participant and documented in the person-centered service plan. If a back-up plan was required during the month, the supports coordinator will discuss the effectiveness of the plan and whether any changes are necessary. If the participant is not satisfied with a provider, the participant is given the choice to change workers or providers. Supports coordinators also confirm all non-waiver services are being furnished and the participant has access to any additional resources required. Participants and their families are provided with telephone numbers to contact waiver agencies and supports coordinators at any time when new needs emerge that require supports coordination interventions and additional support services. Self-determination participants and their support network also monitor the care and plan of service including monitoring service budget utilization, time sheets of providers, and authorization for services to ensure services designated in the plan of service have been accessed and provided in accordance with the plan. Participants and families are also educated on health and welfare and are encouraged to call their supports coordinator in the event of a potential critical incident. Reassessments are conducted in person 90 days after the initial assessment, with an annual reassessment, or upon a significant change in the participant's condition. The supports coordinator evaluates the effectiveness of back-up plans and the health and welfare of the participant at reassessment, upon participant request, and when there is a change in participant status or participant conditions.

If any problems are discovered during monitoring, issues are addressed immediately. If services are not being implemented as outlined in the person-centered service plan or the participant's needs are not being met, a corrective action is developed between the participant and waiver agency to remedy the situation. The participant must approve all changes in the person-centered service plan, and is provided the appropriate adverse benefit determination when required. The corrective action could include changing providers, increasing or decreasing the amount of care, or rescheduling services.

If any critical incidents are suspected during the monitoring process or are reported by the participant, family, service provider, or any other individual, the waiver agency will act immediately to ensure the health and welfare of the participant. The waiver agency will present and discuss options to protect the participant to the participant and the participant's chosen allies. Any revisions to the person-centered service plan will be implemented immediately and followed-up on regularly.

Waiver agencies are responsible for on-going monitoring of service plan implementation and of direct service providers. Waiver agencies conduct a formal administrative review annually according to the MDHHS monitoring plan of direct service providers.
MDHHS examines waiver agency monitoring activities and reports during its AQAR process to ensure that monitoring activities are being conducted, service issues and problems are being resolved appropriately and timely, and any patterns of irregularities or concerns regarding a specific provider are identified.

b. Monitoring Safeguards. *Select one:*

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

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

The supports coordinator or the independent supports broker, along with the participant, are responsible for monitoring service plan implementation based on the participants choice. Although waiver agencies may provide direct waiver services, most are limited to Supports Coordination and Community Transition Services. Therefore, the waiver agency has no conflict in its role of monitoring service plan implementation and participant health and welfare. Participants are encouraged to monitor their own person-centered service plan implementation and alert or contact their supports coordinator or independent supports broker when they need assistance. The supports coordinator assists, supports, and provides training to the participant in evaluating provider performance of tasks based on the participants needs, preferences and goals as stipulated in the person-centered service plan. For participants choosing the self-determination option, use of a fiscal intermediary ensures that a participants individual budget is portable and that the function of selecting and managing providers of services and supports is separated from the function of service plan implementation. MDHHS also ensures that waiver agencies are monitoring service plan implementation and participant health and welfare by checking documentation during the AQAR and CQAR.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs. Numerator: Number of participants whose person-centered service plan includes services and supports that align with their assessed needs. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
EQRO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks. Numerator: Number of participants whose person-centered service plan had strategies to address their assessed health and safety risks. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant. Numerator: Number of participants whose person-centered service plan includes goals and preferences desired by the participant. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: waiver agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process. Numerator: Number of participants whose plan of service was developed appropriately. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

EQRO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: bi-ennial	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS. Numerator: Number of participant person-centered service plans that are updated according to requirements by MDHHS. Denominator: All participant person-centered service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants who received all of the services and supports identified in their person-centered service plan. Numerator: Number of participants who received all of the services and supports identified in their person-centered service plan. Denominator: Number of participant files reviewed.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: waiver agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver participants whose records indicate choice was offered among waiver services. Numerator: Number of waiver participants whose records indicate choice was offered among waiver services. Denominator: All participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose records indicate choice was offered among waiver service providers. Numerator: Number of waiver participants whose records indicate choice was offered among waiver service providers. Denominator: All participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

1. Waiver agencies conduct monthly supervisory reviews of person-centered service plan development and updates to ensure each service plan addresses the participant's assessed needs, including risk management (RM) planning. Additionally, this review ensures supports coordinators include changes noted during participant assessments and reassessments into the person-centered service plan. Supervisory reviews result in written directives to individual supports coordinators requesting corrections and updates to the plan of service as needed.

2. Waiver agencies conduct peer reviews among supports coordinators within their own agency at least annually. This results in written peer feedback recommendations, sharing information resources, and improved care planning.

3. MDHHS requires a person-centered planning (PCP) process for the development of the service plan. Each waiver agency trains its staff and participants. The waiver agency maintains staff training records on attendance by date and total number of attendees, topics, and training evaluations. The EQRO validates that the waiver agency follows the PCP guidelines during the CQAR and MDHHS reviews training records during the AQAR. Participant training is documented in the case record and reviewed during the CQAR.

4. Supports coordinators assist participants in identifying risks during PCP and assure that the person-centered service plan includes RM planning. The person-centered service plan identifies participant risks with strategies and plans to reduce or eliminate risk as approved by participants. Supports coordinators monitor RM strategies and evaluate their effectiveness. MDHHS describes RM procedures in contract requirements.

5. MDHHS contracts with a third party vendor to conduct participant satisfaction and quality of life surveys. Effective October 1, 2018 MDHHS will use the CAHPS HCBS survey. The vendor notifies the Waiver agencies as indicated to follow up with participants to correct any problems with service delivery. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for any trends or possible system improvements that can be made locally or statewide. This analysis is provided to MDHHS and waiver agencies to use for quality improvement initiatives.

6. During the CQAR process, qualified reviewers perform annual service plan and case record reviews on a random sample of participants to ensure supports coordinators conduct plan of service development according to MDHHS contract requirements, policy, and procedures. The CQAR process ensures the waiver agency authorizes and approves services in the plan of service. Home visits confirm that providers furnish services according to the person-centered service plan and participant preferences.
Additionally, the waiver agency confirms service delivery by monitoring direct service providers according to the required MDHHS waiver agency monitoring plan, which is attached to the MDHHS contract. Waiver agencies submit provider monitoring reports to MDHHS who reviews the reports and may request additional information based on the performance.

7. Supports coordinators validate that providers render services as planned during initial service implementation and on a monthly basis with participants. MDHHS requires waiver agency staff to follow-up with new participants within two weeks of arranging services or supports to ensure and document whether providers implemented the service as planned. MDHHS also requires waiver agency staff to contact participants at least monthly to ensure delivery of services as planned and participant satisfaction with services. Qualified reviewers examine these activities as part of the CQAR process. This includes verification that the waiver agency honored the participants choices of service setting (signed Freedom of Choice form) and the type of services rendered, and also ensured choice of service providers. Qualified reviewers analyze findings to ensure that participants receive services and supports consistent with identified needs and preferences. The EQRO then compiles the CQAR results and findings into written reports and sends them to the waiver agencies. The waiver agencies must identify a corrective action plan within 30 days of receiving the report. The EQRO reviews and approves the corrective action plan.

8. MDHHS requires the self-determination fiscal intermediary to send monthly monitoring reports to both the participant and the waiver agency. These reports identify the planned services and budget, the paid services, and a comparison of each. When budgets have more than a 10% discrepancy, MDHHS requires the waiver agency to discuss this discrepancy with the participant to determine the root cause and identify methods of remediation as necessary. When a participant who chose the self-determination option is randomly selected for CQAR, the

qualified reviewers assure the proper use of this, and other self-determination processes while reviewing the record.

Sampling Methodology:
The sampling methodology used randomly selects a statistically significant sample of MI Choice case records to review. The population includes participants who have been enrolled in MI Choice for at least 90 days in the review year. The process for making this selection is to use an online sample size calculator, using 95% confidence level and a standard deviation of .5. Once the total sample size is determined, the EQRO divides that number proportionately across waiver agencies based on population. The only exception to this methodology is that the EQRO selects a minimum of 10 records to review at each waiver agency. The specific records reviewed for each agency are randomly selected using the systemic sampling method.

b. Methods for Remediation/Fixing Individual Problems

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

The EQRO or MDHHS staff may provide technical assistance to waiver agency staff when deficiencies are noted during the CQAR or AQAR.

During the CQAR process, qualified reviewers perform annual person-centered service plan and case record reviews on a random sample of participants to ensure supports coordinators conduct service plan development according to MDHHS contract requirements, policy, and procedures. During this review, if any participant person-centered service plan does not: include services or supports that align with their assessed needs; address health and safety risks; include goals and preferences; or are not developed in accordance with policies and procedures, the waiver agency must redesign the service plan within two weeks. This may require another person-centered planning meeting with the participant and others the participant wants included. The waiver agency must provide enough notice so that everyone can attend if they choose. Prior to implementing the new person-centered service plan, the participant must provide approval. MDHHS will monitor the revised service plan to ensure all requirements have been met.

Waiver agencies are required to update the person-centered service plan at least annually, or as needs change. If any participant service plans are not updated as required and the situation has not already been remediated, MDHHS will require the waiver agency to conduct a face-to-face person centered planning meeting to update the participant service plan as necessary within two weeks. The waiver agency must also follow-up with the participant regarding the person-centered service plan to ensure updates made are effective. The waiver agency must provide MDHHS with documentation that demonstrates the updates have been implemented.

Choice is important in the MI Choice program. During the CQAR, if a participant record does not contain a completed and signed freedom of choice form indicating preference to be in the MI Choice program, the waiver agency is required to obtain a complete and signed form specifying the participant was offered a choice between institution care and waiver services and chose the MI Choice program. The form must be sent to the EQRO to prove the remediation was made and added to the participant's record. If a waiver participant's record does not indicate choice was offered among waiver services or providers, the waiver agency will be required to provide information to the participant offering all waiver services and providers. Documentation must be provided to the EQRO and stored in the participant record to verify the participant was given a choice among services and providers.

Waiver agencies submit provider monitoring reports to MDHHS, who in turn reviews the reports and may request additional information based on performance. MDHHS may request waiver agencies take action with their providers if they are concerned about their performance or interaction with participants. MDHHS may ask waiver agencies to show how any issues were followed up on and remediated during AQAR visits. If necessary, MDHHS may request further corrective action plans to resolve outstanding issues.

A third party vendor conducts the CAHPS HCBS survey biannually to measure participant's satisfaction and quality of life. The vendor notifies the Waiver agencies when indicated to follow up with participants to correct any problems noted on the completed surveys. The surveys are conducted on the phone or in person. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for any trends or possible system improvements that can be made locally or statewide. This analysis and summarized data is provided to MDHHS and waiver agencies to use for quality improvement initiatives.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
waiver agency	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

This option, referred to as self-determination, provides participants the option to direct and control their waiver services through an individual budget. Participants are supported in directing the use of the funds comprising their respective individual budgets for services designated in Appendix C. Supports coordinators work with participants to develop and revise individual budgets. Participants have the option of appointing a representative to assist them with directing their services and supports and obtaining additional assistance through participation in a peer support group and use of a supports broker.

Each waiver agency directly provides supports coordination and holds contracts with providers of services that conform to federal regulations. As participants exercise employer authority, each provider furnishing services is required to execute a Medicaid Provider Agreement with the waiver agency that conforms to the requirements of 42 CFR 431.107. Guidance for participant direction is provided through MDHHS contracts with each MI Choice waiver agency. The contract includes training, technical assistance, technical advisories, and prototype documents.

(a) The nature of the opportunities afforded to participants:

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

Participants may choose to directly employ their worker or use the Agency with Choice option. With direct employment, the participant is the employer and delegates performance of the fiscal or employer agency functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. The MI Choice contract provides detailed guidance to waiver agencies. In the Agency with Choice model, participants contract with an Agency and split the employer duties. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. The agency, as co-employer, is the common law employer, and handles the administrative and human resources functions and may provide other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. The MDHHS contract includes guidance to waiver agencies. A participant may select one or both options. For example, a participant may want to employ a good friend directly to provide community living supports during the week and use Agency with Choice to provide community living supports on the weekends.

(b) How participants may take advantage of these opportunities:

The MI Choice Participant Handbook is provided to each MI Choice participant and contains information on self-determination. Participants interested in the self-determination option start the process by informing their supports coordinator of their interest. The participants are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the person-centered planning process. A person-centered service plan is developed through this process with the participant, supports coordinator, and allies chosen by the participant. The person-centered service plan includes MI Choice waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the service plan and must be sufficient to implement the service plan. The participant selects service providers and has the ability to act as the employer. Waiver agencies provide many options for participants to obtain assistance and support in implementing their service plans.

(c) The entities that support individuals who direct their services and the supports that they provide:

Supports coordinators (usually employed by waiver agencies) are the primary entities that support individuals who direct their own services. Supports coordinators are responsible for working with self-determination participants through the person-centered planning process to develop a person-centered service plan and an individual budget. Participants may choose to include a supports broker to assist them with planning services and supports and negotiating a budget. Supports coordinators are responsible for obtaining authorization of and monitoring the budget and plan. The supports coordinator and participant share responsibility for assuring participants receive the services to which they are entitled and for smooth implementation of the person-centered service plan. The MI Choice waiver provides many options for independent advocacy through involvement of a network of participant allies and independent supports brokersas described in Section E-1k.

Through its contract with MDHHS, each waiver agency is required to offer information and education on self-determination to participants. Each waiver agency also offers support to participants who choose this option. This support can include offering required training for workers, peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each waiver agency is required to contract with fiscal intermediaries to provide financial management services. The fiscal intermediary performs a number of essential tasks to support self-determination while assuring accountability for the public funds allotted to support this option.

The fiscal intermediary has four basic areas of performance:

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

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

3) Facilitate successful implementation of the self-determined services and supports by monitoring the use of the budget and providing monthly budget status reports to the participant and waiver agency; and

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

(d) Other relevant information about the waiver's approach to participant direction:

Participants may use an independent supports broker to assist with the development and implementation of the person-centered service plan and budget. Independent supports brokers, who are chosen by participants, work with and advocate for participants in conjunction with the supports coordinator.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Adult Foster Care and Homes For the Aged

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

(a) The information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction:

General information about self-determination options are provided to waiver participants by the waiver agency with a multi-layered approach that meets each participants' preferred method of communication. Every waiver participant receives the MI Choice Participant Handbook, which includes information about self-determination options. The supports coordinator explains the information in the Participant Handbook and answers questions the participant has. A brochure entitled "Everything You Need To Know About Self-Determination in Long-Term Care" has been developed for, and adapted by, the waiver agencies.

When a MI Choice participant expresses interest in participating in self-determination, the supports coordinator provides information and education to the participant, including the benefits responsibilities, and potential risks of choosing the self-determination option for the participant. Each participant develops a person-centered service plan that addresses specific options and concerns . The person-centered service plan addresses potential risks, concerns, and issues through the interventions included.

MDHHS provides support, training and technical guidance to the waiver agencies on developing local capacity and implementing options for self-direction. MDHHS developed technical advisories and guidelines on all aspects of self-determination to provide resources both to waiver agency staff and MI Choice participants. The documents are included in the MI Choice contract and include:

- Guidance on how to administer self-determination in the MI Choice program
- Guidance on developing individual budgets
- When and how to rescind the self-determination option for participants
- Fiscal Intermediary functions
- Fiscal Intermediary Readiness Review
- Budget Forms
- Self-Determination Enrollment Form
- Medicaid Provider Agreement
- Self-Determination Disenrollment Form
- Back-up Workers
- Agency with Choice Agreement
- Agency with Choice Employment Agreement
- Employee Training Records
- Criminal History Screening Policy
- Right to Hire information
- Right to Hire Driver information
- An informational Self-Determination Flyer
- A Person Centered Planning brochure

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

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

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

This information is provided throughout the participant's enrollment in the MI Choice program. It starts from the time the participant initially enrolls in the program through the MI Choice Participant Handbook. Participants are provided with information about the principles of self-determination and the possibilities, models and options available. The person-centered planning process is a critical time to address issues related to self-determination including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Self-determination options begin when the waiver agency and the participant reach agreement on a person-centered service plan, the funding authorized to accomplish the plan, and implementation of the plan. Each participant (or the participant's representative) who chooses to direct his or

her services and supports signs a Self-Determination Agreement with the waiver agency that clearly defines the duties and responsibilities of the parties.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

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

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Informal supports, such as non-legal representatives freely chosen by adult participants, can be an important resource for the participant. These individuals can include agents designated under a power of attorney or other identified persons participating in the person-centered planning process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the participant. Additionally, the supports coordinator contacts the participant on a regular basis and ensures the participant's representative is not authorizing self-determined services that do not fit the participant's preferences or do not promote achievement of the goals contained in the person's plan of service. The supports coordinator assures the participant's plan of service promotes independence and inclusive community and the representative does not act in a manner that conflicts with the participant's stated interests.

In the event the representative is working counter to the participants interests, the supports coordinator is authorized to address the issue and work with the participant to find an appropriate resolution.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Fiscal Intermediary	☒	☒
Community Transportation	☒	☒
Goods and Services	☒	☒
Private Duty Nursing/Respiratory Care	☒	☒
Environmental Accessibility Adaptations	☒	☒
Community Health Worker	☒	☒
Nursing Services	☒	☒
Respite	☒	☒

Waiver Service	Employer Authority	Budget Authority
Chore Services	☒	☒
Community Living Supports	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Fiscal Intermediary Services

○ **FMS are provided as an administrative activity.**

Provide the following information

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

Waiver agencies contract with private entities to furnish FMS as a waiver service. Each waiver agency must contract with at least one fiscal intermediary that meets the service standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services and has passed the Fiscal Intermediary Readiness Review.

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

FMS entities contract with waiver agencies and are compensated via the waiver agency as a waiver service through the participant's individual budget.

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

related taxes and insurance

☒ **Other**

Specify:

Conducts criminal history screenings on potential self-determined employees and verifies employees receive required provider training.

When the MMIS is able to enroll atypical Medicaid providers, all self-determined workers will enroll as an atypical provider in the MMIS and criminal history screenings will occur automatically through that system. Fiscal intermediaries will retain responsibility for informing participants when chosen providers are not qualified to be Medicaid providers. Fiscal intermediaries will also inform participants of potential providers who have non-excluded convictions on their criminal history screening to assure the participant is fully informed of the potential provider's criminal history before concluding the hiring process.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

a) The fiscal intermediary provides monthly budget reports to the waiver agency and participant. The supports coordinator or independent supports broker ensures that performance and integrity of the fiscal intermediary are appropriate and acceptable to the participant through person-centered planning meetings and monthly contacts with the participant, and follows up with the participant when budget reports indicate that budgets are more than 10 percent over or under the approved amount.

b) Waiver agencies are responsible for monitoring the performance of fiscal intermediaries.

c) Waiver agencies review performance of fiscal intermediares annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

The participant can also obtain an independent supports broker to assist with arranging services and supports, and implementing the arrangements. The independent supports broker advocates for the participant and informs the supports coordinator of the participant's choices to assist the participant in developing and implementing the person-centered service plan.

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

The entity that furnishes intake and assessment (I&A) is the waiver agency through its supports coordinators. I&A is furnished as part of the person-centered planning process to determine the needs and strengths of the individual. I&A is provided based on needs identified through an assessment or as expressed by the participant or on behalf of the participant by their supports broker, caregivers, representatives, service providers, or informal supports at any time. Secondarily, I&A could be provided by fiscal intermediaries and the allies participating in the person-centered planning process. I&A is assessed as part of the case review process and evaluated through participant satisfaction surveys.

MDHHS does not have a different review process for participants who choose self-determination. During the review process, the EQRO examines each record selected to ensure person-centered service plans are appropriate and payments to providers for services delivered are made in accordance with the approved service plan. While self-determined participants may use a different funding mechanism, and the CQAR team may have to look at different documentation to verify the appropriateness, the EQRO ensures the appropriateness of budgets, service plans, and payments within the same protocol used for all other records reviewed.

MDHHS reviews all policies, procedures, and forms used for self-determination as developed and during the AQAR process.

☐ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Fiscal Intermediary	☐
Community Transportation	☐
Supports Coordination	☐
Goods and Services	☐
Counseling	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Community Transition Services (termination effective 7/1/2019)	☐
Home Delivered Meals	☐
Private Duty Nursing/Respiratory Care	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations	☐
Community Health Worker	☐
Adult Day Health	☐
Nursing Services	☐
Respite	☐
Chore Services	☐
Training	☐
Community Living Supports	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

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

Several options for independent advocacy are available through self-determination. These options include utilizing a network of allies in the person-centered planning process and retaining an independent supports broker for assistance throughout plan and implementation of the person-centered service plan and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what works best for the participant, are consistent with his or her needs, and reflect the individual's circumstances. The independent supports broker may assist the participant to explore the availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports. Supports brokerage services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting, hiring and managing workers, effective communication skills, and problem solving. When a participant uses an independent supports broker, the supports coordinator has a more limited role in planning and implementation of services and supports to protect against duplication of services. However, the authority of the supports coordinator in approving the person-centered service plan and individual budget on behalf of the waiver agency is not delegated.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The participant may choose to modify or terminate his or her self-determination option at any time. The most effective method for making changes is the person-centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of self-determination. The decision of a participant to terminate participant direction does not alter the services and supports identified in the person-centered service plan. The waiver agency is obligated to assume responsibility for assuring the provision of the services through its network of contracted provider agencies.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

A waiver agency may involuntarily terminate a participant’s self-determination option when the health and welfare of the participant is in jeopardy or other serious problems are resulting from the participant’s inability to or failure in directing services and supports. Before the waiver agency terminates this option, and unless it is not feasible, the waiver agency informs the participant in writing of the issues that have led to the decision to consider altering or discontinuing this option and provides an opportunity for problem resolution. Typically, the person-centered planning process is used to address the issues, with termination being a last resort when other mutually agreeable solutions cannot be found. The waiver agency is responsible to work with the participant to find agency-based providers when revoking the self-determination option. The decision of the waiver agency to terminate participant direction does not alter the services and supports identified in the person-centered service plan. Waiver agencies notify participants that the self-determination option is being rescinded and of their right to file a grievance about this decision. However, if waiting to terminate these arrangements places the participant in jeopardy, the arrangements are terminated immediately and information on how to file a grievance is provided.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		2684
Year 2		2771
Year 3		2875
Year 4		3002
Year 5		3152

Appendix E: Participant Direction of Services

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

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

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

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

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

The MI Choice contract specifies requirements for the Agency with Choice model. Typically, any agency-based provider who is willing to share employer authority with a participant and enter into a three-way agreement with the participant and employee may be an Agency with Choice provider. Agencies may be included in the waiver agency's provider network or not. When the agency is not included in the provider network, the waiver agency is responsible to assure the provider agency meets all provider requirements. The provider agency may choose to limit the number of Agency with Choice agreements in which they enter with participants and employees.

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

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

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The fiscal intermediary is responsible for conducting criminal history reviews for directly employed personal assistance providers. The cost is built into their monthly fee.

When the MMIS is able to enroll atypical Medicaid providers, all self-determined workers will enroll as an atypical provider in the MMIS and criminal history screenings will occur automatically through that system. MDHHS will incur the cost of these investigations directly.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Fiscal Intermediaries may have their own process, but at a minimum it must include that referenced in Appendix C-2-a.

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

Specify:

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

A simple methodology using reliable cost estimating information is used to develop the budget. Each budget is the sum of the units of service multiplied by the period covered, multiplied by the rate for the service as agreed upon by the participant and authorized by the waiver agency. The state does not set a uniform rate for each service. This formula allows each participant and waiver agency to negotiate rates for providers. Typically, when an existing person-centered service plan is transitioned to a participant-directed set of service arrangements, the overall budget is not more than the costs of delivering the services under the previous provider-driven plan.

The document Self Determination in Long Term Care is an attachment to the MI Choice contract and includes mandatory budget forms that each waiver agency uses to consistently create budgets for each participant across the state. The waiver agency does not set rates, although the waiver agency often assists the participants with setting rates by suggesting a range of hourly rates, because participants commonly are not knowledgeable about how to set rates or what an appropriate rate would be. MDHHS also offers and allows participants to have a supports broker assist with the self-determination process, including setting rates and assisting with appeals. Waiver agencies do have authority to approve budgets.

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

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

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

Guidance provided to participants by waiver agencies:

MDHHS uses a retrospective zero-based method for developing an individual budget. This means the amount of the individual budget is determined by costing out the services and supports in the service plan, after a service plan that meets the individual's needs and goals is developed. Budgeting worksheets are provided by MDHHS to uniformly calculate budgets across the state. The participant and the waiver agency agree to the amounts of the individual budget before the waiver agency authorizes it for use by the participant. The waiver agency explores options in terms of preferences as well as costs with the participant with the aim for arrangements that improve

value.

The waiver agency ensures that all waiver participants have a meaningful copy of the person-centered service plan and the individual budget. The waiver agency also ensures the provision of a monthly spending report based on the individual budget and services used. The waiver agency follows up with participants when spending has a variance of 10% above or below the total monthly budget.

The participant and his or her allies are fully involved in the budget development process and the participant understands the options and limitations for using the funds in the individual budget to obtain the services and supports in the person-centered service plan. The supports coordinator informs participants in writing of the options for, and limitations on, flexibility and portability. Waiver agencies must inform participants as to how, when, and what kind of changes they can make to their individual budget without support coordinator approval and when such changes require approval.

Internal Appeal:
The waiver agency would send the participant a Notice of Adverse Benefit Determination if their request for a budget adjustment was denied, reduced, or suspended. The participant has the opportunity to appeal first with the waiver agency.

Fair Hearing Process:

When there is an internal appeal that upholds the decision to deny, reduce or suspend, or the waiver agency does not respond within the required timeframe, the participant would be provided with the Notice of Internal Appeal Decision - Denial Notice and State Fair Hearing rights and the Hearing Request Form. At this time, the participant would be able to file a State Fair Hearing.

These letters, which are reviewed during the MDHHS Administrative Quality Assurance Review, give instructions on how to file an appeal and request a Fair Hearing by contacting the waiver agency or MDHHS directly. Information on how to file an appeal is also included in the MI Choice Participant Handbook.

Each waiver agency has an internal grievance process that the participant can use.

Public Information:

This information is provided to all MI Choice participants and applicants. Any participant could request the information from the waiver agency at any time. This information is also available in the MI Choice contract and is available on a public MDHHS website: http://egrams-mi.com/dch/User/home.aspx.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Materials provided by the waiver agency include written information on the development of the individual budget. During the planning process, a participant is provided clear information and an explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the participant during individual budget implementation.

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

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

a. Service authorizations allow flexibility across time periods (e.g. month, quarter, etc.) so that participants may schedule providers to meet their needs according to their preferences and individual circumstances. In situations where actual utilization is not exactly the same as initially planned utilization, no notification is necessary on the part of the participant. However, parameters are contained in waiver agency contracts with providers of Fiscal Intermediary services that define ranges of monthly variation outside of what the fiscal intermediary is required to flag for attention and review by the participant and the participants supports coordinator. The participant must be able to shift funds between line items as long as the funding pays for the services and supports identified in the person-centered service plan. Participants may negotiate rates with providers that are different from the rates that the budget is based upon, so long as the participant remains within the overall framework of their respective budgets. These utilization patterns and actual cost differences appear in monthly budget reports provided by the fiscal intermediary. The supports coordinator is expected to review monthly budget reports and interact with the participant to assure that implementation is occurring successfully. When a participant is intending to significantly modify the relative amount of services in comparison to their person-centered service plan, they are expected to inform the fiscal intermediary and the supports coordinator.

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

c. When the participant is not satisfied with the service plan and individual budget that result from the person-centered planning process, the participant may reconvene a person-centered planning meeting, request an internal appeal with the waiver agency, file a fair hearing request if necessary after the internal appeal with the waiver agency, or utilize an informal grievance procedure offered by the waiver agency.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The information below is based on requirements under 42 CFR 438.400...through 42 CFR 438.424.

Adequate Notice
An Adequate Notice is provided to the individual seeking services, allowing immediate access to a State Fair Hearing in the following situations:
- when adding an individual on the waiting list because the waiver agency is at maximum capacity,
- when an individual is not put on the waiting list or assessed because you do not meet criteria according to the MI Choice Intake Guidelines (MIG),
- when an individual does not meet Nursing Facility Level of Care criteria, or
- when an individual does not get enrolled because there is not a need for a MI Choice service.

Adverse Benefit Determination Notice
Waiver agencies also use the Adverse Benefit Determination Notice. This allows for the opportunity for internal review with the waiver agency prior to the individual requesting a State Fair Hearing in some situations.
- The waiver agency provides this Notice to the individual when denying a requested service that is not already in place. This is effective on the decision date.
- The Adverse Benefit Determination Notice is also used when terminating, suspending, reducing a service that is in place, and is provided to the participant 10 days before the effective date, unless there is an exception. As long as a written request is received before the effective date, services remain in place until the Notice of Resolution is sent to the participant.
- If a determination is being made or action is being taken based upon suspect of fraud, the Adverse Benefit Determination Notice is sent to the individual but may only be sent 5 days before the effective date.

Notice of Resolution
This Notice is sent to inform the participant of the outcome of the internal appeal process when the internal appeal decision is unfavorable to the participant. Information about how to request a State Fair Hearing must also be provided to the individual. Benefits must be continued when:
- Request for State Fair Hearing is received within 10 days of the Notice of Resolution AND
- The participant requests continuation of benefits

The participant may also request a State Fair Hearing if the waiver agency does not send Notice of Resolution for internal appeal within 30 days of written request.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following describes the second level review criteria for applicants who did not meet the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). At random and whenever indicated, the MDHHS designee will perform reviews to validate the Michigan Medicaid Nursing Facility LOCD.

If an ineligible applicant is issued an Adverse Action notice from the waiver agency based on an LOCD, the applicant has the right to request a hearing using the Medicaid Fair Hearing process. The applicant also has the right to request an Immediate Review through the MDHHS designee. An Immediate Review is not an appeal; it is another medical/functional review. Medicaid pending or Medicaid eligible beneficiaries may contact the MDHHS designee to request an Immediate Review.

A waiver agency may also request a review as part of the Exception Review. This is available for Medicaid financially pending or Medicaid financially eligible beneficiaries who do not meet medical and functional eligibility based on the web-based Michigan Medicaid Nursing Facility LOCD criteria, but demonstrate a significant level of long term care need.

Upon approval of MDHHS, or its designee, applicants exhibiting the following characteristics and behaviors may be admitted to programs requiring the Nursing Facility Level of Care. An applicant need trigger only one element to be considered for an exception.

Frailty: The applicant has a significant level of frailty as demonstrated by at least one of the following categories:

Applicant performs late loss ADLs (bed mobility, toileting, transferring, and eating) independently but requires an unreasonable amount of time.
Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.

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

Behaviors: The applicant has a one month history of any of the following behaviors, and has exhibited two or more of any these behaviors in the last seven days, either singly or in combination:

Wandering
Verbal or physical abuse
Socially inappropriate behavior
Resists care

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

This review process does not impact the applicant’s right to access the Medicaid Fair Hearing process. If MDHHS, or its designee, affirms the original determination after the Exception Review, the applicant is given an Adequate Action Notice to inform them of their right to an administrative hearing.

Each waiver agency also has its own internal complaint process. MDHHS requires the agency to notify all participants of this process. This process cannot replace the MDHHS process, but the participant can pursue both processes at the same time. MDHHS reviews the complaint policies and procedures during the Administrative Quality Assurance Review process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The types of critical incidents that MDHHS requires to be reported for review and follow-up action are:

Exploitation - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Illegal activity in the home with potential to cause a serious or major negative event Any illegal activity in the home that puts the participant or the workers coming into the home at risk.

Neglect - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law or rules, policies, guidelines, written directives, procedures, or individual plans of service that cause or contribute to non-serious physical harm or emotional harm, death, or sexual abuse of, serious physical harm to a recipient, or the intentional, knowing or reckless acts of omission or deprivation of essential needs (including medication management).

Physical abuse - The use of unreasonable force on a participant with or without apparent harm. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

Provider no shows - Instances when a provider is scheduled to be at participant home but does not come and back-up service plan is either not put into effect or fails to get an individual to the participant home in a timely manner. This becomes a critical incident when the participant is bed bound or in critical need and is dependent on others.

Sexual abuse - (i) Criminal sexual conduct as defined by sections 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

"Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.
"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Theft - A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

Verbal abuse - Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

Worker consuming drugs or alcohol on the job Use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.

Unexplained Death - That which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age. These incidents are often also reported to law enforcement.

Medication errors - Wrong medication, wrong dosage, double dosage, or missed dosage which resulted in death or loss of limb or function or the risk thereof.

Suicide - death occurs.

Suicide attempts -- suicide was attempted but no death occurred.

Waiver agencies have first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur with participants as listed above. Waiver agencies maintain policies and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect and exploitation. Waiver agencies establish local reporting procedures, based on MDHHS requirements, for all complaints and critical incidents that jeopardize or potentially jeopardize the health and welfare of participants conveyed and detected by waiver agencies, provider agencies, individual workers, independent supports brokers and participants and their allies. MDHHS reviews and approves these reporting procedures.

Michigan Public Act 519 of 1982 (as amended) mandates that all human service providers and health care professionals make referrals to the MDHHS Adult Protective Services (MDHHS-APS) unit when the professional suspects or believes an adult is being abused, neglected, or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. Waiver agencies also must report suspected financial abuse per the Financial Abuse Act (MI S.B. 378 of 1999). Policies and procedures that waiver agencies develop must include procedures for follow up activities with MDHHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to MDHHS-APS, must be maintained in the participant's case record.

Timeframes are as follows:

Waiver agencies should begin to investigate and evaluate critical incidents with the participant within two business days of identification that an incident occurred. Unexplained death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

Waiver agencies are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Waiver agencies are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of incident. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies.

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

Waiver agencies train participants and their families or legal representatives how to identify and report suspected abuse, neglect and exploitation, including who to report incidents to, i.e., waiver agencies, MDHHS-APS, and local law enforcement agencies. The training takes place during face to face interviews with participants either during person-centered planning meetings, assessment visits or follow-up meetings. The training is supported by information included in the MI Choice Participant Handbook, which is provided to each participant upon enrollment, and when requested or otherwise indicated thereafter. This training is conducted by supports coordinators initially during enrollment and initial person-centered planning or assessment, and annually thereafter. Training is provided more frequently when there is indication that it may be needed. Participants are also informed that supports coordinators are mandated to report suspected incidents of abuse to the MDHHS-APS and to MDHHS through incident management reports.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Waiver agencies manage critical incidents at the local level. Waiver agencies are responsible to receive reports of critical incidents and assure the immediate health and welfare of the participant. The waiver agency must also make sure to report to the following entities:

Exploitation - Required to report to APS, MDHHS

Neglect - Required to report to APS, MDHHS

Verbal abuse - Required to report to APS, MDHHS

Physical abuse - Required to report to APS, MDHHS

Sexual abuse - Required to report to APS, MDHHS

Theft - MDHHS

Provider no shows, particularly when participant is bed bound all day or there is a critical need - MDHHS

Illegal activity in the home with potential to cause a serious or major negative event - local authorities/police, MDHHS

Worker consuming drugs/alcohol on the job - MDHHS

Unexplained Death - Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect. These types of incidents must also be reported to MDHHS within two business days of the waiver agency receiving the notice.

Medication errors - MDHHS

Suicide and suicide attempts -- MDHHS

Waiver agencies begin to investigate and evaluate critical incidents with the participant within two business days of identification that an incident occurred. Waiver agencies are expected to investigate a critical incident until the participant is no longer in danger. This may include a removal of the service provider effective the date of the incident or it may involve securing an alternate guardian for the participant, which may take several weeks or months. For this reason, MDHHS does not require cases be resolved within a specific timeframe. Cases are only resolved when the participant's health and welfare is assured to the extent possible given the participant's informed choice for assuming risks. However, MDHHS expects to see an attempt at a resolution within 60 days from the date the incident is reported. If the wavier agency does not appear to be resolving the issue in a timely manner, MDHHS will contact the waiver agency to get additional information and provide assistance in resolving the critical incident when possible.

Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion of abuse, neglect or exploitation. This includes identifying and evaluating each incident, initiating prevention strategies and interventions approved by participants to reduce or ameliorate further incidents, and follow-up, track, and compile mandatory critical incident reports. The policies and procedures must include procedures for follow-up activities with MDHHS-APS and law enforcement to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory.

The participant and any chosen family or allies are updated on the investigation as it progresses. Waiver agencies communicate with the participant and family or allies at a minimum of monthly via telephone, but more often as updates or actions occur with the critical incident. Remediation of a critical incident often includes changing services or providers. Supports coordinators use a person-centered planning approach with participants when suggesting and selecting various options to ensure the health and welfare of the participant.

MDHHS evaluates and trends the incident reports submitted by the waiver agencies. Analysis of the strategies employed by the waiver agencies in an attempt to reduce or ameliorate incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. Training is provided to the waiver agencies as necessary to educate staff on abuse and to strengthen preventive interventions and strategies.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

MDHHS is the state agency responsible for oversight of reporting and response to critical incidents.

Waiver agencies are required to input critical incidents into the online Critical Incident Reporting system. All critical incident reports must include location of incident, provider involved (if applicable), reporting person, information about the participant, a description of each incident, action steps, strategies implemented to reduce and prevent future incidents from recurring and follow-up activities conducted through the resolution of each incident. Waiver agencies must initially enter incidents in the system within 30 days of the date of the incident. MDHHS has access to the Critical Incident Reporting system where they can review reports and follow-up with questions or address concerns with the waiver agencies, including questions on missing information or completeness of the report.

It is required that waiver agencies report suspicious or unexpected deaths to MDHHS within two business days. They can notify MDHHS via phone, email or the Critical Incident Reporting system and must follow-up with the formal report due within 30 days of the date of incident.

MDHHS monitors and reviews report submissions. MDHHS reviews, evaluates, and trends individual and summary incident reports submitted by the waiver agencies at a minimum of every quarter. MDHHS reviews reports that involve providers and alert waiver agencies if a trend is discovered so new providers can be secured, if necessary. Analysis of the strategies employed by waiver agencies in an attempt to reduce or prevent incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. MDHHS verifies that waiver agencies use appropriate related planned services and supportive interventions to prevent future incidents. Training is provided to waiver agencies as necessary to educate staff on abuse and to strengthen preventive interventions and strategies. MDHHS also verifies that waiver agencies report incidents of abuse, neglect and exploitation to the Michigan Department of Health and Human Service Adult Protective Services (MDHHS-APS) as required.

Aggregate reports are created and shared with waiver agencies and with the Quality Management Collaborative to assist in identifying trends or issues that need to be addressed system-wide to prevent or reduce future occurrences.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

MDHHS contracts with an EQRO that has qualified reviewers who conduct annual CQARs and home visits (additional detail about the CQAR is available in Appendix H). The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a critical incident report. If there was not a report, the EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from occurring again.

Supports coordinators also discuss the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of restraint usage are discussed. The supports coordinator will include alternatives to using restraints during the discussion. When a paid provider uses restraints, additional follow-up with the provider is required since Michigan does not allow use of restraints by paid providers.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

MDHHS prohibits providers from using restrictive interventions as part of the provision of waiver services. Lap belts used to keep a person secure in their wheel chair and other restrictive interventions can only be used if a participant requests this intervention through the person-centered planning process and it is clearly documented in the participant's person-centered service plan.

MDHHS contracts with an EQRO that has qualified reviewers conduct annual CQARs and home visits. Part of this process is a discovery process to examine the use of restrictive interventions by family and informal caregivers. The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a critical incident report. If there was not a report, the EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. Upon the waiver agency reporting the critical incident in the online database, MDHHS would look for information in the critical incident that addresses ways to prevent this restrictive action from occurring again.

The supports coordinator also discusses the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of restrictive interventions are investigated.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

MDHHS prohibits providers from using seclusion as part of the provision of waiver services.

MDHHS contracts with an EQRO that has qualified reviewers conduct annual CQARs and home visits. Part of this process is a discovery process to examine the use of seclusion by family and informal caregivers. The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a report. If there was not a report, The EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. Upon the waiver agency reporting the critical incident in the online database, MDHHS would look for information in the critical incident that addresses ways to prevent this seclusion from occurring again.

The supports coordinator also discusses the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of seclusion are investigated.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Most MI Choice participants live in their own homes, in which case the waiver agencies have ongoing responsibility for second line management and monitoring of participant medication regimens (first line management and monitoring is the responsibility of the prescribing medical professional). As part of the assessment and reassessment (reassessments are conducted in person 90 days after the initial assessment, with a reassessment occurring annually thereafter, or upon a significant change in the participant's condition), supports coordinators collect complete information about the participant's medications, including what each medication is for, the frequency and dosage. An RN supports coordinator reviews the medication list for potential errors such as duplication, inappropriate dosing, or drug interactions. The RN supports coordinator is also responsible for contacting the physician(s) when there are questions or concerns regarding the participant's medication regimen. Regular supports coordinator monitoring of participants includes general monitoring of the effectiveness of the participant's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with participants, and discussion with direct care and other staff as appropriate.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the waiver agency must follow-up to address the participant's health and welfare as applicable, submit a report via the critical incident reporting system and conduct an investigation. The same is true if a medication error results in the death of a participant with the additional requirement that the waiver agency contact the local authorities for a legal investigation.

Michigan's Department of Licensing and Regulatory Affairs (LARA) licenses and certifies Adult Foster Care and Homes for the Aged. A significant number of MI Choice participants reside in these types of settings. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. LARA licensing inspections occur every two years, as well as conducting special investigations when needed. These individuals also benefit from additional review of medications by the supports coordinators during assessment and reassessments.

The Michigan Administrative Rule 330.7158 addresses medication administration:
(1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
(2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
(3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
(4) A provider shall review the administration of a psychotropic medication periodically as set forth in the recipient's individual plan of service and based upon the recipient's clinical status.
(5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the recipient's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The state requires waiver agencies to report medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The waiver agencies must report these incidents within 30 days and MDHHS reviews those reports. MDHHS also reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS is responsible for follow-up and oversight of proper medication management practices. MDHHS contracts an EQRO that employs qualified reviewers who conduct an annual CQAR process to meet CMS requirements for the review of service plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require the waiver agencies to receive additional technical assistance or training as a result of CQAR and critical incident data.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Michigan Department of Health and Human Services

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

Medication errors that required medical follow-up or hospitalization. "Medication errors" means wrong medication, wrong dosage, double dosage or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which consumers have refused medication. Critical incident reporting requirements require a report when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

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

Medication errors that required medical follow-up or hospitalization. "Medication errors" means wrong medication, wrong dosage, double dosage, or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which consumers have refused medication. Critical incident reporting requirements require a report when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The state requires waiver agencies to report medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The waiver agencies must report these incidents within 30 days and MDHHS is responsible for oversight and reviews each incident. MDHHS reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS contracts with an EQRO that employs qualified reviewers who conduct an annual CQAR process to meet CMS requirements for the review of service plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require waiver agencies or service providers to receive additional technical assistance or training as a result of CQAR and critical incident data.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days. Numerator: Number of critical incidents for which investigations were resolved within 60 days. Denominator: Total number of participant critical incidents. Exclude those incidents requiring law enforcement or external entity involvement.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants or legal guardians who report having received information and education in the prior year. Denominator: Number of participant home visits conducted.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred. Numerator: Number of critical incidents due to unexplained death reported within two business days of notification the incident occurred. Denominator: Total number of critical incidents due to unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred. Numerator: Number of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred. Denominator: Total number of all critical incidents except unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver agencies that utilize the Critical Incident Database to track incidents through effective resolution. Numerator: Number of waiver agencies that utilize the Critical Incident Database to track incidents through effective resolution. Denominator: All waiver agencies.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver agencies with staff who have completed required training to prevent incidents. Numerator: Number of waiver agencies with staff who have completed required training to prevent incidents. Denominator: All waiver agencies.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: bi-ennial	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: bi-ennial

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident. Numerator: Number of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident. Denominator: Number of unauthorized use of restraints, restrictive interventions, or seclusions.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO reviews and home visits

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = =/- 5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver). Numerator: Number of participants with an individualized contingency plan for emergencies. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant suicide attempts that resulted in follow up by the waiver agency. Numerator: Number of participants with suicide attempts that resulted in follow up by waiver agencies. Denominator: All suicide attempts by participants.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error. Numerator: Number of participants requiring emergency medical treatment or hospitalization due to medication error. Denominator: All participants requiring emergency medical treatment or hospitalization.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

critical incident reporting database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of CIs reporting hospitalization/ER visit within 30 days of the previous hospitalization due to neglect or abuse. Numerator: Number of CIs reporting hospitalization/ER visit within 30 days of the previous hospitalization due to neglect or abuse. Denominator: All CIs reporting hospital/ER visit due to neglect or abuse.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of properly reported suicide attempts in the critical incident database. Numerator: Number of properly reported suicide attempts in the critical incident database. Denominator: Number of suicide attempts by waiver participants.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: For EQRO reviews, use a representative sample of +/- 5%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Additional Strategies

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

2) The EQRO verifies that RM planning is occurring during the CQARs conducted annually. The EQRO report includes findings in written monitoring reports, with corrective actions and training as needed. MDHHS, waiver agencies and the QM Collaboration review reports.

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

4) Waiver agencies use Quality Indicators (QI) extracted via a report from their assessment data base to measure 20 Participant Health Status Outcomes. Two Quality Indicators address abuse and neglect. The first is Prevalence of neglect/abuse. The numerator for this indicator is the number of clients who have unexplained injuries or have been abused or neglected. The denominator is all clients. The second is the Prevalence of any injuries. The numerator for this indicator is the number of clients with fractures or unexplained injuries. The denominator is all clients. The waiver agencies can examine records for participants scoring into either of these quality indicators to assure that the participant's plan of service contains interventions for the indicator, including methods to prevent future occurrences. Waiver agency staff runs and monitors the reports quarterly. MDHHS has access to these reports for review and analysis.

b. Methods for Remediation/Fixing Individual Problems

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

The waiver agency periodically examines Quality Indicator (QI) reports. For each QI, waiver agency staff obtains a list of participants who scored into that indicator. Waiver agency staff can then drill down to determine the reason that each participant scored into the specific indicator and whether or not supports coordinators included appropriate interventions for the identified issue on the service plan. Waiver agency staff initiates corrective actions as needed after the thorough examination of the data.

MDHHS reviews critical incident reports at a minimum of once every quarter. During this review, MDHHS reviews the data to ensure investigations were started and reports were submitted within the required timeframes. If during the review any critical incidents were discovered to not be investigated within required timeframes, the waiver agency must begin investigation within two business days of the finding. If an investigation had already been started but not in a timely manner, the waiver agency must include information in their corrective action plan that will explain how they will ensure future critical incidents are investigated timely. The waiver agency must also follow-up with MDHHS as the investigation of the specific incident is conducted.

If any critical incidents are found to have not been reported within required timeframes, the waiver agency must submit reports for those critical incidents within two weeks. If any critical incident was reported but not within required timeframes, the waiver agency must include information in the corrective action plan that will explain how they will ensure future reports are submitted timely.

During the CQAR, qualified reviewers conduct home visits with a sample of participants from each waiver agency. If during those home visits any participants or legal guardians report not receiving information and education on how to report abuse, neglect, exploitation and other critical incidents, information and education must be provided to those participants or guardians within two weeks, and documentation proving this information has been provided must be submitted to MDHHS and kept in the participant record.

Qualified reviewers examine a sample of participant files and look for individualized contingency plans for emergencies. If any participants are missing these plans, the waiver agency will be required to develop a contingency plan within two weeks and then must provide a copy of the contingency plan to the participant, to MDHHS, and keep one copy in the participant's record.

The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a report. If there was not a report, the EQRO would consider this a non-evident finding that would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent future occurrences of the critical incident and development of methods to assure timely reporting in the future.

The waiver agency must submit a critical incident report within two business days. The critical incident report must include all information about how the incident was investigated and how it is being followed up on. The waiver agency must update MDHHS as the investigation continues. The corrective action plan must also describe how the waiver agency will prevent the lack of reporting from happening again.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: waiver agency	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

MDHHS designed this strategy to assess and improve the quality of services and supports managed by the waiver agencies. MDHHS is the Single State Agency responsible for establishing the components of the quality management plan. The quality improvement strategy (QIS) includes using several tools to gather data and measure individual and system performance. Tools utilized in this plan include the MDHHS Quality Management Plan (QMP), waiver agency-specific QMPs, Clinical Quality Assurance Review (CQAR), Administrative Quality Assurance Review (AQAR), and Critical Incident Reporting (CIR) system.

Michigan developed its QIS with contributions from participants and other stakeholders in collaboration with MDHHS and the waiver agencies. A leadership group composed of seven participants and advocates and seven waiver agency staff provides support as the MI Choice Quality Management Collaboration (QMC). The purpose of the QMC is to include participants and advocates in the development and review of MI Choice quality management activities. The QMC provides a venue where participants, advocates and providers can review quality outcomes, identify areas that need improvement, develop strategies for remediation of service delivery, and recommend improvements.

MDHHS establishes a QMP biennially which includes statewide goals and strategies identified in part by the QMC. The QMP focuses on meeting CMS assurances and requirements for protecting health and welfare of waiver participants, MDHHS contract requirements, and targeted participant outcome improvement goals. MDHHS requires each waiver agency to have its own QMP that it reviews and approves biennially. The waiver agency may update its QMP as frequently as it deems necessary to accomplish its goals.

The QMP addresses how the waiver agency intends to meet State and Federal assurances and requirements stipulated in MDHHS contracts, the CMS approved waiver plan, selected CMS protocols, and Medicaid requirements for assuring the health and welfare of the participants in the waiver program. Each waiver agency includes the MDHHS required goals in its QMP and adds its own unique quality improvement goals, or self-targeted quality improvement strategies, including service provider performance requirements and administrative improvements. The waiver agencies submit annual reports that describe what the waiver agency did over the year as part of their QIS and what outcomes came from those activities.

MDHHS developed protocols for the CQAR and AQAR with input from the QMC, advocates, Area Agency on Aging Association, the Michigan Disability Resource Center (MDRC), and other stakeholders. MDHHS updates the protocols annually to incorporate general improvements, policy changes, CMS initiatives, and MDHHS priorities. The CQAR includes a participant home visit protocol. A scoring system allows EQRO staff to calculate compliance equitably for each waiver agency, based on data obtained from the AQAR and CQAR, regardless of sample size.

The AQAR focuses on assuring that each waiver agency has policies and procedures consistent with waiver requirements. MDHHS staff completes the AQAR biennially for each waiver agency. During the on-site AQAR, MDHHS staff examines waiver agency policies and procedures, contract templates, provider files, financial systems, claims accuracy, and QMPs in detail seeking evidence of compliance to the AQAR standards. MDHHS conducts an on-site AQAR exit interview with the waiver agency staff to discuss non-evident findings, recommendations for improvements and identifies outstanding performance. MDHHS sends a report to the waiver agency within 30 days of the review that identifies the deficiencies noted. The waiver agency has 30 days to submit a corrective action plan to MDHHS. Upon receipt of the corrective action plan, MDHHS reviews the plan to determine if it addresses and resolves the identified deficiencies. If it does, MDHHS issues a corrective action approval letter to the waiver agency. If it does not, MDHHS works with the agency to develop a plan that will correct the identified deficiencies.

MDHHS contracts with an EQRO that employs qualified reviewers who conduct the annual CQAR and evaluate the waiver agency’s enrollment, assessment, level of care evaluations, care planning, and reassessment activities seeking evidence of compliance to the CQAR standards. The reviewers collect and review both qualitative and objective data and evaluate the participant assessments and supports coordinators’ actions to assure that the person-centered service plans include every participant need identified in the assessments or by the participant. The reviewers determine the waiver agency’s level of compliance to the standards included in the protocol. The qualified reviewers send an initial report of all non-evident findings and a listing of any findings that require immediate remediation. Any findings related to the health and welfare of an enrolled participant would require remediation within two weeks. Waiver agencies also must provide any additional documentation to rebut non-

evident findings within two weeks. Additional documentation is reviewed and some scores may be revised if documentation was overlooked or missing during the initial review.

The qualified reviewers then compile the data from the CQAR and issue final reports to the waiver agency within 30 days of the receipt of the additional information. The EQRO sends each final CQAR report, which includes a summary of deficiencies. The EQRO divides the deficiencies into citations and recommendations based upon algorithms for each standard. The waiver agency has 30 days to respond to the citations with a corrective action plan. The corrective action plan may also include actions to address recommendations, but this is not mandatory. The EQRO works with the waiver agency to assure the corrective action plan will produce quality improvements. Once the waiver agency and the EQRO agree on the final corrective action plan, the EQRO sends approval to the waiver agency.

Corrective action plans for CQAR and AQAR should demonstrate that the waiver agency has:
1. Analyzed all non-evident findings and determined possible causes;
2. Developed a remediation strategy, including timelines, that address and resolve the problems;
3. Identified a quality improvement goal for the remediation strategy; and
4. Planned ongoing monitoring of remediation activities to assure improved performance.

Waiver agencies must provide evidence of their remediation strategy by submitting documentation to the EQRO. This documentation might include training materials, revised policies and procedures, information from staff meetings, methods for monitoring improvements, results of monitoring, or case record documentation to support the corrective action plan. The EQRO reviews, then either approves the corrective action plan or works with waiver agency to amend the plan to assure the plan leads to desired outcomes and improvements. The EQRO monitors the implementation of each corrective action plan item to assure that the waiver agency meets established timelines for implementing corrective action. The EQRO notifies MDHHS of all activities to assure compliance to requirements. When waiver agencies update policies and procedures, the EQRO forwards these to MDHHS staff for review and approval.

MDHHS developed the CIR system with assistance from the QMC and other stakeholders. MDHHS requires each waiver agency to report all critical incidents in the web-based CIR System. MDHHS defines procedures for reporting critical incidents in the Supports Coordination Service Performance Standards and Waiver Operating Criteria, which is an attachment to the waiver agency contract with MDHHS. Waiver agencies manage critical incidents at the local level by identifying, investigating and evaluating each incident. Supports coordinators initiate strategies and interventions approved by participants to prevent further incidents and follow-up, track, and compile mandatory critical incident reports.

MDHHS conducts a review, compiles a summary report, and trends and analyzes report submissions for review every six months. The review includes an evaluation of individual and summary reports, investigation and reporting timeliness, the prevention strategies and interventions used, and verification that waiver agency staff reports incidents of abuse, neglect, and exploitation to the MDHHS APS as required. MDHHS provides technical assistance and training as necessary to improve reports and quality outcomes for the participants involved and checks that the waiver agency used appropriate related planned services and supportive interventions to reduce or ameliorate further incidents.

Waiver agencies are required to submit encounter data to MDHHS on a submission schedule set by MDHHS. These encounters include data about services provided and service costs. MDHHS compiles this data into reports to analyze the effectiveness of services and costs and to assist the actuary in setting rates.

During each contract year, MDHHS will withhold a portion of the approved capitation payment from each waiver agency. These funds will be used for the waiver agency performance bonus incentive. These incentives will be given to waiver agencies according to criteria established by MDHHS. The criteria will include assessment of performance in quality of care and administrative functions. Each year, MDHHS will establish and communicate to the waiver agencies the criteria and standards to be used for the performance bonus incentives.

Additional QIS Activities

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

RM planning includes strategies and methods for addressing health and welfare issues negotiated with the participant. Supports coordinators and participants monitor and evaluate effectiveness of RM plans, noting successful strategies and modifying unsuccessful strategies with the participant. RM planning and updates occur during reassessment or more frequently, if needed. Supports coordinators document RM planning in the service plan.
2) Waiver agencies train participants, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic, content, and training evaluations.
3) Waiver agencies use Quality Indicators (QI) reported from their assessment database to measure 20 participant health status outcomes. The waiver agency runs and monitors the reports quarterly. MDHHS also reviews the reports annually.
4) Waiver agencies monitor service providers annually. Waiver agencies compile provider monitoring reports of provider performance, corrective actions, trainings, and follow-up activities conducted, as necessary. Waiver agencies submit provider monitoring schedules to MDHHS annually and all provider monitoring reports to MDHHS upon completion. MDHHS reviews the waiver agency provider monitoring schedules and administrative monitoring reviews, results, and findings as submitted on an on-going basis. MDHHS also requires the waiver agency to conduct in home participant visits to gauge the effectiveness of service delivery. The waiver agency reviewer is required to conduct two home visits with waiver participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned.
5) The State reviews all NFLOC determinations and provides the final approval or denial for eligibility or disenrollments prior to the first date of service.
6) MDHHS monitors administrative hearings and decisions as they occur.
7) MDHHS contracts with a third party vendor to conduct the CAHPS for HCBS biannually with participants .

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Waiver agencies	☒ **Other** Specify: Every six months, biennial

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Waiver agency QMPs and QI data

MDHHS compiles data from waiver agency quality management plan and QI reports and disseminates the information to QMC members, waiver agency staff and other stakeholders annually. This information includes statewide averages for each QI in the MDHHS QMP, individual waiver agency QI data, and progress in meeting established benchmarks. MDHHS presents this information at QMC meetings, waiver director meetings, and as requested by other audiences.

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

CQAR/Home Visits
The EQRO shares individual waiver agency CQAR scores and aggregated data with MDHHS, QMC members, waiver agency staff, and other interested parties annually. The aggregated report includes the percentage of compliance found for each standard in the CQAR, including the home visits, summarized compliance for each section of the CQAR, and an overall compliance score. The EQRO usually presents this data at QMC and waiver director meetings. The presentation includes a summary of successes in practice, noted deficiencies, and improvements from previous data. The discussion may also include methods utilized to improve compliance and common reasons for deficiencies.

CIR Reports
Biannually, MDHHS analyzes critical incident data including the number of incidents, data trends, remediation methods, and incident resolutions. MDHHS monitors reported incidents that did not include a resolution until the waiver agency finalizes interventions to the satisfaction of the participant involved. MDHHS presents the CIR report to the QMC annually.
Participant Satisfaction Reports
MDHHS shares the data from the biannual participant satisfaction reports with waiver agencies, QMC members and other interested parties biannually.

MI Choice Quality Website
MDHHS has developed a MI Choice Quality Website. The website includes a summary of the following information for each waiver agency:
• Results from the last two years of CQAR reports, including the compliance determination
• Accreditation status (organization, type, and expiration date)
• Participant Satisfaction scores (overall from surveys)

Links to each report are available on the website. MDHHS will continue to enhance this website as needed.

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

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

MDHHS updates service standards and contract requirements, as needed, to assure the health and welfare of MI Choice participants and maintain compliance to state and federal requirements. Contract requirements include the person-centered planning guidelines, Supports Coordination Service Performance Standards and Waiver Program Operating Criteria, reporting requirements, waiver agency MI Choice Waiver Program Provider Monitoring Plan, and billing procedures and coding systems.

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

A third party vendor under contract with MDHHS has conducted two participant surveys, January 2018 and June 2018. The surveys were developed in collaboration between MDHHS and the vendor.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) Independent Audit Requirements of Provider Agencies

Provider agencies (including waiver agencies) are required to submit a Single Audit, Financial Statement Audit, Financial Related Audit or Audit Exemption Status Notification Letter to the Department as described below. Provider agencies must also submit a corrective action plan in accordance with 2 CFR §200.511(c) for any audit finding that impacts the program and management letter (if issued) with a response.

1. Single Audit
Provider agencies that are a state, local government or non-profit organization that expend $750,000 or more in federal awards during the contractor's fiscal year must submit a Single Audit to the Department, regardless of the amount of funding received from MDHHS. The Single Audit must comply with the requirements of 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

2. Financial Related Audit
Provider Agencies that are for-profit organizations that expend $750,000 or more in federal awards during the Grantee's fiscal year must submit either a financial related audit prepared in accordance with Government Auditing Standards relating to all federal
awards; or an audit that meets the requirements contained in 2 CFR, Subpart F, if required by the federal awarding agency.

3. Audit Exemption Notice
Provider agencies exempt from the Single Audit and Financial Related Audit requirements must submit an Audit Exemption Notice that certifies these exemptions.

4. Financial Statement Audit
Provider agencies exempt from the Single Audit and Financial Related Audit requirements (that are required to submit an Audit Exemption Notice as described above) must also submit to the Department a Financial Statement Audit prepared in accordance with generally accepted auditing standards if the audit includes disclosures that may negatively impacts the Department funded programs including, but not limited to fraud, going concern uncertainties, financial statement misstatements, and violations of contract and grant provisions. If submitting a Financial Statement Audit, Grantees must also submit a corrective action plan for any audit findings that impacts the Department funded programs.

The required audit and any other required submissions (i.e. corrective action plan and management letter with a response), or audit Status Notification Letter must be submitted to MDHHS within nine months after the end of the contractor's fiscal year by e-mail to MDHHS.

(b) Financial Audit Program to Insure Provider Billing Integrity

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to waiver agencies. The 834 process generates an enrollment file based upon the PAHP provider ID number and the beneficiary's assignment to the MI Choice Managed Care benefit plan. This process uses edits to assure only the PAHPs that have a contract with the State are provided the capitation payment for the MI Choice program. Each PAHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PAHP. This process includes verifying the participant's Medicaid eligibility and nursing facility level of care evaluation. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PAHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a six month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PAHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the MI Choice Waiver program during a given month when the PAHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the MI Choice Waiver program but the PAHPs received capitation payments due to data lags in the 834 process.

A second form of monitoring is that all waiver service providers contracting with a waiver agency must submit bills to the waiver agency detailing the date of service, type of service, unit cost, and the number of units provided for each waiver participant served. Provider bills are then matched and verified against the participant's approved person-centered service

plan by the waiver agency prior to submitting encounter data to MMIS. The waiver agencies process payments for all verified encounters by the providers.

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

(c) Agencies Responsible for Conducting the Financial Audit Program

The Michigan Office of the Auditor General (OAG) performs the Medicaid Cluster major federal program compliance review as part of the MDHHS Single Audit. Within this review, expenditures of the MI Choice waiver are included in the Medicaid Cluster population and are subjected to statistical sample testing. Expenditures of the MI Choice waiver were selected and reviewed in the most recent Single Audit for federal compliance requirements and will continue to be subjected to future sample testing.

Additional Information:
The waiver agencies have first line responsibility to ensure services they are paying for were delivered as appropriate and do meet the participant's needs. Also, during CQAR and AQAR site visits or record reviews, MDHHS or its designees review sources of information to determine if services were rendered.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of encounters submitted to MDHHS with all required data elements. Numerator: Number of encounters submitted to MDHHS with all required data elements. Denominator: Number of all encounters submitted to MDHHS.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Waiver agency*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the waiver agencies for MI Choice participants with active Medicaid. Denominator: Total number of all MI Choice capitation payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Waiver agency*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of encounters submitted to MDHHS within required timeframes.
Numerator: Number of encounters submitted to MDHHS within required timeframes.
Denominator: Number of encounters submitted to MDHHS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
Number and percent of service plans that supported paid services. Numerator: Number of service plans that supported paid services. Denominator: Number of service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+/- 5%*
☒ ***Other*** *Specify:* *EQRO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *bi-ennial*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *EQRO*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *bi-ennial*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of capitation payments that have been paid at rates approved by the Actuary. Numerator: Number of capitation payments that have been paid at rates approved by the Actuary. Denominator: All capitation rates paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS data for capitation payments

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Financial Monitoring and Audit

MDHHS requires waiver agencies to conduct annual financial monitoring according to the waiver agencies' MI Choice Waiver Program Provider Monitoring Plan. This methodology is designed to ensure and verify that:

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

2) Providers deliver services according to the MI Choice participant person-centered service plan;

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

4) Providers maintain participant case record documentation to support encounter data.

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

MDHHS also requires the waiver agencies to conduct participant home visits to gauge accurately the effectiveness of service delivery. The waiver agency reviewer conducts a minimum of two home visits with participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned. MDHHS reviews all waiver agency provider monitoring reports either as completed and submitted to MDHHS.

Additionally, MDHHS conducts on site reviews to verify the waiver agency maintains administrative and financial accountability. MDHHS biennially conducts financial reviews of waiver agencies using a methodology similar to the MI Choice Waiver Program Provider Monitoring Plan during the AQAR process. MDHHS reviews and evaluates a sample of participant claims from the person-centered service plan during a three-month period. This process includes reviewing the service record from inception through reported encounter data to verify that records match by date of service, amount, duration, and type of service.

b. Methods for Remediation/Fixing Individual Problems

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

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

Immediately after completing the AQAR, MDHHS conducts on-site exit interviews with the waiver agency staff. During these exit interviews, the waiver agency is provided with a report of all non-evident findings and a listing of any findings that require immediate remediation. The immediate remediation is typically due within two weeks. MDHHS also compiles AQAR findings into reports that are sent to the waiver agency. When these reports indicate a need for corrective action, the waiver agency has 30 days to respond with a corrective action plan.

Corrective action plans should demonstrate that the waiver agency has:
1. *Analyzed all non-evident findings and determined possible causes;*
2. *Developed a remediation strategy, including timelines, that address and resolve the problems; and*
3. *Planned ongoing monitoring of remediation activities and performance.*

Waiver agencies are required to provide evidence of their remediation strategy by submitting documentation to MDHHS. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan. MDHHS reviews, then either approves the corrective action plan and documentation or works with waiver agency staff to amend the plan to meet MDHHS requirements. MDHHS monitors the implementation of each corrective action plan item to assure the waiver agency meets established timelines for implementing corrective action.

Specific remediation steps to be taken for each performance measure in Financial Accountability:

If any provider bills are paid for individuals who are not waiver participants:
1. Waiver agencies must recover payments made for services rendered for individuals who were not waiver participants. Provider billing adjustments can be made in MMIS using individual encounter adjustment to date of service or through gross adjustment methodology.

2. MDHHS utilizes MMIS edits to ensure capitation payments are paid for participants of the waiver program only and will not generate capitation payments for non-eligible individuals.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* *waiver agency*	☒ ***Annually***
	☒ ***Continuously and Ongoing***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Capitation Rate Development

PAHPs are provided a monthly capitation rate for all enrolled participants. The rates conform to the managed care regulations found at 42 CFR § 438 and payments of the rates are contingent upon CMS approval. The following lists the steps taken to develop the capitation rates.

• Summarize direct services base period data;
• Application of trend year;
• Adjust for Supports Coordination/Case Management;
• Apply administration load; and,
• Withhold percentage.

Summary of Base Period Data

Milliman collected historical FFS experience and capitation payments made. Corresponding enrollment records were summarized for the same incurred period. The MI Choice beneficiaries were split by age and Significant Support Participant (SSP) status for comparison.

A list of beneficiaries identified as Significant Support Participants was provided by MDHHS for purposes of rate development. These beneficiaries represent a population that requires a higher need for services and supports than those classified as non-SSP. Typically, these beneficiaries are those that were previously placed in a nursing facility, but have transitioned into a home or community setting.

Based on the list of services covered by the waiver, services were summarized into 16 different categories. The HCPCS or procedure code included on the claim/encounter was used to assign the experience to a service category. The historical experience was converted to a per member per month (PMPM) basis and summarized into actuarial cost models.

Each waiver agency uses an open bid process to contract with qualified providers in their service area that are willing to furnish MI Choice services. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of its expected utilization for each MI Choice service, and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDHHS. This assures network capacity as well as choice of providers.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers of waiver services bill the waiver agency for services furnished as authorized in the person-centered service plan, and according to the contract between the waiver agency and the provider. Each waiver agency reviews the bills submitted by provider agencies to assure that all claims for services have been rendered in compliance with the approved person-centered service plan. Waiver agencies pay the rendering provider directly once verification for the provision of service in accordance with the approved person-centered service plan is done. The State's capitation payments made to the PAHPs are in accordance with the managed care contracts and the 1915(b) waiver.

In the self-determination option, workers submit timesheets to the fiscal intermediary who, in turn, submits bills to the waiver agency for reimbursement. The waiver agency reimburses the fiscal intermediary according to the process identified in the contract between the fiscal intermediary and the waiver agency. Worker timesheets must be signed by both the worker and the participant or the participant’s authorized representative. The fiscal intermediary then pays the self-determination worker based upon the work reported on the time sheet. The fiscal intermediary submits monthly budget reports to both the waiver agency and the participant. Waiver agencies cost settle with fiscal intermediaries on a monthly or annual basis, according to the terms of their mutual contract.

Waiver agencies submit encounter data to the MMIS system based upon bills paid to providers for traditionally arranged service provision and through the fiscal intermediary services supported through the self-determination option, according to the requirements of the managed care contracts and the §1915(b) waiver.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) When the individual is eligible for Medicaid waiver payment on the date of service.

The 820 Premium Payment process is designed to assure the MI Choice capitation payment is only generated for persons enrolled in the MI Choice benefit plan. To enroll in the MI Choice benefit plan, persons must be deemed eligible for MI Choice and enrolled. The 820 payment process also verifies the beneficiary has a valid Level of Care Determination in the system that indicates the person meets nursing facility level of care criteria. These checks are made before the payment to the PAHP is generated. MDHHS also employs a recoupment and repayment process with a six-month look back period to make adjustments to capitation payments made as eligibility and enrollment information is updated.

PAHPs verify participant eligibility for all dates of service billed by the rendering providers prior to paying provider bills for MI Choice services delivered. When the PAHP finds a provider bill for a date of service when the participant was not eligible, the PAHP either does not pay this bill, or uses alternate funding sources. The PAHP will not submit encounter data for dates of service in which the participant was not eligible. MDHHS requires the PAHP to modify encounter data as necessary so that it only reflects encounters for participants eligible for MI Choice on the dates of service claimed.

b) When the service was included in the participant's approved person-centered service plan.

The waiver agency is responsible for assuring that only services authorized in a participant's person-centered service plan are submitted as encounter data. The waiver agency utilizes their information system to compare bills submitted by provider agencies for authorized waiver services in each participant's person-centered service plan. Only those services contained within the approved service plan are paid. Claims paid by the waiver agency to the provider agency are then submitted to MMIS as encounter data. The MMIS will only accept encounter data for dates of service for which the participant was eligible for MI Choice enrollment.

MDHHS verifies participant eligibility against dates of service during the AQAR and during the CQAR processes. The AQAR process specifically compares dates of service with eligibility dates for a selected sample of MI Choice participants at each waiver agency. The CQAR process will identify inaccuracies between dates of service and participant eligibility during the course of the case record review and will provide for additional examination as needed if inaccuracies are found in the case record.

c) When the services were provided.

Each waiver agency periodically monitors service provider agencies. This monitoring includes an audit of the paid services compared to documentation including in-home logs kept by paid caregivers, time sheets, and other source documents. Additionally, waiver agencies have systems for participants and service provider agencies to notify the supports coordinator when services are not delivered as planned. Any services reported as not delivered will not be paid during the remit process. Verification of the provider no-show rate is part of the overall Quality Management Plan. Waiver agencies have methods within their respective information systems to track services not provided.

MDHHS requires waiver agencies and providers of service to maintain all records for a period of not less than ten years.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

At the end of each month, MDHHS will run the 834 Enrollment file for each waiver agency. This file contains an electronic listing of persons who are enrolled in the MI Choice program with each provider. MMIS then performs quality checks including: verification of current Medicaid eligibility; a valid LOCD indicating the participant meets nursing facility level of care; and the participant is not enrolled in any other long term care program. On the 4th pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each participant enrolled with each PAHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

This is a concurrent §1915(b)/1915(c) waiver, and therefore, this section is not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Fourteen of the twenty waiver agencies are Area Agency on Aging (AAA) organizations. These entities are quasi-public organizations that generally report to a board with some county oversight. In addition to the AAAs, Northern Lakes Community Mental Health, and Macomb-Oakland Regional Center (MORC) are community mental health agencies; A & D Home Health Care, Inc. is a home health agency; Reliance Community Care Partners is a stand-alone care management agency; and The Information Center, Inc. and Senior Services, Inc. are information, referral and assistance agencies that function as a waiver agency.

All PAHPs directly employ qualified supports coordinators who furnish Supports Coordination and Community Transition Services. One waiver agency, Tri-County Office on Aging, prepares and provides home delivered meals. A&D Home Health Care, Inc. offers workers who furnish Community Living Supports. All waiver agencies may also make purchases from retail stores for items falling into the Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, and Goods and Services categories.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

The monthly capitated payment to the managed care entities is not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

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

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ( ) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- (●) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Residential service providers are limited to billing under a finite set of Healthcare Common Procedure Coding System (HCPCS) codes for their services. The codes do not include reimbursement for room and board. MDHHS did not include costs associated with room and board in the capitation rate development process. Waiver agencies negotiate rates with each residential services provider based upon the unique needs and circumstances of each participant in the residential setting on an individual basis. All MI Choice services are based upon the assessed medical and functional needs of the participant, and specifically exclude room and board. Waiver agencies do not remit payments for room and board if such is received from the residential services provider. All payments to providers in residential settings are for approved MI Choice services only. MMIS will only approve encounter data claims for the approved HCPCS codes.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20003.62	5187.00	25190.62	42657.00	3466.00	46123.00	20932.38
2	20100.29	5289.00	25389.29	43613.00	3535.00	47148.00	21758.71
3	20030.94	5393.00	25423.94	44591.00	3605.00	48196.00	22772.06

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
4	20119.53	5500.00	25619.53	45590.00	3676.00	49266.00	23646.47
5	20287.14	5608.00	25895.14	46613.00	3748.00	50361.00	24465.86

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	16856	16856
Year 2	17402	17402
Year 3	18056	18056
Year 4	18854	18854
Year 5	19796	19796

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Average Length of Stay (ALOS) was determined based on historic information regarding the number of days of participation in the MI Choice waiver program that each waiver agency reported. The rate of growth of the number of days was estimated based on the trend determined from past information. The estimated ALOS for the upcoming 5-year period was calculated by dividing the total estimated number of participation days per fiscal year by the projected unduplicated number of participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D values were estimated using historic information obtained from claim data submitted by waiver agencies for SFY 2016 and 2017 and compared against CMS-372 for 2015. Costs associated with waiver services that are to be continued as in the past, were calculated based on projecting the number of users per service, the average units per user, the average cost per unit and the number of units.

The numbers of users of each service were based on the projection using change in unduplicated participant count by waiver year. The average cost per unit in each year was estimated by reviewing recent cost trends observed in the waiver program. The average units per user for each year was based on change in average length of stay by waiver year.

The two transportation services were combined into one service called Community Transportation. Community Health Worker service was also added as a new service.

For the Amendment removing Community Transition Services, there was a slight decrease in Factor D costs due to removing this service for the last quarter and all of Waiver Years 2-5. Projected utilization for the last quarter of Waiver Year 1 has been removed. The utilization for Community Transition Services for Waiver Years 2-5 have been zeroed out. THE STATE PROJECTS NO UTILIZATION OF COMMUNITY TRANSITION SERVICES FOR WAIVER YEAR 1, EFFECTIVE 10/1/2018, AND THERE HAS BEEN NO UTILIZATION OF THIS SERVICE FROM 10/1/2018-PRESENT. ESTIMATES HAVE BEEN REVISED ACCORDINGLY.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' values were estimated using historic information obtained from past CMS 372 reports from fiscal years 2015 projected forward to SFY 2019-2023 based on State budget trends specific to State Plan services.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G values were estimated using historic information obtained from past CMS 372 reports from fiscal years 2015 projected forward to SFY 2019-2023 based on State budget trends specific to nursing facility services.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' values were estimated using historic information obtained from past CMS 372 reports from fiscal years 2015 projected forward to SFY 2019-2023 based on State budget trends specific to State Plan services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Respite	
Supports Coordination	
Specialized Medical Equipment and Supplies	
Fiscal Intermediary	
Goods and Services	
Chore Services	
Community Health Worker	
Community Living Supports	

Waiver Services	
Community Transition Services (termination effective 7/1/2019)	
Community Transportation	
Counseling	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Nursing Services	
Personal Emergency Response System	
Private Duty Nursing/Respiratory Care	
Training	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**3665266.26**
Adult Day Health - Per 15 minutes	☒	15 Minutes	504	2183.89	3.33	**3665266.26**	
Respite Total:							**1179190.37**
Respite - Per Diem	☒	Per Diem	155	13.67	141.18	**299139.24**	
Respite - Per 15 minutes	☒	Per 15 Minutes	296	719.89	4.13	**880051.13**	
Supports Coordination Total:							**73579116.21**
Supports Coordination - Per Month	☒	Month	15966	9.38	491.31	**73579116.21**	
Specialized Medical Equipment and Supplies Total:							**1971176.11**
Specialized Medical Equipment and Supplies	☒	Item	4929	195.08	2.05	**1971176.11**	
Fiscal Intermediary Total:							**3425539.81**

GRAND TOTAL:	**337181066.57**
Total: Services included in capitation:	337181066.57
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**16856**
Factor D (Divide total by number of participants):	**20003.62**
Services included in capitation:	20003.62
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	257

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Fiscal Intermediary	☒	Month	2684	10.56	120.86	3425539.81	
Goods and Services Total:							291683.39
Goods and Services	☒	Item	628	7.70	60.32	291683.39	
Chore Services Total:							836009.25
Chore Services	☒	15 Minutes	1277	91.69	7.14	836009.25	
Community Health Worker Total:							1099991.92
Community Health Worker	☒	visit	1686	162.70	4.01	1099991.92	
Community Living Supports Total:							223414494.18
Community Living Supports	☒	15 Minutes	15965	3489.78	4.01	223414494.18	
Community Transition Services (termination effective 7/1/2019) Total:							0.00
Community Transition Services (termination effective 7/1/2019)	☐	Item	0	0.00	0.01	0.00	
Community Transportation Total:							2520706.55
Community Transportation	☒	Trip/Mile	4046	958.48	0.65	2520706.55	
Counseling Total:							92220.61
Counseling	☒	Visit	201	12.17	37.70	92220.61	
Environmental Accessibility Adaptations Total:							739494.60
Environmental Accessibility Adaptations	☒	Item	369	1.32	1518.22	739494.60	
Home Delivered Meals Total:							7142220.20
Home Delivered Meals	☒	Meal/Prep	4742	267.05	5.64	7142220.20	
Nursing Services Total:							3324744.15
Nursing Services	☒	15 Minutes	1850	177.06	10.15	3324744.15	
Personal Emergency Response System							1693631.79

GRAND TOTAL:	337181066.57
Total: Services included in capitation:	337181066.57
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	16856
Factor D (Divide total by number of participants):	20003.62
Services included in capitation:	20003.62
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	257

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Emergency Response System	☒	Month/Install	6334	8.54	31.31	1693631.79	
Private Duty Nursing/Respiratory Care Total:							12175620.72
Private Duty Nursing/Respiratory Care	☒	15 Minutes	156	7836.23	9.96	12175620.72	
Training Total:							29960.43
Training	☒	15 Minutes	515	2.63	22.12	29960.43	

GRAND TOTAL:	337181066.57
Total: Services included in capitation:	337181066.57
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	16856
Factor D (Divide total by number of participants):	20003.62
Services included in capitation:	20003.62
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	257

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							3797258.04
Adult Day Health - Per 15 minutes	☒	15 Minutes	520	2166.89	3.37	3797258.04	
Respite Total:							1223930.25
Respite - Per Diem	☒	Per Diem	160	13.56	143.02	310296.19	
Respite - Per 15 minutes	☒	Per 15 Minutes	306	714.29	4.18	913634.05	
Supports Coordination Total:							76380018.22

GRAND TOTAL:	349785301.88
Total: Services included in capitation:	349785301.88
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	17402
Factor D (Divide total by number of participants):	20100.29
Services included in capitation:	20100.29
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	255

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Coordination - Per Month	☒	Month	16483	9.31	497.73	76380018.22	
Specialized Medical Equipment and Supplies Total:							2048855.83
Specialized Medical Equipment and Supplies	☒	Item	5089	193.56	2.08	2048855.83	
Fiscal Intermediary Total:							3555667.40
Fiscal Intermediary	☒	Month	2771	10.48	122.44	3555667.40	
Goods and Services Total:							302538.50
Goods and Services	☒	Item	648	7.64	61.11	302538.50	
Chore Services Total:							866961.16
Chore Services	☒	15 Minutes	1318	90.98	7.23	866961.16	
Community Health Worker Total:							1141061.50
Community Health Worker	☒	visit	1741	161.43	4.06	1141061.50	
Community Living Supports Total:							231707865.53
Community Living Supports	☒	15 Minutes	16482	3462.62	4.06	231707865.53	
Community Transition Services (termination effective 7/1/2019) Total:							0.00
Community Transition Services (termination effective 7/1/2019)	☐	Item	0	0.00	0.01	0.00	
Community Transportation Total:							2621790.96
Community Transportation	☒	Trip/Mile	4177	951.02	0.66	2621790.96	
Counseling Total:							95957.72
Counseling	☒	Visit	208	12.08	38.19	95957.72	
Environmental Accessibility Adaptations Total:							767656.14
Environmental Accessibility Adaptations	☒	Item	381	1.31	1538.05	767656.14	

GRAND TOTAL:	349785301.88
Total: Services included in capitation:	349785301.88
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	17402
Factor D (Divide total by number of participants):	20100.29
Services included in capitation:	20100.29
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	255

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**7407543.72**
Home Delivered Meals	☒	Meal/Prep	4896	264.97	5.71	**7407543.72**	
Nursing Services Total:							**3449441.66**
Nursing Services	☒	15 Minutes	1910	175.68	10.28	**3449441.66**	
Personal Emergency Response System Total:							**1756822.67**
Personal Emergency Response System	☒	Month/Install	6539	8.47	31.72	**1756822.67**	
Private Duty Nursing/Respiratory Care Total:							**12630815.87**
Private Duty Nursing/Respiratory Care	☒	15 Minutes	161	7775.25	10.09	**12630815.87**	
Training Total:							**31116.73**
Training	☒	15 Minutes	532	2.61	22.41	**31116.73**	

GRAND TOTAL:	**349785301.88**
Total: Services included in capitation:	349785301.88
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**17402**
Factor D (Divide total by number of participants):	**20100.29**
Services included in capitation:	20100.29
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	255

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(7 of 9)*

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**3927522.06**

GRAND TOTAL:	**361678639.32**
Total: Services included in capitation:	361678639.32
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**18056**
Factor D (Divide total by number of participants):	**20030.94**
Services included in capitation:	20030.94
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health - Per 15 minutes	☒	15 Minutes	540	2132.90	3.41	3927522.06	
Respite Total:							1266845.21
Respite - Per Diem	☒	Per Diem	166	13.35	144.89	321090.73	
Respite - Per 15 minutes	☒	Per 15 Minutes	318	703.09	4.23	945754.48	
Supports Coordination Total:							78989807.77
Supports Coordination - Per Month	☒	Month	17102	9.16	504.23	78989807.77	
Specialized Medical Equipment and Supplies Total:							2122545.22
Specialized Medical Equipment and Supplies	☒	Item	5280	190.52	2.11	2122545.22	
Fiscal Intermediary Total:							3680266.80
Fiscal Intermediary	☒	Month	2875	10.32	124.04	3680266.80	
Goods and Services Total:							312858.47
Goods and Services	☒	Item	672	7.52	61.91	312858.47	
Chore Services Total:							896732.21
Chore Services	☒	15 Minutes	1368	89.55	7.32	896732.21	
Community Health Worker Total:							1179460.67
Community Health Worker	☒	visit	1806	158.90	4.11	1179460.67	
Community Living Supports Total:							239552740.41
Community Living Supports	☒	15 Minutes	17101	3408.30	4.11	239552740.41	
Community Transition Services (termination effective 7/1/2019) Total:							0.00
Community Transition Services (termination effective 7/1/2019)	☐	Item	0	0.00	0.01	0.00	
Community Transportation Total:							2718228.46
Community Transportation	☒					2718228.46	

GRAND TOTAL:	361678639.32
Total: Services included in capitation:	361678639.32
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	18056
Factor D (Divide total by number of participants):	20030.94
Services included in capitation:	20030.94
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Trip/Mile	4334	936.10	0.67		
Counseling Total:							99365.21
Counseling	☒	Visit	216	11.89	38.69	99365.21	
Environmental Accessibility Adaptations Total:							793950.24
Environmental Accessibility Adaptations	☒	Item	395	1.29	1558.14	793950.24	
Home Delivered Meals Total:							7658007.54
Home Delivered Meals	☒	Meal/Prep	5080	260.81	5.78	7658007.54	
Nursing Services Total:							3567792.65
Nursing Services	☒	15 Minutes	1982	172.92	10.41	3567792.65	
Personal Emergency Response System Total:							1818137.10
Personal Emergency Response System	☒	Month/Install	6785	8.34	32.13	1818137.10	
Private Duty Nursing/Respiratory Care Total:							13062176.17
Private Duty Nursing/Respiratory Care	☒	15 Minutes	167	7653.29	10.22	13062176.17	
Training Total:							32203.13
Training	☒	15 Minutes	552	2.57	22.70	32203.13	

GRAND TOTAL:	361678639.32
Total: Services included in capitation:	361678639.32
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	18056
Factor D (Divide total by number of participants):	20030.94
Services included in capitation:	20030.94
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	251

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**4117118.22**
Adult Day Health - Per 15 minutes	☒	15 Minutes	564	2115.90	3.45	**4117118.22**	
Respite Total:							**1329623.58**
Respite - Per Diem	☒	Per Diem	173	13.24	146.78	**336202.53**	
Respite - Per 15 minutes	☒	Per 15 Minutes	332	697.49	4.29	**993421.06**	
Supports Coordination Total:							**82921012.16**
Supports Coordination - Per Month	☒	Month	17858	9.09	510.82	**82921012.16**	
Specialized Medical Equipment and Supplies Total:							**2229787.98**
Specialized Medical Equipment and Supplies	☒	Item	5513	189.00	2.14	**2229787.98**	
Fiscal Intermediary Total:							**3862848.72**
Fiscal Intermediary	☒	Month	3002	10.24	125.66	**3862848.72**	
Goods and Services Total:							**328459.62**
Goods and Services	☒	Item	702	7.46	62.72	**328459.62**	
Chore Services Total:							**941327.32**
Chore Services	☒	15 Minutes	1428	88.84	7.42	**941327.32**	
Community Health Worker Total:							**1236727.15**
Community Health Worker	☒	visit	1886	157.63	4.16	**1236727.15**	
Community Living Supports Total:							**251168390.64**
Community Living Supports	☒	15 Minutes	17857	3381.14	4.16	**251168390.64**	
Community Transition Services (termination effective 7/1/2019) Total:							**0.00**
Community Transition Services (termination effective 7/1/2019)	☐	Item	0	0.00	0.01	**0.00**	
Community Transportation Total:							**2858056.76**

GRAND TOTAL:	**379333690.61**
Total: Services included in capitation:	379333690.61
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**18854**
Factor D (Divide total by number of participants):	**20119.53**
Services included in capitation:	20119.53
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	249

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transportation	☒	Trip/Mile	4526	928.64	0.68	2858056.76	
Counseling Total:							104538.56
Counseling	☒	Visit	226	11.80	39.20	104538.56	
Environmental Accessibility Adaptations Total:							832432.49
Environmental Accessibility Adaptations	☒	Item	412	1.28	1578.49	832432.49	
Home Delivered Meals Total:							8043217.13
Home Delivered Meals	☒	Meal/Prep	5305	258.73	5.86	8043217.13	
Nursing Services Total:							3746176.29
Nursing Services	☒	15 Minutes	2070	171.54	10.55	3746176.29	
Personal Emergency Response System Total:							1907200.52
Personal Emergency Response System	☒	Month/Install	7085	8.27	32.55	1907200.52	
Private Duty Nursing/Respiratory Care Total:							13672991.08
Private Duty Nursing/Respiratory Care	☒	15 Minutes	174	7592.31	10.35	13672991.08	
Training Total:							33782.40
Training	☒	15 Minutes	576	2.55	23.00	33782.40	

GRAND TOTAL:	379333690.61
Total: Services included in capitation:	379333690.61
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	18854
Factor D (Divide total by number of participants):	20119.53
Services included in capitation:	20119.53
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	249

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**4366532.80**
Adult Day Health - Per 15 minutes	☒	15 Minutes	592	2107.40	3.50	**4366532.80**	
Respite Total:							**1411609.87**
Respite - Per Diem	☒	Per Diem	182	13.19	148.70	**356966.25**	
Respite - Per 15 minutes	☒	Per 15 Minutes	349	694.69	4.35	**1054643.62**	
Supports Coordination Total:							**87811584.38**
Supports Coordination - Per Month	☒	Month	18750	9.05	517.49	**87811584.38**	
Specialized Medical Equipment and Supplies Total:							**2364286.87**
Specialized Medical Equipment and Supplies	☒	Item	5788	188.24	2.17	**2364286.87**	
Fiscal Intermediary Total:							**4092745.92**
Fiscal Intermediary	☒	Month	3152	10.20	127.30	**4092745.92**	
Goods and Services Total:							**347939.32**
Goods and Services	☒	Item	737	7.43	63.54	**347939.32**	
Chore Services Total:							**997389.03**
Chore Services	☒	15 Minutes	1499	88.48	7.52	**997389.03**	
Community Health Worker Total:							**1308720.60**
Community Health Worker	☒	visit	1980	157.00	4.21	**1308720.60**	
Community Living Supports Total:							**265812590.07**
Community Living Supports	☒	15 Minutes	18749	3367.56	4.21	**265812590.07**	
Community Transition Services (termination effective 7/1/2019) Total:							**0.00**
Community Transition Services (termination effective 7/1/2019)	☐	Item	0	0.00	0.01	**0.00**	
Community Transportation Total:							**3032668.90**

GRAND TOTAL:	**401604225.47**
Total: Services included in capitation:	401604225.47
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**19796**
Factor D (Divide total by number of participants):	**20287.14**
Services included in capitation:	20287.14
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	248

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transportation	☒	Trip/Mile	4752	924.91	0.69	3032668.90	
Counseling Total:							110582.42
Counseling	☒	Visit	237	11.75	39.71	110582.42	
Environmental Accessibility Adaptations Total:							879366.58
Environmental Accessibility Adaptations	☒	Item	433	1.27	1599.11	879366.58	
Home Delivered Meals Total:							8525879.80
Home Delivered Meals	☒	Meal/Prep	5570	257.69	5.94	8525879.80	
Nursing Services Total:							3968737.86
Nursing Services	☒	15 Minutes	2173	170.85	10.69	3968737.86	
Personal Emergency Response System Total:							2021586.93
Personal Emergency Response System	☒	Month/Install	7439	8.24	32.98	2021586.93	
Private Duty Nursing/Respiratory Care Total:							14516199.00
Private Duty Nursing/Respiratory Care	☒	15 Minutes	183	7561.82	10.49	14516199.00	
Training Total:							35805.11
Training	☒	15 Minutes	605	2.54	23.30	35805.11	

GRAND TOTAL:	401604225.47
Total: Services included in capitation:	401604225.47
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	19796
Factor D (Divide total by number of participants):	20287.14
Services included in capitation:	20287.14
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	248