DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

September 27, 2019

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

Dear Ms. Massey:

The Centers for Medicare & Medicaid Services (CMS) approves Michigan's section 1915(c) home and community-based services waiver renewal of the Habilitation Supports Waiver (HSW), control number 0167.R06, effective October 1, 2019. This renewal will continue serve individuals of all ages who require the level of care of an intermediate care facility for individuals with intellectual and/or developmental disabilities. The waiver will operate statewide under a managed care delivery system authorized through the section 1115 Behavioral Health Waiver.

The HSW renewal estimates the following utilization and cost of waiver services:

	Unduplicated Recipients (Factor C)	**Community Costs (Factor D+D')**	**Institutional Costs (Factor G+G')**	**Total Waiver Costs (Factor C x Factor D)**
Year 1	8268	$75,163.56	$126,550.74	$439,666,278.48
Year 2	8268	$76,851.58	$129,714.51	$447,268,869.84
Year 3	8268	$78,742.08	$132,957.37	$456,314,640.60
Year 4	8268	$80,675.19	$136,281.31	$465,482,199.00
Year 5	8268	$82,840.61	$139,688.34	$476,332,047.36

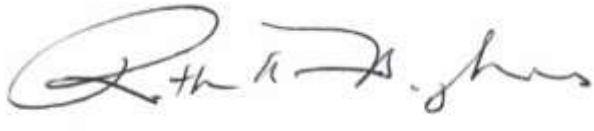
The renewed §1915(c) waiver makes the following changes from the previous waiver application:

- Adds the following waiver services: Non-Family Training, Fiscal Intermediary, and Overnight Health and Safety Support.
- Eliminates Supports Coordination as a waiver service. Waiver enrollees will continue to receive this service through the Medicaid State Plan.
- Eliminates certain limits for Out-of-Home Non-Vocational Habilitation.
- Eliminates encounter-related recoupment in order to transition to a traditional capitated managed care payment methodology.
- Revises and adds performance measures in the Quality Improvement Strategy.

It is important to note that CMS' approval of the HSW renewal 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.

Enclosed for your records is a flowchart that outlines the renewal due dates throughout the waiver review cycle. We would greatly appreciate ongoing communication with the state to help keep us informed of any changes or updates related to this waiver. If you have any questions, please contact Eowyn Ford at (312) 886-1684 or Eowyn.Ford@cms.hhs.gov.

Sincerely,

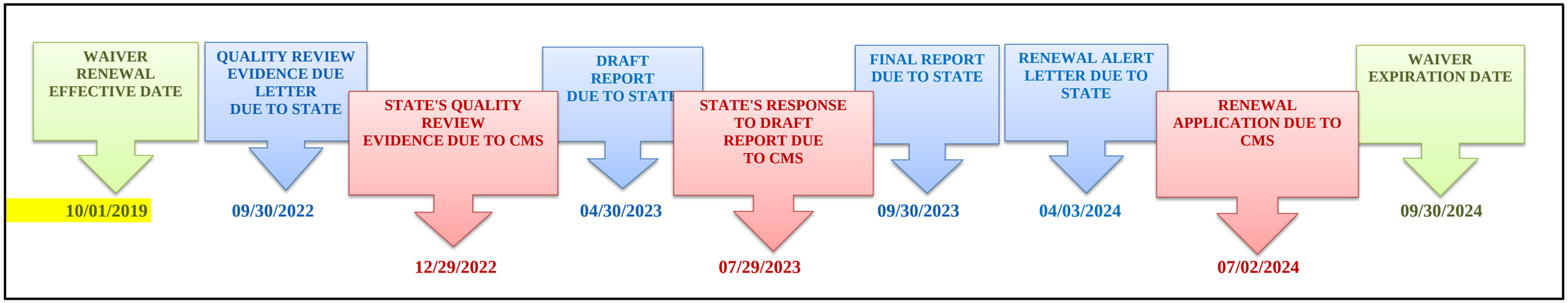


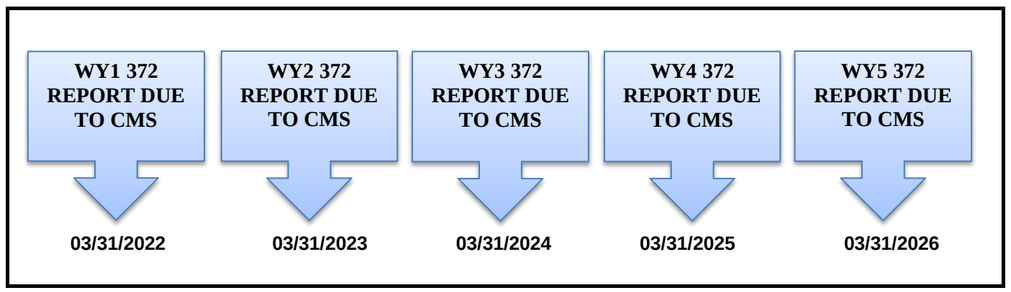
Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Office Group

Enclosure

cc: Jacqueline Coleman, MDHHS

State: Michigan
1915(c) Waiver Name: Habilitation Supports Waiver
Waiver Control Number: 0167.R06





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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The major changes being made for this waiver renewal are as follows:

1) Addition of a service called non-family training to provide coaching, training, supervision and monitoring of Community Living Supports and Respite staff by clinical professional working within the scope of their practice.

2) Addition of a service called Fiscal Intermediary to support for participant direction.

3) Addition of a service called Overnight Health and Safety Support to prevent, oversee, manage, direct, or respond to a beneficiary’s disruptive, risky, or harmful behaviors, during the overnight hours.

4) Elimination of Supports Coordination from the waiver as the service will be covered under the State Plan Amendment. Supports Coordination will continue to be available to HSW participants through the State Plan Amendment. The State plans to continue allowing current providers to furnish supports coordination services which will not significantly change how services are delivered to participants.

5) Elimination of the limit on the duration of service under Out of Home Non-vocational Habilitation. The State removed the limit of "four or more hours per day" from the service which would allow more flexibilities for HSW participants receiving this service.

6) Elimination of the encounter related recoupment in order to move to a traditional capitation payment methodology.

7) Revision of the level of care (LOC) determination process for MDHHS to make determinations on the LOC evaluations and re-evaluations.

8) Revision and addition of some performance measures for the Quality Improvement Strategy.

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

1. Request Information (1 of 3)

A. The **State** of **Michigan** requests approval for a Medicaid home and community-based services (HCBS) waiver under the

authority of §1915(c) of the Social Security Act (the Act).

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

Habilitation Supports Waiver

C. Type of Request: renewal

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.0167
Waiver Number:MI.0167.R06.00
Draft ID: MI.014.06.00

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

Regular Waiver

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

10/01/19

Approved Effective Date: 10/01/19

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:

○ **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:

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:

Michigan 1115 Behavioral Health Demonstration
§1115 Healthy Michigan Plan

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.

Originally approved by HCFA effective 10/1/1987, the Habilitation Supports Waiver (HSW) was Michigan's primary vehicle for reducing use of its Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) by allowing a strategic set of long-term services and supports to be delivered in community settings. Since that approval, unduplicated ICF/IID users have dropped from just under 4000 to nearly zero. The HSW now functions as the state's primary vehicle for supporting people in the community by enrolling people who were placed out of the ICF/IID and deflecting those who might otherwise require ICF/IID level of services. The purpose of the Habilitation Supports Waiver (HSW) is to provide community-based services to people with intellectual/developmental disabilities who, if not for the availability and provisions of HSW services would otherwise require the level of care services provided in an ICF/IID. The goal of the HSW is to enable people with intellectual/developmental disabilities who have significant needs and who meet the HSW eligibility requirements to live and fully participate in their communities. The objective is to provide regular Medicaid State Plan and Additional Services through the Michigan 1115 Behavioral Health Demonstration and waiver services through the HSW that address the participant's identified needs.

The HSW eligibility requirements include: 1) the participant is a person of any age with an intellectual/developmental disability, 2) the participant is living in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving HSW services, 3) the participant has current Medicaid eligibility, and 4) the participant would otherwise require the level of care services provided in an ICF/IID if not for the availability and provision of HSW services in the community. The HSW participant must require and receive at least one HSW habilitative service per month.

Waiver services include: Community Living Supports (CLS), Enhanced Medical Equipment & Supplies, Enhanced Pharmacy, Environmental Modifications, Family Training, Fiscal Intermediary, Goods & Services, Non-Family Training, Out-of-Home Nonvocational Habilitation, Overnight Health and Safety Support, Personal Emergency Response System, Prevocational Services, Private Duty Nursing, Respite Care, and Supported Employment.

Oversight of the HSW is provided by Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. Two administrations within MDHHS - Behavioral Health and Development Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) have responsibility for operations and payments, respectively. The HSW operates concurrently with the Michigan 1115 Behavioral Health Demonstration as a managed care program. The HSW is administered locally by the Prepaid Inpatient Health Plans (PIHP) under contract with MDHHS. Services are provided by the PIHP, its affiliate community mental health services programs (CMHSPs) if applicable, or its contracted entities. HSW participants may receive any medically necessary services provided under Michigan 1115 Behavioral Health Demonstration as well as all HSW services. Participants enrolled in the HSW 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 sent a Tribal notice on 04/18/2019 to provide an opportunity for Tribal members to review the waiver applications and submit comments. The period of Tribal comment was 04/18/19 - 06/03/2019. The general public notice/comment period was 06/14/19 - 7/15/2019. 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 on 05/16/19 and 6/14/2019. 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/0,5885,7-339-71550_2941---,00.html

Responses to specific comments are addressed below:

Comment: several commenters expressed concerns about the 298 pilot implementation. Specific concerns include:
- Commenters were opposed to the privatization of Michigan's Public Mental Health System through Boilerplate 298.

Response: Thank you for your comment. MDHHS has removed the 298 pilot from the new draft waiver application. The new draft application went out for public comments on 6/14/19.

Comment: One commenter expressed difficulties in navigation of MDHHS website and offered suggestion for improvement.
Response: Thank you for your comment. MDHHS will take this under advisement.

Comment: Several commenters submitted comments about Overnight Health and Safety Support services. Specific comments include:
- Supporting the addition of Overnight Health and Safety Support within this application.
- Adding medical necessity within the definition.
- Concerns over adequate funding and scope of service.
- Concerns over the potential replacement of CLS with Overnight Health and Safety Support service.
- Recommending a more specific definition of Overnight Health and Safety Support services.
- Concerns over coordination of CLS and Overnight Health and Safety Support services

Response: Thank you for your comment. MDHHS has created a work group to develop details about the use of Overnight Health and Safety Support services and will provide notification once more information is available. Medicaid Provider Manual changes will address the above concerns with more detailed requirements, training information, and resources.

Comment: One commenter suggested more specific language related to the duplication of Supported Employment as not to supplant of otherwise funded services.
Response: Thank you for your comment. There is a statement under the service limits section for supported employment indicating that supported employment service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (IDEA)... However, this section was not displayed properly when we converted the waiver application from the web portal to a PDF document. This technical issue has been addressed by the Waiver Management System support team.

Comment: One commenter expressed concerns about Medicaid deductibles not being processed in a timely manner.
Response: Thank you for your comment.

Comment: One commenter requested that a process be created to communicate with a beneficiary when HSW disenrollment is pursued.
Response: Thank you for your comment. MDHHS expects the current approved Grievance and Appeals process to be followed in the event of a disenrollment.

Comment: One commenter recognized the value of self-determination and recommended an increase on the use of Fiscal Intermediary service and choices across the State.
Response: Thank you for your comment.

Comment: One commenter suggested edits to the definition of Goods and Services so that this service is not to replace human support.
Response: Thank you for your comment. Goods and Services are designed to promote independence in the absence of human support.

Comment: One commenter requested a reduction of HSW bed limit on residential group home.
Response: Thank you for your comment. The implementation of the HCBS rule will assure all settings for HSW are home and community based by 2022.

Comment: One commenter expressed concerns over assuring quality monitoring is occurring by behavioral health providers.
Response: Thank you for your comment. MDHHS will continue to monitor quality assurance practices of the behavioral health providers.

Comment: One commenter expressed the need for clarification and provided recommendations around HCBS implementation.
Response: Thank you for your comment. MDHHS will continue to work with the behavioral health providers to assurance consistence around the HCBS requirements.

Comment: One commenter requested the Department adding transportation as a separate covered service for employment.
Response: Thank you for your comment. MDHHS is adding transportation cost in the risk factor to inform the managed care payment rate.

Comment: One commenter suggested changes to the statewide code structure to an outcome based structure.
Response: Thank you for your comment. MDHHS will take this under advisement

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, MDHHS

Address:
400 South Pine St

Address 2:

P.O. Box 30479

City:

Lansing

State: **Michigan**

Zip:

48909

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 Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and

certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Kathleen Stiffler

State Medicaid Director or Designee

Submission Date: Sep 19, 2019

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

Last Name: Stiffler

First Name: Kathleen

Title: Director

Agency: Medical Services Administrtation

Address: 400 South Pine Street

Address 2:

City: Lansing

State: **Michigan**

Zip: 48933

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

Fax: (517) 335-5007

E-mail: StifflerK@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:

There will be no need for a transition plan as Supports Coordination is not being terminated. This service has been transitioned to a state plan authority. Supports Coordination services will continue to be available to HSW participants through the State Plan Amendment. The scope of service will remain the same in the State Plan. The State plans will allow the same providers to furnish supports coordination services to the HSW participants. This authority change on the service will be seamless to HSW participants.

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.

The state assures that this waiver 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):

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:

(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.

Michigan Department of Health and Human Services (MDHHS) - Behavioral Health and Developmental Disabilities Administration (BHDDA)

(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:

a) The Michigan Department of Health and Human Services (MDHHS) is the Single State Medicaid Agency and is comprised of the following administrations: The Medicaid Services Administration (MSA), which administers Medicaid for MDHHS; the Behavioral Health and Developmental Disabilities Administration (BHDDA), which operates the Habilitation Supports Waiver and other mental health programs; and the Public Health Administration. More specifically, the MDHHS-BHDDA performs the following operational and administrative functions: all administrative functions related to the HSW including review and approval of initial waiver applications and annual re-evaluation submitted by Prepaid Inpatient Health Plans (PIHPs), waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, MDHHS-BHDDA staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, conduct utilization management functions, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

b) The Michigan Medicaid Provider Manual describes roles and responsibilities for waiver operations by the MDHHS in the Behavioral Health and Intellectual and Disability Supports and Services Chapter. Per the MDHHS Organizational Chart, operation of the HSW is within the MDHHS-BHDDA Bureau of Community Based Services.

c) The MDHHS Director oversees and provides guidance related to the administration and operation of the HSW through regular and as-needed (if issues arise) contacts with the directors of MDHHS-BHDDA.

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.:*

Michigan operates a concurrent 1115 Behavioral Health Demonstrationwith the §1915(c) waiver. MDHHS contracts with regional non-state public managed care entities known as Prepaid Inpatient Health Plans (PIHPs) to conduct operational and administrative functions at the regional and local levels in accordance with the Balanced Budget Act and managed care requirements. Michigan's PIHPs are comprised of one or more Community Mental Health Services Programs (CMHSPs).

PIHPs are delegated the responsibility to perform the following functions: disseminating information concerning the waiver to potential enrollees; assisting individuals in applying for waiver enrollment; managing waiver slot allocation; compiling information for level of care evaluation and re- certifications; assuring participants have been given freedom of choice of providers and have consented to HSW services in lieu of ICF/IID; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the participant's needs; conducting prior authorization or utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining, monitoring and managing the qualified provider network for managed care and HSW services.

Michigan utilizes an External Quality Review (EQR) to address PIHP compliance with Balanced Budget Act (BBA) requirements. The EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented, as well as providing a mechanism for discovering problems and issues at PIHPs/CMHSPs.

○ **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:

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:

Michigan Department of Health and Human Services (MDHHS) - Behavioral Health and Developmental Disabilities Administration (BHDDA) is responsible for assessing the performance of the PIHPs in conducting HSW functions.

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:

Within MDHHS-BHDDA, the Division of Quality Management and Planning (QMP) monitors implementation of the concurrent Michigan 1115 Behavioral Health Demonstration and the §1915(c) HSW. This Division also compiles and analyzes encounter data reported by the PIHPs for services delivered to participants under Michigan 1115 Behavioral Health Demonstration and §1915(c) HSW services. The QMP Federal Compliance Section has responsibility for performing on-site reviews at each PIHP. A full on-site review is completed at each PIHP/CMHSP on a biennial basis. The Site Review Team reviews a random sampling of HSW participants at each PIHP and any affiliate CMHSPs within a PIHP region as applicable. Those reviews include clinical record reviews and consumer interviews using the Site Review Protocols. The protocols are derived from requirements of the Michigan Mental Health Code, Administrative Rules, federal requirements, and Medicaid policies. The Site Review team monitors the following of the PIHP delegated responsibilities: 1) individual plans of service (IPOS) meet the HSW participant's identified needs for habilitation; 2) needed services are provided in the amount, scope and duration defined in the IPOS, including any PIHP prior authorization and/or utilization management functions that were part of the allocation of services; and 3) provider qualifications and adequacy of the provider network available for HSW participants. The Site Review Team also conducts a follow-up review approximately 90 days after the Corrective Action Plan has been approved to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. The QMP Division oversees all quality improvement efforts and ongoing quality assurance by the PIHPs.

Within MDHHS-BHDDA, the Bureau of Community Based Services has responsibility for operation of the HSW on a day-to-day basis. The HSW Program staff from the Federal Compliance Section, on a continual basis, monitor the following PIHP delegated responsibilities: 1) reviewing quality of individual plans of service (IPOS) using person-centered planning (PCP) process and appropriateness for HSW eligibility; 2) reviewing and approving PIHP recommendations for involuntary disenrollments from the HSW; 3) monitoring timeliness of freedom of choice in lieu of ICF/IID services completed at least every three years; and 4) monitoring health and welfare issues by way of recipient rights complaints, critical incidents, Medicaid fair hearing requests, and the use of restrictive or intrusive behavioral interventions.

Michigan utilizes an External Quality Review (EQR) to address PIHP compliance with Balanced Budget Act (BBA) requirements. The EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented, as well as providing a mechanism for discovering problems and issues at PIHPs/CMHSPs.

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	Contracted 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 PIHPs that have filled at least 95% of all slots allocated.
Numerator: Number of PIHPs that have filled at least 95% of all slots allocated.
Denominator: All PIHPs.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Electronic record-keeping

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 LOC compliance issues that were remediated within 90 days. Numerator: Number of LOC compliance issues remediated within 90 days. Denominator: All LOC compliance issues.

Data Source (Select one):
Trends, remediation actions proposed / taken
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: proportionate random sample, 95% Confidence Interval

	☐ **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 PIHPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of PIHPs that implement required Q A/I activities. Denominator: All PIHPs.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
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: EQR	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: sampling methodology determined by EQR
	☐ **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 compliance issues for provider qualifications that were remediated within 90 days. Numerator: Number of compliance issues remediated within 90 days. Denominator: All compliance issues.

Data Source (Select one):
Trends, remediation actions proposed / taken
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: proportionate random sample, 95% confidence interval
	☐ **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 IPOS compliance issues that were remediated within 90 days. Numerator: Number of IPOS compliance issues remediated within 90 days. Denominator: All IPOS compliance issues.

Data Source (Select one):
Trends, remediation actions proposed / taken
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:

		proportionate random sample, 95% Confidence Interval
	☐ **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 administrative hearings related to utilization management issues.
Numerator: Number of administrative hearings related to utilization management.
Denominator: All hearings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Hearing Decision and Order

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

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

Data Aggregation and Analysis:

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

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 PIHPs implementing prior authorization according to established policy. Numerator: Number of PIHPs implementing prior authorization according to policy. Denominator: All PIHPs 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate random sample, 95% confidence interval
	☒ **Other** Specify: Bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

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

The Division of Quality Management and Planning (QMP) site review process includes a full review on a biennial basis and a follow-up review 90 days after the corrective action plan is approved. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, the same proportionate random sample used for the review is used. The data source is the plan of correction remediation evidence submitted by the PIHP for any issues identifies during the review of the sample. Timely remediation is completed within 90 days after the PIHP's plan of correction has been approved by MDHHS-BHDDA.

For the performance measure related to the delegation of managing expenditures against approved limits, underexpenditure is monitored through a proxy measure of the percent of filled slots at each PIHP. The data source is the HSW database, which has a report for slot allocation/utilization which calculates the percentages of slots filled. The methodology is a review of all PIHPs on a monthly basis.

For the performance measure related to utilization management, a strong proxy indicator that utilization management problems may be present is the volume and type of hearings. The methodology for this measure is to review all hearing decision and order documents related to PIHP utilization management decisions for HSW participants.

Michigan's concurrent §1115 Behavioral Health Demonstration/1915(c) waiver includes a comprehensive quality improvement program that includes participants from the HSW, the Children's Waiver, the Waiver for Children with Serious Emotional Disturbances and the 1915(i) SPA. PIHPs are required to submit data on a quarterly basis on Performance Indicators specified by MDHHS. These indicators are used to identify trends, outliers, and potentially, may be used for performance improvement programs. The EQR is an additional strategy employed by the State to discover problems and identify trends. EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. One EQR component addresses PIHP compliance to Balanced Budget Act (BBA) requirements. The other two EQR activities - Performance Improvement Program Validation and Performance Indicators Validation - provide a mechanism for discovering problems / issues.

The QMP site review team also conducts a comprehensive administrative review focused on policies, procedures, and initiatives that are not otherwise reviewed by the External Quality Review (EQR) and need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, and customer complaints.

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.

As described in a.ii. above, a standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit plans of correction to MDHHS-BHDDA within 30 days. The plans of correction are reviewed by staff that completed the site review and are subsequently reviewed and approved by MDHHS- BHDDA. The PIHP has 90 days after the plan of correction has been approved to provide evidence to MDHHS-BHDDA that all issues have been remediated. The remediation process continues until all concerns have been appropriately addressed. If the PIHP is having difficulty meeting the timeframes for remediation, MDHHS-BHDDA staff will work with the PIHP to identify strategies to improve timeliness.

If individual issues are noted as a result of review of any of the administrative authority performance measures, MDHHS-BHDDA will contact the PIHP and monitor to assure the PIHP addresses concerns.

Remediation for slot utilizations occurs when a PIHP has a filled slot percentage of 95% or lower for three consecutive months. If that occurs, the HSW program staff contact the PIHP and offer technical assistance to the supports coordinators and QIDPs to help them identify potentially eligible Medicaid beneficiaries and how to complete LOC evaluations.

On an ongoing basis, customer service functions at the MDHHS-BHDDA and the PIHPs provide assistance to individuals with problems and inquiries regarding services. This would include participants in the HSW. As part of customer services within MDHHS-BHDDA, the HSW staff also handle multiple participant phone and email inquiries per month and work with the participant and PIHP to address the issues or concerns.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to 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			☐
	☐	Disabled (Physical)			
	☐	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	0		☒
	☒	Intellectual Disability	0		☒
☐ 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:

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	8268
Year 2	8268
Year 3	8268
Year 4	8268
Year 5	8268

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	7902
Year 2	7902
Year 3	7902
Year 4	7902
Year 5	7902

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Enrollment of Priority Groups	

Appendix B: Participant Access and Eligibility

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

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

Enrollment of Priority Groups

Purpose *(describe):*

The MDHHS-BHDDA retains 7 slots for a temporary enrollment in the HSW for individuals who are prioritized as described in B-3-e. The temporary slots are loaned to a PIHP until the PIHP has a vacancy within its allocation. At that point, the participant is assigned by HSW Program staff into the available PIHP slot and the MDHHS-BHDDA slot is returned to the pool for re-use.

Describe how the amount of reserved capacity was determined:

Highest priority of entrants into the HSW is as follows: 1) Children's Waiver Program (CWP) participants who are aging off from the CWP at the end of their 18th birthday month (approx. 40-50 people annually); 2) people applying to the HSW who are age 21 and older, who require private duty nursing services and meet all other eligibility requirements for HSW enrollment (approx. 10 people annually); and then 3) people who are at imminent risk of being placed in the ICF/IID (approx. 10 people annually). To ensure no delay in services for the priority groups, MDHHS-BHDDA determined that a small bank of slots should be retained at the State to loan temporarily to a PIHP that did not have a vacancy at the time of enrollment. The calculation of 7 slots was based on 10% of the people from the three priority groups (approximately 70 people annually).

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

Waiver Year	Capacity Reserved
Year 1	7
Year 2	7
Year 3	7
Year 4	7
Year 5	7

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) Slots are allocated to each PIHP.

b) The methodology for determining the number of slots each PIHP was issued is based on several factors, including the historical demand/use of the Habilitation Supports Waiver when the waiver was established; evaluating the penetration rate for each PIHP of persons served with intellectual/developmental disabilities compared to the number of HSW slots allocated; seeking input from PIHPs that either are requesting additional HSW slots or have unused capacity; and monitoring the usage by PIHP on the HSW database. The distribution of slots among the PIHPs is re-evaluated at least annually or more frequently if necessary. The HSW staff oversee the procedure to assist participants who move from one PIHP to another in order to assure continuity of services. The procedure requires that the current and future PIHP HSW coordinators are notified of the impending move as soon as the move is known. The directors of both PIHPs must submit a letter to the Federal Compliance Section Manager indicating their awareness of the move and assuring continuity of services for the HSW participant. At the time of the move, the participant's enrollment is transferred to the new PIHP by way of the HSW database slot allocation report which is controlled by the HSW Program staff at the state level. If there is no vacancy at the new PIHP, the slot is loaned from the current PIHP to the new PIHP by way of the HSW database. As an alternative to a temporary loan/borrow arrangement, the two PIHP directors may also negotiate a permanent transfer of a slot for the participant in writing to the Federal Compliance Section Manager.

Highest priority of entrants into the HSW is as follows: 1) Children's Waiver Program (CWP) participants who are disenrolling from the CWP at the end of their 18th birthday month; 2) people applying to the HSW who are age 21 and older, who require private duty nursing services and meet all other eligibility requirements for HSW enrollment; and then 3) people who are at imminent risk of being placed in the ICF/IID.

c) There is no unused capacity among the PIHPs at the time of this renewal. Over a period of the past five years, adjustments have been made to the distribution of slots among the PIHPs to a point now where the HSW averages more than 98% full state-wide and every PIHP is over 95% capacity on a monthly basis. Adjustments that were made followed the methodology described above in which PIHPs self-reported to MDHHS-BHDDA either unused capacity or greater need and slots were re-allocated to assist in meeting these needs. The BHDDA Federal Compliance Section Manager and staff monitor slot utilization by PIHP on a monthly basis and work with any PIHPs that are less than 97% filled for three consecutive months by providing technical assistance, regional training, and on-site record reviews to assist staff in identifying and applying for HSW enrollment on behalf of individuals who are eligible.

Since private duty nursing for age 21 and older is not available in the State Plan, MDHHS may loan a slot to the PIHP until a vacancy occurs, then move the participant into that PIHP slot and return the loaned slot to the State reserved pool for re-use. This will ensure no delay in service for those applicants in priority group 2 (beneficiary age 21 and older who needs private duty nursing).

The HSW uses an application management process to closely manage utilization through enrollments against the appropriations. The PIHPs are responsible for entering disenrollments into the web-based HSW database and can monitor their utilization of enrollment slots through a report in the database in real time. As a vacancy occurs, the PIHP HSW Coordinator submits an application packet to re-fill that vacancy in the next month after the slot became available. The HSW program staff enroll eligible applicants as slots become vacant in this manner up to the approved limit noted in B.3.a.

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

The selection of entrants into the HSW is made at the state level. The procedure for enrollment begins at the PIHP. Each PIHP has an HSW Coordinator, who has primary responsibility for working with supports coordinators and potential enrollees to identify those individuals for whom the PIHP will submit an application. Identification of prospective applicants may come directly from the individual or his/her family requesting the HSW or from the supports coordinator or other staff at the PIHP/CMHSP. Many of the PIHPs have a clinical committee that reviews records to identify those Medicaid beneficiaries who meet the HSW eligibility requirements. The HSW Coordinators have participated in numerous training and technical assistance opportunities and are well-versed in the HSW eligibility requirements. This training enables the HSW Coordinators to be able to explain the waiver and its requirements to clinicians, supports coordinators, prospective applicants and families. In addition, the MDHHS/PIHP contract requires that each PIHP have a customer services office, where recipients of mental health services can obtain information on services, including the HSW. If the PIHP determines that an application will be submitted for a Medicaid beneficiary, the HSW Coordinator compiles the required documentation to submit to MDHHS-BHDDA. Required documentation consists of a completed HSW certification form, the current plan of services, documentation regarding the person's functional skills (Performance on Areas of Major Life Activities form or Supports Intensity Scale), and any relevant supporting documentation such as professional assessments, individual educational plans (IEP) from schools, or medical reports. If the PIHP determines that an application will not be submitted or will be delayed in submission, the PIHP must give the Medicaid beneficiary an adequate notice of right to fair hearing to appeal that decision.

Once the PIHP submits an application to MDHHS-BHDDA, the Federal Compliance Section staff begin the review process. Michigan uses the Code of Federal Regulations (42 CFR 483.400 and 42 CFR 442 Subpart C) as the basis for evaluations of the participant’s need for the ICF/IID level of care (but for the availability of home and community-based services). Each application is reviewed by a QIDP (qualifications for these staff are noted in B.6.c of this application), who completes a worksheet that addresses each of the HSW eligibility requirements: Presence of a intellectual/developmental disability; Medicaid eligibility; priority population, community residence, need for HSW services with amount, scope, and duration of HSW services to be provided if approved. The reviewing QIDP at MDHHS-BHDDA then makes a decision, based on the information contained in the application, to either approve, deny, or pend the application for additional information.

If approved, the HSW Program staff prioritizes enrollment of eligible applicants by giving first available vacant slots in a PIHP to a member of one of the priority populations specified in B.3.c and then, by date received within the PIHP's applications (first in, first approved). As noted previously, if a member of a priority group is eligible for enrollment but the PIHP does not have any slots available, one of the reserved slots is issued to the PIHP until a vacancy occurs. When approved, the PIHP receives the signed certification form from the secured web-based HSW database.

If denied, the Medicaid beneficiary or his/her legal representative is issued an adequate notice of right to fair hearing.

If pended, the application is held at the State's Federal Compliance Section office, and staff communicate to the PIHP HSW Coordinator about what documentation is lacking via the secure web-based HSW database. An offer is made at that time by the HSW Program staff to provide telephone consultation with the supports coordinator and HSW Coordinator. This process has helped improve understanding of the HSW requirements and facilitated receipt of additional information to continue the enrollment review process. Once the additional information is received, the QIDP again reviews the application and determines whether to approve enrollment or deny. While the application is in pending status, the beneficiary continues to receive all medically necessary mental health services using the Specialty Mental Health Supports and Services.

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:

Parents & caretaker relatives
42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Pregnant Women
42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Infants and Children
42 CFR 435.118
1902(a)(10)(A)(i)(III)(IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **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:

Personnel with responsibility for conducting the LOC evaluations and reevaluations are Qualified Intellectual Disability Professional (QIDP). A QIDP is a individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, or a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor’s degree or higher in a human services field.

The initial evaluation and re-evaluation of the beneficiary's LOC, as submitted by the PIHP, is reviewed and approved by the MDHHS-BHDDA HSW Program staff who are QIDPs or who are obtaining QIDP designation under the direct supervision and co-signature of a QIDP.

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.

Medicaid beneficiaries evaluated for the HSW must meet the level of care criteria for an ICF/IID as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). The MPM states in section 3 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter: "Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications."

Additionally, the eligibility requirements that relate to level of care include: The person must have a intellectual/developmental disability, and if not for the HSW services, would otherwise require ICF/IID level of care services.

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:

Information for initial evaluation of LOC may be gathered at any time by the PIHPs at the request of a Medicaid beneficiary or when professional assessments identify a potential need for HSW services. When vacancies are available at the PIHP, the HSW Coordinator will submit the LOC information as part of the HSW application. Applications received prior to the 16th of the month are processed for enrollment that month; applications received on and after the 16th of the month are processed for enrollment in the following month. Applications for the groups identified for prioritization are reviewed within five working days and if there is an emergency need to enroll a beneficiary who requires private duty nursing and without enrollment into the HSW would be at risk for health and welfare, the application is reviewed within one working day. If an application is pended by MDHHS for additional information, the PIHP must respond within 15 days or request an extension to gather the information. It is in the beneficiary's best interest to allow additional time when the information submitted with the application is insufficient to support enrollment in the HSW. With technical assistance, most applications are approved once the additional information is provided.

Services commence immediately upon approval and enrollment in the HSW as the PIHPs have access to real-time enrollment information via the web-based HSW database.

Once the initial determination has been made that the participant has an intellectual/developmental disability, the subsequent re- evaluations of LOC do not require that the presence of I/DD be again determined. The PIHP HSW Coordinator will compile and submit the LOC re-evaluation information with other required documentation to MDHHS within one year of the previous evaluation. MDHHS re-evaluates and determines continued eligibility (including LOC reevaluation). The HSW eligibility certification form documents that the person continues to otherwise need ICF/IID level of care but for the availability of HSW services on.

Personnel from MDHHS with responsibility for conducting the LOC evaluation and reevaluations are Qualified Intellectual Disability Professional (QIDP).

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:

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 web-based HSW database tracks timeliness of re-evaluations through several processes and contains edits in the system to prevent user errors on timelines. The PIHP is responsible for monitoring the re-evaluation dates in the web-based HSW database. The system automatically generates the end-date so the PIHP is always aware of when the next re-evaluation is due. There are "tickler" reports that the PIHP can generate to identify those re-evalations coming due in 60 days and 30 days, as well as a report for overdue re-evaluations. The system is designed so the PIHP must account for every day, meaning if a re-evaluation date occurs beyond the 365th day, the PIHP must report a "recertification missing" entry. Because FFP cannot be used if the participant does not meet HSW eligibility, the web-based HSW database is designed to prevent the entry of a re-evaluation while the participant is not residing in a community-based setting, e.g., nursing facility or ICF/IID. In those situations, there will be a gap in re-evaluation dates while the participant was ineligible for HSW services.

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 PIHP maintains clinical records, including the HSW initial evaluation and re-evaluations of level of care, as well as any supporting documentation. The MDHHS-BHDDA retains a copy of the initial enrollment application, which would include the initial level of care certification. If an application is denied, a copy of the fair hearing notice to the applicant or legal representative is sent to the PIHP for inclusion in the applicant's clinical record and a copy is retained at MDHHS-BHDDA. All records are retained for a minimum period of three years.

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 newly enrolled waiver participants who have a need for an ICF/IID LOC prior to receipt of services. Numerator: Number of newly enrolled waiver participants who have received an ICF/IID LOC prior to receipt of services. Denominator: All new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC evaluation documentation

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.

Performance Measure:
Number and percent of enrolled participants whose LOC evaluations are completed within 365 days of the previous evaluation. Numerator: Number of enrolled participants with LOC evaluations completed within 365 days of the previous evaluation. Denominator: All enrolled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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 = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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 initial LOC evaluations that are completed by a QIDP.
Numerator: Number of initial LOC evaluations that are completed by a QIDP.
Denominator: All LOC evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC evaluation documentation

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of initial LOC evaluations where the LOC criteria was accurately applied. Numerator: Number of initial LOC evaluations where the LOC criteria was accurately applied. Denominator: All initial LOC evaluations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC evaluation documentation

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 LOC annual re-evaluations that are documented on the HSW certification form. Numerator: Number of LOC re-evaluations that are documented on the HSW certification form. Denominator: All LOC re-evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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 = 95%
☐ **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 LOC re-evaluations where the LOC criteria was accurately applied. Numerator: Number of LOC re-evaluations where the LOC criteria was accurately applied. Denominator: All LOC re-evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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 = 95%
☐ **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**

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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC re-evaluations that are completed by a QIDP.
Numerator: Number of LOC re-evaluations that are completed by a QIDP.
Denominator: All LOC re-evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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 = 95%
☐ **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 initial LOC evaluations that are documented on the HSW certification form. Numerator: Number of initial LOC evaluations that are documented on the HSW certification form at the time of initial application for HSW. Denominator: All LOC evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC documentation

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:

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-BHDDA Federal Compliance Section conducts the LOC evaluation and re-evaluation. Data regarding re-evaluation may also be drawn from HSW database overdue reports, which are reviewed by the BHDDA Federal Compliance Section staff.

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 HSW database is used to communicate electronically with the PIHPs regarding questions or issues on individual LOC determinations that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information to make the LOC decision. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days.

Any problems noted with initial or re-evaluation of LOC will be addressed in writing to the PIHP with a plan of correction required to be submitted within 30 days.

Issues with overdue re-evaluations are addressed with the PIHP by way of communication with the HSW coordinator. If the issue relates to a particular individual, which might occur if a guardian does not return paperwork in time, the PIHP identifies a plan of correction to address that individual for future re- evaluations. If a trend is noted, a system-wide plan of correction is submitted by the PIHP to the HSW staff, which monitors for improvement and compliance.

Additionally, during its biennial site visits, the MDHHS-BHDDA Division of Quality Management and Planning (QMP) Site Review Team, which includes several QIDPs, reviews HSW records. If, during its review, a team member notes issues about the accuracy of the LOC decision, the PIHP must submit a copy of the current IPOS for review by the HSW program staff, who will consult with the PIHP and either assist the PIHP with correcting the IPOS to demonstrate the LOC or to determine the person no longer meets HSW eligibility for LOC and needs to disenroll. Issues identified by the Site Review Team are documented on the Site Review Protocol and a report of findings is issued to the PIHP. The PIHP/CMHSP is required to respond to MDHHS's site review report within 30 days of receipt of the report with a plan of correction. This plan of correction must be reviewed and approved by MDHHS staff that completed the site review and by MDHHS administration. The remediation process continues until all concerns have been appropriately addressed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The supports coordinator, supports coordinator assistant, or the independent supports broker are required to provide participants choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. Supports Coordination services will continue to be available to HSW participants through the State Plan.

The HSW eligibility Certification form is also used to document freedom of choice. This section is completed by the participant, legally responsible adult (typically the parent of a minor aged child), legal guardian or other legal representative with authority to make such decisions on behalf of the participant. By signing the form, the participant, family and/or legal representative verifies that they have been informed of their right to choose between the community based services provided by the HSW and the level of care that would be provided in an ICF/IID.

The participant or his/her legal representative consent to receiving HSW in lieu of ICF/IID level of care at the time of initial application and give consent at least every three years thereafter.

The HSW Eligibility Certification form is maintained in the participant's clinical record at the PIHP. The MDHHS-BHDDA retains a copy of the initial certification form that is completed for enrollment into the HSW.

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.

As stated above, Freedom of Choice is part of the HSW eligibility certification form and is maintained by the PIHP in the participant's record. The MDHHS-BHDDA retains a copy of the initial certification form. All forms are retained for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

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

The contract between MDHHS and the PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with intellectual/developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. The contract does specifically require that PIHPs must address cultural differences within its region by making materials available in the languages appropriate to the people served in the area.

In the MDHHS/PIHP and MDHHS/CMSHP contracts, Section 6.3.2 requires: Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:
1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. All materials shall be available in the languages appropriate to the people served within the PIHP's area. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002).
3. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA). Beneficiaries shall be informed of how to access the alternative formats.

The MDHHS/PIHP contract, section 18.1.6 requires that the PIHP shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with Limited English Proficiency. This guidance clarifies responsibilities for providing language assistance under Title VI of the Civil Rights Act of 1964.

The MDHHS/PIHP contract, Section 38 also requires that any subcontracts executed by the PIHP must address compliance with Office of Civil Rights Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency".

Attachment P 7.10.2.3 also requires that services must be designed and delivered that respond to an individual’s ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

Each PIHP/CMHSP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP/CMHSP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHP/CMHSP access system. The customer services staff must be trained to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained regarding a number of areas, including Limited English Proficiency and cultural competence.

Access system services must be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. The PIHP/CMHSP must arrange for an access line that is available 24 hours per day, seven days per week, that includes in-person and by-telephone access for hearing impaired individuals. Telephone lines must be toll-free and accommodate Limited English Proficiency (LEP) and other linguistic needs, as well as be accessible for individuals with hearing impairments and must accommodate persons with diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.

PIHP customer service activities and informational documents that are made available to the public are subject to MDHHS-BHDDA review during its regular site visits to PIHPs to assure compliance with the contract requirements stated above. Also, the site review team interviews a number of people who receive mental health services and inquires about their experience and satisfaction with accommodations in the area of LEP.

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	**Out-of-Home Non-Vocational Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		

Service Type	Service		
Statutory Service	Supports Coordination (Authority Change Effective 10/1/2019)		
Extended State Plan Service	Enhanced Medical Equipment and Supplies		
Extended State Plan Service	Enhanced Pharmacy		
Supports for Participant Direction	Fiscal Intermediary		
Supports for Participant Direction	Goods and Services		
Other Service	Community Living Supports		
Other Service	Environmental Modifications		
Other Service	Family Training		
Other Service	Non-Family Training		
Other Service	Overnight Health and Safety Support		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing		

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:

Habilitation

Alternate Service Title (if any):

Out-of-Home Non-Vocational Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the participant resides.

Examples of incidental support include:
- Aides helping the participant with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.
- When necessary, helping the participant to engage in the habilitation activities (e.g., interpreting).

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

Services must be furnished on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the participants plan of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide
Agency	Community based program operated by CMHSP or other subcontractor
Agency	staffing agency, home care agency or other subcontractor

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:
Individual
Provider Type:

Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP must verify provider qualifications. If the provider is hired directly by a participant through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:

Agency

Provider Type:

Community based program operated by CMHSP or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Community based program sites must be approved by MDHHS prior to delivery of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency must assure that all employees delivering the service meet the provider qualifications specified in the Medicaid Provider Manual. If the agency is hired directly by a participant through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:
Agency
Provider Type:

staffing agency, home care agency or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications as specified in the Medicaid Provider Manual. If the agency is hired directly by a participant through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational services involve the provision of learning and work experiences where a participant can develop general, non-job-task-specific strengths and skills that contribute to individual competitive integrated employment. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the participant and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a participant's employability. Individual competitive integrated employment or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required pre-requisite for individual competitive integrated employment or receiving supported employment services.

Prevocational services should enable each participant to attain individual competitive integrated employment in the community in which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, and matched to the participants interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Support of employment outcomes is a part of the person-centered planning process, and emphasizes informed consumer choice. This process specifies the participants personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the participants outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. Prevocational services provide learning and work experiences, including volunteering, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in competitive integrated employment.

Participants who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home nonvocational habilitation, or community living supports at other times. Participants who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational systems responsibility, e.g., after school or on weekends and school vacations.

Participants participating in prevocational service may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment.

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

Prevocational services needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).

Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home nonvocational habilitation services. Coordination with the participant's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program.

Transportation provided between the participant's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.

Assistance with personal care or other activities of daily living that are provided to a participant during the receipt of prevocational services may be included as part of prevocational services, or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service.

Only activities that contribute to the participant's work experience, work skills, or work-related knowledge can be included in prevocational 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	prevocational support staff
Agency	Community-based prevocational program operated by CMHSP or other subcontractor

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Individual

Provider Type:

prevocational support staff

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The support staff must, at a minimum, meet provider qualifications for an aide. Additionally, the support staff must be knowledgeable about the unique abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive integrated employment.

Provider qualifications for an aide:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Community-based prevocational program operated by CMHSP or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Program must be approved by MDHHS prior to delivery of services per Medicaid Provider Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite care services are provided to a waiver eligible participant on a short-term, intermittent basis to relieve the participants family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). Intermittent means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. Primary caregivers are typically the same people day after day who provide at least some unpaid supports. Unpaid means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the participant is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult participants living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. The participants record must clearly differentiate respite hours from community living support services.

Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service.

Respite care may not be provided by a parent of a minor participant, the spouse of the participant, the participants legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings that are approved by the participant and identified in the individual plan of services:
- Participants home
- Home of a friend or relative (not the parent of a minor or the spouse of the participant or the legal guardian)
- Licensed foster care home or respite care facility
- Licensed camp
- In community settings accompanied by a respite worker

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

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite is not covered if the care is being provided in an institution (i.e., ICF/IID, nursing facility, or hospital).

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	Independent Nurse (RN or LPN)
Individual	Individual respite provider
Agency	staffing agency, home care agency, other PIHP network provider agency
Agency	Licensed children's foster care, licensed adult foster care
Agency	Licensed Camp

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

Other Standard *(specify):*

Nurses may provide respite only in situations where the participant's medical needs are such that a trained respite aide cannot care for the participant during times where the unpaid caregiver is requesting respite.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:

Individual respite provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aide must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:

staffing agency, home care agency, other PIHP network provider agency

Provider Qualifications

License *(specify):*

If respite is provided by an agency nurse, either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN, the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Respite is typically provided by aides employed by the agency. Aides must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed; in good standing with the law; able to perform basic first aid procedures; and is trained in the individuals plan of service, as applicable.

If the agency is providing respite rendered by a nurse, the nurse must be licensed by the State of Michigan as indicated above.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent

Frequency of Verification:

prior to delivery of services and every two years 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:

Licensed children's foster care, licensed adult foster care

Provider Qualifications

License *(specify):*

Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.9506 and R400.1401-.15411 and R400.1901-1906, MCL 722.115-118(a)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every two years 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:

Licensed Camp

Provider Qualifications

License *(specify):*

Children's Camps: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11413
Adult's Camps: MCL 400.703, Act 218 of 1979 as amended, Administrative Rule 400.11101-.11413

Certificate *(specify):*

N/A

Other Standard *(specify):*

The camp must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s)

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03030 career planning
Category 3:	**Sub-Category 3:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 4:	**Sub-Category 4:**
03 Supported Employment	03022 ongoing supported employment, group

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Competitive integrated employment (CIE) is employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services seek to align with the Work Innovation and Opportunity Act (WIOA) to achieve desired outcomes for beneficiaries. Supported employment services support competitive integrated employment in the general workforce where an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment services can be provided through many different service models.

Specific supported employment services include the two following categories:

Individual Employment Services:
o Individual Supported Employment Support services for Job Development/Career Planning support competitive integrated employment (CIE) that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Such services may provide ongoing supports to participants who, because of their disabilities, need some fading level of supports to be successful. Additionally; this service array may include intensive on-going support to obtain or maintain an individual job in competitive or customized employment, or self-employment, in competitive integrated employment in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Self - employment refers to an individual-run business that nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings. This service supports sustained paid employment at or above the minimum wage in competitive integrated employment in the general workforce, in a job that meets personal and career goals.
o Individual supported employment services are individualized and may include any combination of the following services:

- vocational/job-related discovery or assessment
- person-centered employment planning
- job placement/job development, with prospective employers
- job analysis
- customized employment and job carving
- training and systematic instruction
- benefits management, financial literacy, asset development and career advancement services
- training and planning
- transportation
- other workplace support services including services not specifically related to job skill training that enable the person to attain a job in a competitive integrated community setting of his/her choice

Group Employment Services for 2-6 individuals.
o Supported Employment Small Group employment support are services and training activities provided in regular business, industry and community settings for groups of two (2) to six (6) workers with disabilities paying at least minimum wage in an integrated setting. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. Funding for this service is to support sustained paid employment and work experience leading to further career development in individual competitive integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include volunteer work or vocational services provided in facility-based work settings.
o Supported employment small group employment supports may include any combination of the following services:

- job analysis
- training and systematic instruction
- job coaching

•benefits management support and financial literacy
•training and planning
•transportation
•career advancement services
•other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the workplace.

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

FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:

- Incentive payments made to an employer to encourage or subsidize the employers participation in a supported employment program;
- Payments that are passed through to users of supported employment programs;
or
- Payments for vocational training that is not directly related to a participants supported employment program.

Supported employment service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (IDEA), Bureau of Services for Blind Persons (BSBP), or Michigan Rehabilitation Services (MRS). Documentation must be maintained by the PIHP that the participant is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change.

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	employment specialist
Individual	job coach

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:

employment specialist

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

An employment specialist must possess skills related to developing job opportunities for participants, including educating the public about employing people with intellectual/ developmental disabilities, working with prospective employers, identifying barriers and helping to resolve those to facilitate employment for the participant. An employment specialist must meet the provider qualifications for an aide.

In order to promote best practices, supported employment services staff must complete related specialized employment training

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

job coach

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

A job coach must be trained in assisting a participant with work-related activities in the participant's workplace. A job coach must also meet provider qualifications for an aide.

In order to promote best practices, supported employment services staff must complete specialized employment training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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 (Authority Change Effective 10/1/2019)

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supports Coordination has a change of authority from 19159(c) to the State Plan effective 10/1/19.

Supports coordination works with the waiver participant to assure all the necessary supports and services are provided to enable the participant to achieve community inclusion and participation, productivity and independence in a home- and community-based setting. Without the supports and services, the participant would otherwise require the level of care services provided in an ICF/IID. Supports coordination involves the waiver participant and others identified by the participant, such as family member(s), in developing a written individual plan of services (IPOS) through the person-centered planning process. The waiver participant may choose to work with a supports coordinator through the provider agency, or an independent supports coordinator, or a supports coordinator assistant, or an independent supports broker.

Functions performed by a supports coordinator, supports coordinator assistant, or independent supports broker include an assurance of the following:
1. Planning and/or facilitating planning using person-centered principles. This function may be delegated to an independent facilitator chosen by the participant.
2. Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the participant's request or as the participant's changing circumstances may warrant.
3. Linking to, coordinating with, follow-up of, and advocacy with all supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.
4. Monitoring of Habilitation Supports Waiver and other mental health services.
5. Brokering of providers of services/supports
6. Assistance with access to entitlements and/or legal representation.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant.

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, when the participant selects an assistant in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant.

The HSW participant may select an independent supports broker to perform supports coordination functions. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what will work best for him/her, are consistent with his/her needs and reflect the participant's circumstances. The independent supports broker helps the participant explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the participant with those supports. Supports brokerage services offer practical skills training to enable participants to be as independent as possible, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving. When an independent supports broker is used, a qualified supports coordinator must supervise the broker.

Many participants choose a independent supports broker rather than traditional case management services or supports coordination provided directly by a supports coordinator. If a participant does not want any case management or supports coordination services, the PIHP will assist the participant to identify who will assist him in performing each of the functions, including the use of natural supports or other qualified providers to assure the supports coordination functions are provided. The IPOS must reflect the participant's choices, the responsible person(s) for each of the functions listed in this section, and the frequency at which each will occur.

When the participant has chosen a supports coordinator assistant or an independent supports broker or a natural support to perform any of the functions, the IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant, the independent supports broker or the natural support. The PIHP must assure that it is not paying for the supports coordinator, supports coordinator assistant, or the independent supports broker to perform the same function. Likewise, if a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of a supports broker who also attends. During its on-site visits, MDHHS will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a supports broker are assigned supports coordination responsibilities in a participant's IPOS.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety

assurances, and the use of natural supports. Support coordinators, supports coordinator assistants, or independent supports brokers work closely with the participant to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources. Supports coordination is reported only as face-to-face contact with the participant; however, the function includes not only the face-to-face contact but also related activities (e.g., making telephone calls to schedule appointments or arrange supports) that assure:

- The desires and needs of the participant are determined.
- The supports and services desired and needed by the participant are dentified and implemented.
- Persons chosen by the participant are involved in the planning process.
- Housing and employment issues are addressed.
- Social networks are developed.
- Appointments and meetings are scheduled.
- Person-centered planning is provided and independent facilitation of person-centered planning is made available.
- Natural and community supports are used.
- The quality of the supports and services, as well as the health and safety of the participant, is monitored.
- Income/benefits are maximized.
- Information is provided to assure the participant (and his representative(s), if applicable) is informed about self -determination.
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided.
- Activities are documented.
- Plans of supports/services are reviewed at such intervals as are indicated during planning.

Additionally, the supports coordinator, supports coordinator assistant, or independent supports broker coordinates with, and provides information as needed to, the Qualified Intellectual Disability Professional (QIDP) for the purpose of evaluation and reevaluation of participant level of care for eligibility in the HSW.

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to- day supports and/or training, or provision of other Medicaid services. Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. Supports coordination may not duplicate another Medicaid service.

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

The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence.

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	Supports Coordinator Assistant
Individual	Independent Supports Broker
Individual	Independent Supports Coordinator
Agency	Supports Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination (Authority Change Effective 10/1/2019)

Provider Category:
Individual
Provider Type:

Supports Coordinator Assistant

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Chosen by the participant.
2. Minimum of a high school diploma and one year of experience working directly with people who have developmental disabilities.
3. Functions under the supervision of a supports coordinator.

Verification of Provider Qualifications
Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination (Authority Change Effective 10/1/2019)

Provider Category:
Individual
Provider Type:

Independent Supports Broker

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Chosen by the participant.
2. Minimum of a high school diploma and demonstrated skills and knowledge to perform the functions.
3. Functions under the supervision of a supports coordinator.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination (Authority Change Effective 10/1/2019)

Provider Category:

Individual

Provider Type:

Independent Supports Coordinator

Provider Qualifications

License *(specify):*

The supports coordinator must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Chosen by the participant.
2. The independent supports coordinator must be a QMRPQIDP as defined in the Michigan Medicaid Provider Manual: An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP is responsible for verifying provider qualifications.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination (Authority Change Effective 10/1/2019)

Provider Category:

Agency

Provider Type:

Supports Coordinator

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. 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. The supports coordinator employed by an agency must be a QIDP as defined in the Michigan Medicaid Provider Manual and maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider

Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:

Enhanced Medical Equipment and Supplies

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the individual plan of service, and must enable the participant to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.

The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the participant will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed. This coverage includes:
- Adaptations to vehicles;
- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items;
- Durable and non-durable medical equipment not available under the Medicaid State Plan.

Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

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

Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the participant are excluded from coverage.
- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

Coverage excludes furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home; items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs); purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle; and educational supplies that are required to be provided by the school as specified in the childs Individualized Education Plan. Eye glasses, hearing aids, and dentures are not covered.

The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers that participate with that program.

The size of a generator is limited to the wattage required to provide power to essential life-sustaining equipment.

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	Durable Medical Equipment and Supplies Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment and Supplies Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The durable medical equipment and supplies (DMES) provider must meet any requirements by private insurance, Medicare or Medicaid as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for verifying provider qualifications.

Frequency of Verification:

prior to contracting with the DMES provider for the item.

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:

Enhanced Pharmacy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Physician ordered, non-prescription "medicine chest items" as specified in the individual plan of service. Only the following items are allowable: cough/cold/pain/headache/ allergy and gastro-intestinal distress remedies; vitamin and mineral supplements; special dietary juices and foods that augment, but do not replace, a regular diet; thickening agents for safe swallowing when the participant has a diagnosis of dysphagia and either a) recent history of aspiration pneumonia within the past year or b) documentation that the participant is at risk of insertion of a feeding tube without thickening agents for safe swallowing; first aid supplies (i.e. band aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); special oral care products to treat specific oral conditions beyond routine mouth care (i.e. special toothpastes, tooth brushes, anti-plaque rinses, antiseptic mouthwashes); and special items (i.e. accommodating common disabilities - longer, wider handles) tweezers and nail clippers. These items are not covered under Michigan's State Plan, not considered part of routine room and board costs, are required for decent level of personal hygiene, and, from a health and hygiene maintenance perspective, are considered necessary to prevent institutionalization. Products or prostheses necessary to ameliorate negative visual impact of serious facial disfigurements (absence of ear, nose, or other feature, massive scarring,) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered.

The services under the Enhanced Pharmacy are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

FFP cannot be used to pay for co-pays for other prescription plans the participant may have.

Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included.

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	retailers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Enhanced Pharmacy

Provider Category:

Agency

Provider Type:

retailers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Retailers must sell the enhanced pharmacy items. Participants may freely select the provider based on location or other factors.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP verifies prior to purchase that the retailer sells the item.

Frequency of Verification:

prior to purchase

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Fiscal Intermediary services are defined as services that assist the participant, or a representative identified in the participant's individual plan of services, to meet the participant's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the participant, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring 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 selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), 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.

Fiscal intermediary services may not be authorized for use by a participant's representative where that representative is not conducting tasks in ways that fit the participant's preferences, and/or do not promote achievement of the goals contained in the participant's plan of service so as to promote independence and inclusive community living for the participant, or when they are acting in a manner that is in conflict with the interests of 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	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.
3. Demonstrated ability to manage budgets and perform all functions of the fiscal intermediary including all activities related to employment taxation, worker's compensation and state, local and federal regulations.
4. Fiscal Intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
5. Neither providers of other covered services to the participant, the family or guardians of the participant may provide fiscal intermediary services to the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for assuring the provider is credentialed.

Frequency of Verification:

Prior to delivery of services and every two years 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:

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:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the HSW participant using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must (1) increase independence, facilitate productivity, or promote community inclusion and (2) substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support described in HSW or the Medicaid funded Specialty Mental Health Supports and Services) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS.

Purchase of a warranty may be included when it is available for the item and is financially reasonable.

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

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.

Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.

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	goods and services provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

goods and services provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Provider must be reputable and able to provide the good or service necessary.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. When the participant chooses to purchase the good or service from a reputable provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to purchasing or contracting to obtain the good or service

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:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Living Supports (CLS) facilitate an individuals independence, productivity, and promote community inclusion and participation. The supports can be provided in the HSW participants residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.)

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973, or the waiver or State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite).

Coverage for Community Living Supports includes:

- Assisting, reminding, observing, guiding or training the participant with:
- Meal preparation;
- Laundry;
- Routine, seasonal, and heavy household care and maintenance;
- Activities of Daily Living (ADLs), such as bathing, eating, dressing, personal hygiene;
- Shopping for food and other necessities of daily living.

In addition. CLS Coverage includes:
- Assisting, supporting and/or training the participant with:
- Money management;
- Non-medical care (not requiring nurse or physician intervention);
- Socialization and relationship building;
- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence;
- Leisure choice and participation in regular community activities;
- Attendance at medical appointments; and
- Acquiring goods and services other than those listed under shopping
- Reminding, observing, and/or monitoring of medication administration.

For participants living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the MDHHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings.

If participants living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs and/or shopping, the participant must request Home Help, and if necessary Expanded Home Help, from MDHHS. CLS may be used for those activities while the participant awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the participant requests it, the PIHP must assist with applying for Home Help or filling out and submitting a request for a Fair Hearing when the participant believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs based on the findings of the MDHHS assessment. CLS may also be used for those activities while the participant awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

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

The costs associated with room and board are excluded from CLS. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

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	licensed children's foster care, licensed adult foster care
Agency	home care agency, staffing agency, or other PIHP network provider agency
Individual	personal assistant, CLS aide

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:

licensed children's foster care, licensed adult foster care

Provider Qualifications

License *(specify):*

Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.14601, R400.15101-.15411, R400.2231-.2246, R400.1151-.1153, R400.1901-1906 and R400.2101-2475, MCL 722.115-118(a)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every two years 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, staffing agency, or other PIHP network provider agency

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Verification of Provider Qualifications
Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Individual
Provider Type:

personal assistant, CLS aide

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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 Modifications

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Physical adaptations to the home and/or workplace required by the participant's individual plan of services (IPOS) that are necessary to ensure the health, safety, and welfare of the participant, or enable him to function with greater independence within the environment(s) and without which the participant would require institutionalization. Adaptations may include:
- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom 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 modifications are included as a part of the cost of the service.

All modifications must be ordered on a prescription as defined in the General Information Section of Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. An order is valid for one year from the date it was signed.

There must be documented evidence that the item is the most cost-effective and reasonable alternative to meet the participants 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.

Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the plan as to how it is essential in the treatment of the participants illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the participant must use.

Environmental modifications that are 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 participants home.

The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the participant and builder to ensure that 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. In the event that the contract is terminated prior to the completion of the work, HSW funds may not be used to pay for any additional costs resulting from the termination of the contract.

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

The environmental modification 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 by the PIHP 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. A record of efforts to apply for alternative funding sources must be documented in the participants records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the PIHP 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:

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental modifications that are essential to the implementation of the IPOS. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The HSW 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 his/her family purchases or builds a home while receiving waiver services, it is the participants or familys responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the participant has mobility limitations. HSW 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 HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the participants need.

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

Environmental modifications for licensed settings includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.

Adaptations to the work environment are limited to those necessary to accommodate the person’s individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act or the Americans with Disabilities Act (ADA), or covered by the Michigan Rehabilitation Services or the Bureau of Services for Blind Persons.

Environmental modifications for licensed settings includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or 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	Licensed Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Licensed Building Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for verifying provider qualifications

Frequency of Verification:

Prior to provision of service

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:

Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Training and counseling services for the families of participants served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a participant served on the waiver, and may include a parent, spouse, children, relatives, foster family, unpaid caregivers or in-laws.

Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the participant at home. All family training must be included in the individual's written plan of service.

The services under the Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

Not included are individuals who are employed to provide waiver services for 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	CMHSPs, home care agencies, clinic service agency providers, outpatient clinics
Individual	Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency
Provider Type:

CMHSPs, home care agencies, clinic service agency providers, outpatient clinics

Provider Qualifications
License *(specify):*

The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The hands-on service provider must be either a licensed psychologist, Master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications
Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:

Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications
License *(specify):*

The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers for Family Training must be either a licensed psychologist, Master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) and respite staff by clinical professional working within the scope of their practice. Professional staff work with CLS and respite staff to implement the consumer's IPOS, with focus on all behavioral health services designed to assist the consumer in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of his/her competency in the aspect of the IPOS on which training is conducted.

The services under the Non-Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Up to four sessions per day but no more than 12 sessions per 90 day period

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	CMHSPs; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Family Training

Provider Category:

Agency

Provider Type:

CMHSPs; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency

Provider Qualifications

License *(specify):*

The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The hands-on service provider must be either a licensed psychologist, Master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Family Training

Provider Category:

Individual

Provider Type:

Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License *(specify):*

The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

The social worker must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers Non-Family training must be either a licensed psychologist, Master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent

Frequency of Verification:

prior to delivery of services and every two years 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:

Overnight Health and Safety Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Overnight Health and Safety Support is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a beneficiary's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Health and Safety Support is indicated for a person who is non-self-directing, confused, has a cognitive impairment or whose physical functioning is such that they are unable to respond appropriately in an emergency. It is further indicated for beneficiaries who have inconsistency in, or an inability to, regulate sleep patterns.

For purposes of this service, "overnight" includes the hours between 8:00 p.m. and 8:00 a.m.
Overnight Health and Safety Support may be appropriate when:
- Service is necessary to safeguard against injury, hazard, or accident
- Service will allow recipient to remain at home safely after all other available preventive interventions have been undertaken, and the risk of injury, hazard or accident remains
- Assistance is needed with instrumental activities of daily living (IADLs) that cannot be pre-planned or scheduled

The need for Overnight Health and Safety Support must be reviewed and established through the person centered planning process with the specific reasons for this service and what support activities will be provided.

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

Payments for Overnight Health and Safety Support may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

The Overnight Health and Safety Support service cannot be provided in a licensed residential setting.

If the participant receiving Overnight Health and Safety Support demonstrates the need for CLS or Respite, the IPOS must document coordination of services to assure no duplication of services provision with Overnight Health and Safety Support.

The following exceptions apply for Overnight Health and Safety Support:
- It does not include friendly visiting or other social activities.
- Is not available when the need is caused by a medical condition and the form of supervision required is medical.
- Is not available in anticipation of a medical emergency.
- Is not available to prevent or control anti-social or aggressive recipient behavior.
- Is not available for a person without a physical, cognitive, or memory impairment who has anxiety about being alone at night
- Is not an alternative to inpatient psychiatric treatment and is not available to prevent potential suicide or other self-harm behaviors.

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, staff agency and other PIHP contracted providers
Individual	Aide

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Overnight Health and Safety Support

Provider Category:
Agency
Provider Type:

Home care agency, staff agency and other PIHP contracted providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. Overnight Health and Safety Support is provided by aide level staff. Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law ; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to contracting and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Overnight Health and Safety Support

Provider Category:
Individual

Provider Type:

Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

Prior to delivery of services and every two years 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	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.

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

PERS services are limited to those participants who live alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day, and have no regular caregiver support/service provider for extended periods of time, and who would otherwise require extensive routine supervision and guidance.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	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 PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to contracting and every two years

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Private Duty Nursing (PDN) services consist of skilled nursing interventions to meet the participant's health needs that are directly related to his or her developmental disability. PDN includes the provision of nursing assessment, treatments 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 written health care plan which is part of the beneficiary's IPOS.

PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services through the waiver.
- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.

Medical Criteria I – The beneficiary 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) due to a substantiated medical condition directly related to the developmental disability.
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 developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
• "Substantiated" means documented in the clinical/medical record, including the nursing notes.
Medical Criteria III – The beneficiary 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/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.

- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.

Skilled nursing care includes, but is not limited to:
- performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
- managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;
- deep oral (past the tonsils) or tracheostomy suctioning;
- 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);
- nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
- total parenteral nutrition delivered via a central line and care of the central line;
- continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 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;
- 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.

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:
- The beneficiary’s medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

High Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.

Medium Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.

Low Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The participant has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN, i.e., the number of hours, that can be authorized for a beneficiary is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be

considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances, e.g., the availability of natural supports; and other resources for daily care, e.g., private health insurance, trusts, bequests. Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a participant who has Low Category PDN needs would require eight or fewer hours per day, a participant who has Medium Category PDN needs would require 12 or fewer hours per day, and a participant who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the participant receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing assessments, treatments, observation, judgment and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a participant at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

The services under the Private Duty Nursing are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

PDN services are provided to participants age 21 and older up to a maximum of 16 hours per day. Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

Exceptions to the hours-per-day limit: An exception process to ensure the participant's health, safety and welfare is available if the participant's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the participant's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:
-current medical necessity for the exception, and
-additional PDN services are essential to the successful implementation of the participant's written plan of care, and are essential to maintain the participant within the least restrictive, safe, and humane environment suitable to his or her condition.

Exceptions must be based on the increased identified medical needs of the participant or the impact on the participant's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the participant's or family's control that place the participant in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

1. A temporary alteration in the participant's care needs, resulting in one or both of the following:
•A temporary increase in the intensity of required assessments, judgments, and interventions.
•A temporary need for additional training to enable the primary caregiver(s) to identify and meet the participant's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the participant's increased medical needs for a maximum of six months.

or

2. The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
•In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the participant as it relates to those limitations, not to exceed six months.
•The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
•The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

Definitions: "Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.
"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the participant resides in a licensed setting or in a home where all care is provided by paid caregivers.

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

This exception is not available if the participant resides in a licensed setting or in a home where all care is provided by paid caregivers.

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

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	private duty nursing agency, home care agency
Individual	Private Duty Nurse (RN or LPN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

private duty nursing agency, home care agency

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency should assure that personnel providing this HSW service are knowledgeable in the unique abilities, preferences and needs of the individual(s) receiving the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the agency through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Private Duty Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

It is the LPN's responsibility to secure the services of an RN to supervise his or her work.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP contracting with the nurse must verify provider qualifications. An LPN must provide the supervising RN's information to the PIHP for verification of provider qualifications as well. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.

Frequency of Verification:

prior to delivery of services and every two years 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:

The PIHPs or their contracting agency are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver consumers. Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP): A QIDP is a individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, or a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor’s degree or higher in a human services field.

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):

(a)Criminal history/background investigations are completed for all direct care aide-level staff, all clinicians, and other employees providing waiver services in the PIHP provider network panels.

(b) The PIHP or its contracted provider agency is responsible for completing the criminal history/background investigation by checking statewide databases and for providing documentation in the employees personnel file. Investigations must be of sufficient scope to conclude that the aide is in good standing with the law. Requirements for waiver service providers are set forth in the Michigan Medicaid Provider Manual.
Additionally, for those HSW participants receiving services within Adult Foster Care Facilities, MCL 400.734b provides that all applicants for employment that include direct access to residents to whom the AFC provider has made a good faith employment offer shall, prior to reporting for said employment, have been found to have: 1) no relevant criminal history via a comprehensive criminal history check performed by the department of state police including running the individual's fingerprints through the automated fingerprint identification system database; and, 2) no substantiated findings of abuse, neglect, or misappropriation of property via checks of all relevant registries established pursuant to federal and state law and regulations by the relevant licensing or regulatory department.

(c) The QMP site reviews are the mechanisms for ensuring the background checks are completed through random sampling of records.

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).**

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.*

If a relative who is not the legally responsible individual, i.e., parent of minor child, spouse, or legal guardian, meets the provider qualifications, he or she may be paid for provision of that service. The services that may be provided by a relative are: out-of-home nonvocational habilitation, prevocational (if the relative is employed by the agency, respite, supported employment, community living supports, overnight health and safety support, and private duty nursing. The HSW service descriptions include language that prohibits payment to legally responsible individuals. The PIHPs are responsible for assuring that all providers meet the provider qualifications as specified in the Medicaid Provider Manual for HSW services. The supports coordinator or other provider selected by the participant reviews service logs against planned hours, makes home visits and discusses service provision with the participants and others involved in his/her IPOS to help evaluate congruence between planned and billed hours and the documentation of the types of services delivered as specified in the IPOS.

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

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

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Habilitation Supports Waiver operates concurrently with the State's §1115 managed care authority. The enrollment of providers is governed under the provisions of the MDHHS/PIHP contract, which were derived from 42 CFR §438.207. PIHPs are required to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs/assure services and supports provision consistent with the plans of services of their participants, and to include participant-requested providers on their enrolled provider panels when they meet the PIHPs qualifications, cost, and reasonable accommodation parameters.

MDHHS/PIHP contract:
7.0 provider network services
7.1 provider credentialing
37.0 provider procurement
attachment P 7.1.1 credentialing and re-credentialing processes
https://www.michigan.gov/documents/mdch/FY09-10MAContractwithallattachments_312218_7.pdf

Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter >> Section 15 HSW) https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes:
https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf

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 applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Denominator: Number of HSW providers 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample.
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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 providers of HSW services that continue to meet credentialing standards. Numerator: Number and percent of providers of HSW services that continue to meet credentialing standards. Denominator: Number of providers of HSW services 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 =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure 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, non-certified waiver service providers that meet provider qualifications as stated in the Michigan Medicaid Provider Manual. Numerator: Number of non-licensed, non-certified waiver providers that meet qualifications. Denominator: Number of non-licensed, non-certified waiver providers 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure 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 waiver providers that meet staff training requirements. Numerator: Number of waiver service providers that meet staff training requirements. Denominator: Number of HSW providers 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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):*

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.

Attachment P 7.1.1 of the contract between the MDHHS and the PIHPs specifies provider network requirements. The PIHP is responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements to provide services.

The biennial QMP site reviews verify that the PIHP/CMHSPs have documentation of training required by policy, as published in the Michigan Medicaid Provider Manual. These reviews include discussions with PIHP/CMHSP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

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.

Any findings noted during the site review process are included in a formal report issued by the MDHHS- BHDDA to the PIHP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA HSW staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDHHS. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately 90 days after the Corrective Action Plan has been approved to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

When the Site Review Team notes issues related to provider qualifications related to the waiver, the team leader informs the Federal Compliance Section Manager for follow-up, which may include providing training, consultation, or monitoring of PIHP follow-up

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):*
	☐ **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. Approximately 60% of individuals enrolled in the HSW are living in settings that are in compliance with the federal HCBS Settings Rule. These settings include living in their own home where their names are on the leases and if they have roommates, have chosen those people who live with them; or living with family members in the home of their relative (non- provider owned or controlled), or living with a foster family where only one or two individuals with disabilities share a home with their foster family. In each of these settings, individuals have full access to the home, such as meals and snacks available at any time, ability to have visitors, having privacy for conducting personal business, and can come and go in the community. These settings allow the participants to be in control of their life and be fully integrated in the community.

2. The State completed a system-level scan of all licensing rules and regulations, as well as other state laws, rules, etc. that may be involved in settings where HSW is delivered. The State is in the process of modifying rules, standards, policies, etc. to ensure that all entities that oversee and monitor settings where HSW services are delivered will achieve and maintain compliance with the HCBS through a consistent, coordinated set of standards and policies.

3. As noted in the Statewide Transition Plan, MDHHS uses an HCB Settings assessment tool, developed using guidance from CMS and stakeholders, to determine adherence to the requirements. PIHPs are required to use this tool, to assess residential and non-residential HSW providers. For those settings not in compliance, the PIHP will be responsible for working with its provider network to bring those settings into compliance.

4. MDHHS is validating the assessment results and remediation. Methods of validation include the comparison of responses from providers and participants (Mismatch report), onsite reviews, and/or MDHHS site reviews.

4. Effective 10/1/2017, the contract between MDHHS and the Prepaid Inpatient Health Plans requires that PIHPs evaluate any new providers whose settings will serve HSW participants prior to delivery of HCBS services under the HSW. This includes residential and non-residential settings and will be part of provider network monitoring by the PIHP.

5. MDHHS-BHDDA continues to monitor settings as part of its on-site reviews and will be exploring ways to engage stakeholders outside state government to provide monitoring to assure settings are working toward, or maintaining, compliance.

6. MDHHS-BHDDA will continue to review bed size as part of the waiver enrollment which includes a limit of no more than 12 beds.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan of Services (IPOS)

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:

If the participant chooses to not have a supports coordinator, there are a number of alternatives available for assisting the participant with the development of the IPOS. The participant could also choose a supports coordinator assistant or an independent services and supports broker to help with developing the IPOS.

Qualifications:
Supports coordinator assistants and independent services and supports brokers: minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

If the participant wants another provider instead of a supports coordinator or supports coordinator assistant or independent supports broker, the PIHP will assist the participant to identify a provider within the network (or enroll a qualified provider upon request if possible) who possesses equal qualifications to a 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:*

The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs. The PIHPs delegate the responsibilities of plan development to CMHSP supports coordinator or other qualified staff chosen by the individual or family. These individuals responsible for the IPOS are not providers of any HCBS for that individual, and are not the same people responsible for the independent HCBS needs assessment. The CMHSPs authorize the implementation of service through a separate service provider entity. The development of the IPOS through the person-centered planning (PCP) process is led by the participant with the involvement of allies chosen by the participant to ensure that the service plan development is conducted in the best interests of the participant. The participant has the option of choosing an independent facilitator (not employed by or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to participants about the array of services and supports available and the choice of providers. The participant has the option to choose his or her supports coordinator employed by a PIHP or subcontractor, or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the participant to identify who he or she wants to assist with service plan development that meets the participant's interests and needs. Person-centered planning is one of the areas that QMP Site Review Team addresses during biennial reviews of each PIHP.

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) 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.

The Michigan Mental Health Code requires that the service plan (individual plan of services or IPOS) be developed through a person-centered planning (PCP) process. Michigan law and policy provide guidance as to how PCP is implemented, including Administrative Regulations and the MDHHS/PIHP contract attachment entitled "Person Centered Planning Policy ". The PIHPs are responsible for supporting each participant to develop the IPOS through the PCP process. Each agency is required to describe the process through the Customer Services Handbook. Each participant is offered supports coordination to support him or her with the planning development and implementation of his or her services and supports. If a participant chooses to not have supports coordination or case management, the PIHP assists the participant to identify others who are qualified and able to assist with service plan development.

The following essential elements of the PCP process have been identified to measure the effectiveness of the process in ensuring that participants are directly and actively engaged:

Person-Directed. The person directs the planning process (with necessary sup- ports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

Person-Centered. The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.

Outcome-Based. The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

Information, Support and Accommodations. As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

Independent Facilitation. Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

Pre-Planning. The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):
-When and where the meeting will be held.
-Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).
-Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.
-The specific PCP format or tool chosen by the person to be used for PCP.
-What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
-Who will facilitate the meeting.
-Who will take notes about what is discussed at the meeting.

(b) the participant's authority to determine who is included in the process.
As described in (a) above, the participant has full authority to decide who is involved in the process. Through the pre-planning process, the participant identifies allies (friends, family members, staff, professionals) that he or she wants to be involved and schedules the planning process to accommodate him or her.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) who develops the plan, who participates in the process, and the timing of the plan

The plan is developed by the participant with the support of one or more of the following (i) supports coordinator (if desired), or supports coordinator assistant, or independent supports broker (ii) an independent facilitator (if the participant chooses to have one) (iii) Friends, family members, paid staff and others chosen by the participant (collectively called "allies"). The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the PCP process. Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the PCP process or changes in the personal preferences for support). The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually (Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration Person-Centered Planning Policy June 5, 2017).

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status.

The PCP process eliminates the need for many assessments as the participant's needs, preferences goals, and health status are determined through pre-planning and the PCP process. An assessment is conducted to determine functional eligibility for services and supports. The assessments necessary to determine level of care eligibility for the HSW are determined by the PIHP; no standard assessment is required. Most often, a psychosocial assessment is completed. Depending on the individual participant, other assessments may be needed (PT, OT, Speech). Assessment of level of care for HSW eligibility is completed by a QIDP as noted in Appendix B.

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

The participant is informed of services available under the Habilitation Supports Waiver through the Customer Services Handbook and other print materials available from the PIHP, through the pre-planning and PCP process and through other discussions with the supports coordinator, supports coordinator assistant, or independent supports broker.

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

By using the PCP process, the entire focus is on how the services and supports available in the HSW can support the participant to achieve his or her goals, preferences and meet his or her needs. Health care needs (wellness and well-being) are specifically addressed through the PCP process [MDHHS Administrative Rule 330.7199].

(e) how waiver and other services are coordinated.

The supports coordinator, supports coordinator assistant, or independent supports broker are responsible for ensuring that the waiver services and other services are coordinated. If the participant chooses not to have a supports coordinator, supports coordinator assistant or independent supports broker, the PIHP must offer a choice of other qualified providers who can assist the participant with this function.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

Through the PCP process, the participant, allies, and others at the meeting help in identifying who will be responsible for implementing and monitoring various components of the plan. The responsibilities are documented in the IPOS. The supports coordinator, supports coordinator assistant, or independent supports broker selected by the HSW participant maintains responsibility for general oversight and monitoring to ensure that the HSW services and supports authorized are being provided. If the participant chooses not to have a supports coordinator, supports coordinator assistant, or independent supports broker, the PIHP must offer a choice of other qualified providers who can assist the participant with this function [MDHHS Administrative Rule 330.7199].

(g) how and when the plan is updated, including when the participant's needs change.

The PCP process is not only useful in the initial planning stages. It is an excellent forum for addressing changes in needs, problems in implementation, and other challenges that arise. A PCP meeting can be convened to address issues whenever the need arises and with whatever frequency is appropriate [MDHHS Administrative Rule 330.7199].

The person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. A copy of the plan is distributed to the individual and all providers responsible for its implementation.

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.

The PCP process is the main method through which issues related to risk are identified, strategies for mitigating risk are developed, and methods for monitoring are determined. This process is described below in detail and it is effective because it involves the people most trusted and valued by the participant, including family, friends and other allies. The process is an open one in which the pros and cons of alternatives can be discussed. In this manner, health and welfare issues are balanced with the participants right to make his or her own choices. Solutions to these health, safety and welfare issues are brought up, discussed and resolved to assure the health and welfare of the participant in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction. In the person-centered planning process, the participant is informed of identified potential risk(s) to enable the participant to make informed decisions and choices with regard to these risks. Often the discussion leads to better alternatives that both meet the participants needs and satisfy his or her dreams and goals.

A participant may choose to address a sensitive health and welfare issue privately with the supports coordination provider, rather than within the group PCP process. Regardless of how it is done, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) has an obligation to ensure that all health and welfare issues are addressed. When the participant makes a decision contrary to the recommendation of a member of his or her circle of support, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) must ensure that the participant has information about all available options, documents the participant choice, and revisits the issue as needed.

Sometimes, a participant's choices about how their supports and services are provided cannot be supported by the HSW because the choices pose an imminent risk to the health and welfare of the participant or others. However, these decisions are made as part of the planning process in which the participant and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the participant's needs and satisfy their dreams and goals. Participant-approved risk strategies are documented and written into the IPOS. Participants may be required to acknowledge situations in which their choices pose risks for their health and welfare.

Back-up plans provide alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them. A copy of the back-up plan should be provided to the participant, left in the participant's home, included in the participant's case record, and given to applicable service providers. Back-up plans include developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the supports coordinator when planned for services are not available. Additionally, emergency plans are developed for each participant that clearly describes a course of action when an emergency situation occurs with the participant. Plans for emergencies are discussed and incorporated into the IPOS during the PCP process. In an effort to make improvements in the way back-up plans are developed with participants, agencies must monitor and track situations in which back-up plans are activated, as well as when they are successful or unsuccessful.

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.

In Michigan, all Medicaid beneficiaries who are participants in the HSW have a right under the federal Balanced Budget Act (BBA) of 1997 (42 CFR §438.6) to choose the providers of the services and supports that are identified in their individual plan of service (IPOS) to the extent possible and appropriate. PIHPs or their subcontractors must provide information to participants regarding any restrictions on the participants freedom of choice among providers in the network. Qualified providers chosen by the participants but which are not currently in the network or on the provider panel can be added to the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The participant must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances (See 42 CFR §438.52(b)). Choice of providers is essential to ensuring that participants are satisfied with their services and supports and who provides them. For example, most people have strong preferences about who provides their most intimate personal care.

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):

The responsibility for approving the individual plan of services (IPOS) is delegated to the PIHPs. Each PIHP develops its own process by which it approves the IPOS. The Michigan Department of Health and Human Services provides oversight through its QMP site review process.

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 PIHP is responsible for assuring that a written or electronic record of the participant's IPOS is maintained for a minimum of three years as required by 45 CFR §92.42. Each PIHP determines the location for storing records and makes these records available for the State to review upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PIHP is responsible for monitoring how the participant implements services and supports, assuring that the funding is expended pursuant to the IPOS and individual budget and that risk management issues are addressed. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the participant to provide these functions) will provide assistance to the participant as requested or needed throughout the process of obtaining and implementing waiver services. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the participant) must offer information and support to the participant and directly address concerns that the participant may have either over the phone or in a face-to-face meeting. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the participant) must have face-to-face contact with the participant at the frequency specified in the IPOS. The frequency of face-to-face visits should be determined based upon the participant's preference, the participant's health and welfare, and other circumstances identified for that participant. Continued assistance is available throughout the time that the participant receives services and supports. Participants and their allies contact the supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant responsible for this function) when new needs emerge.

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 PIHPs, which have responsibility for monitoring implementation of the IPOS and participant health and welfare, may provide direct waiver services to the participant. However, the monitoring is done by the participants supports coordinator, supports coordinator assistant, or independent supports broker or other qualified provider chosen by the participant, who may not provide other direct services to the participant. In fact, all monitoring functions (supports coordination, recipient rights, etc) are administratively separate from the service provision functions. In addition, a participant may contract with an independent supports broker to assist the participant with implementation of the IPOS.

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 enrolled participants whose IPOS include services and supports that align with the individual's assessed needs. Numerator: Number of enrolled participants whose IPOS include services and supports that align with their assessed needs. Denominator: All enrolled participants sampled.

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

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

		proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year period	

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 enrolled participants whose IPOS reflect their goals and preferences. Numerator: Number of enrolled participants whose IPOS reflect their goals and preferences. Denominator: All enrolled participants sampled.

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

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

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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 enrolled participants whose IPOS had adequate strategies to address their assessed health and safety risks. Numerator: Number of enrolled participants whose IPOS had adequate strategies to address their assessed health and safety risks. Denominator: All enrolled participants sampled.

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

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

	bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure 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 IPOS for enrolled participants that are developed in accordance with policies and procedures established by MDHHS. Numerator: Number of IPOS for enrolled participants that are developed in accordance with policies and procedures established by MDHHS. Denominator: All enrolled participants sampled.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered across a two-year time period	

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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **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 enrolled participants whose IPOS changed when the individual's needs changed. Numerator: Number of enrolled participants whose IPOS was changed when the individual's needs changed. Denominator: All enrolled participants sampled.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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 enrolled participants whose IPOS are updated within 365 days of their last plan of service. Numerator: Number of enrolled participants whose IPOS were updated within 365 days of their last plan of service. Denominator: All enrolled participants sampled.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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:
 # and % of IPOS for enrolled participants in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency. Numerator: Number of IPOS for enrolled participants with services and supports provided as specified in the plan, including type, amount, scope, duration and frequency. Denominator: All IPOS for enrolled participants sampled.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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 enrolled participants who are informed of their right to choose among the various waiver services. Numerator: Number of enrolled participants who are informed of their right to choose among the various waiver services. Denominator: All enrolled participants sampled.

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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 enrolled participants who are informed of their right to choose among waiver providers. Numerator: Number of enrolled participants who are informed of their right to choose among waiver providers. Denominator: All enrolled participants sampled.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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.

A proportionate random sample will be obtained to assure that HSW participants receiving services at each PIHP are reviewed.

In addition to the QMP site reviews, the Federal Compliance Section staff may identify issues related to the IPOS through activities such as reviews of HSW applications, monitoring the HSW database for timeliness of consents for freedom of choice, reviewing requests for Medicaid fair hearing on HSW-related services, and numerous requests for technical assistance by PIHPs, CMSHPs, providers, HSW participants and their families.

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.

Any findings noted during the site review process are included in a formal report issued by the MDHHS- BHDDA to the PIHP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA HSW staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDHHS. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately 90 days after the Remedial Action Plan/Plan of Correction has been approved to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

Additionally, when individual problems are discovered by either the QMP site review or by the HSW Program staff, that issue is addressed directly with the HSW coordinator at the PIHP to determine how to 1) resolve the issue for that individual and 2) provide any needed technical assistance or training at the regional or local level.

Documentation of individual actions may be in the form of emails, fax transmittals, phone calls, training logs or visits to an HSW participant's home.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Michigan has a long history of supporting opportunities for participant self-direction. In the early 1990's, as one of the eight Community Supported Living Arrangements (CSLA) states, Michigan collaborated with consumers of developmental disability services, their family members, advocates, providers, and other stakeholders to develop and operate a variety of Medicaid-funded services and supports pilots. These pilots were tightly governed under a values template of consumer choice and control. In 1995, when the Congressional "sun" set on the federal CLSA program, all of the CSLA consumers and as many of that program's self-directed features as the state was able to negotiate within its renewal were incorporated within this Waiver program. In 1996, the Michigan legislature made person centered planning a requirement for all participants receiving services and supports under the Mental Health Code. Since 1997, when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, MDHHS has continued to build the demand and capacity for self directed services. Elements of participant direction are embedded in both policy and practice from Michigan's Mental Health Code, the Department's Person-Centered Policy Practice Guideline and Self-Determination Policy and Practice Guideline, the contract requirements in the contracts between the state and the PIHPs, and technical assistance at the state level for multiple methods for implementation by the PIHP.

The Self-Determination Policy and Practice Guideline requires that PIHP/CMHSPs "assure that full and complete information about self-determination and the manner in which it may be accessed and applied is available to each consumer. This shall include specific examples of alternative ways that a consumer may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully." (I.C. page 4). Moreover, the policy states: "A CMHSP shall actively support and facilitate a consumer's application of the principles of self determination in the accomplishment of his/her plan of services." (I.E.. page 4).

Waiver participants have opportunities for both employer authority and budget authority. Participants may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. Resources to support the chosen consumer-directed services are transferred to a fiscal intermediary (this is the Michigan term for the entity that provides Financial Management Services-FMS), which administers the funds and makes payment upon authorization of the consumer's representative. Consumers can directly employ staff or contract with clinical providers through Choice Voucher/Self Determination arrangements. The responsible parent of the HSW consumer represents the common law employer of the providers of hourly care staff (until age 18) and directs clinical providers through purchase of service agreements. The responsible parent delegates performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The responsible parent of the HSW consumer directly recruits, hires and manages service providers. Detailed guidance to CMHSP entities on the Choice Voucher System is provided in the Choice Voucher System Technical Advisory.

(a)The nature of the opportunities afforded to consumers

Waiver participants have opportunities for both employer and budget authority. Participants may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The participant may direct the budget and directly contract with chosen providers. The individual budget is transferred to a fiscal intermediary (this is Michigan's term for an agency that provides financial management services or FMS) which administers the funds and makes payment upon participant authorization.

There are two options for participants choosing to directly employ workers: Self Determination/Choice Voucher System and Agency with Choice. Through the first option, the participant is the common law employer and delegates performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions through Self Determination, Choice Voucher is for Children on the waiver where a legal guardian would perform the functions of a common law employer on behalf of the child. The participant directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Self Determination Technical Advisory. In the Agency with Choice model, participants may contract with an agency with choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Agency with Choice Technical Advisory. A participant may select one or both options. For example, a participant may want to use self directed services to directly employ a good friend to provide CLS during the week and Agency with Choice to provide CLS on the weekends. The Customer Services Handbook, which includes information about self-directed services, is disseminated to all consumers of mental health services and is provided at the onset of services.

(b)How consumers may take advantage of these opportunities

Information about self-directed services is also provided by the supports coordinator (or other QIDP) to all HSW-enrolled consumers and their families – at initial enrollment and on an on-going basis. Participants interested in arrangements that support self-determination start the process by letting their supports coordinator or other chosen qualified provider know of their interest. The participants are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the PCP process. An individual plan of service (IPOS) will be developed through this process with the participant, supports coordinator or other chosen qualified provider, and allies chosen by the participant. The plan will include the HSW waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The participant will choose service providers and have the ability to act as the employer. In Michigan, PIHPs provide many options for participants to obtain assistance and support in implementing their arrangements.

(c)The entities that support individuals who direct their services and the supports that they provide

PIHPs are the primary entities that support participants who direct their services. Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the participant) are responsible for providing support to participants in arrangements that support self-determination by working with them through the PCP process to develop an IPOS and an individual budget. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and arrangements. Supports coordinators, supports coordinator assistants, or independent supports brokers (or other qualified provider chosen by the participant) make sure that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. Participants are provided many options for Independent Advocacy, through involvement of a network of participant allies and independent supports brokerage, which are described in Section E-1k below.

Through its contract with MDHHS, each PIHP and PIHP contracted network provider is required to offer information and education to consumers on participant direction. Each PIHP and PIHP contracted network provider also offers support to consumers and their families who choose self-direction. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each PIHP is required to contract with one or more fiscal intermediaries to provide financial management services. Fiscal Intermediary Services is a service in the HSW. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:

- function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements;
- 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.
- facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to participant and agency; and
- offer supportive services to enable participants to direct the services and supports they need.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's

representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the 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

Although all consumers are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the consumer's representative. While consumers have the right to choose among service providers who are on contract with or employed by the PIHP or hired through Self Directed service, the following 3 waiver services are considered provider managed services only: 1. Environmental Modification, 2. Enhanced Medical equipment and Supplies, and 3 Fiscal Intermediary.

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.

The PIHPs are responsible for providing information about participant direction opportunities. General information about self-directed services is made available to all waiver participants (new and current) by providing them with a general brochure and with directions how to obtain more detailed information. When a person receiving waiver services expresses interest in participating in arrangements that support self-determination, the supports coordinator, supports coordinator assistant, independent supports broker, or other qualified provider as selected by the participant, who has specific training and expertise in the various options available, will assist the participant in gaining an understanding about self-determination arrangements and how those might work for the participant. Many PIHPs have a Self-Determination Coordinator who has expertise in arrangements that would promote self-determination.
Specific options and concerns such as the benefits of participant-direction, consumer responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each consumer develops an Individual Plan of Service (IPOS) through the person-centered planning (PCP) process, which involves his or her family and friends and a case manager (or other QIDP). The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The PCP Policy and Practice Guideline require that health and safety concerns be addressed. The MDHHS Self Determination staff provide support and technical guidance to CMHSPs with developing local capacity and with implementing options for participant direction.

(b) the entity or entities responsible for furnishing this information

The PIHPs are responsible for disseminating this information to consumers and their representatives. In addition, the program staff from MDHHS provide information and training to provider agencies, advocates and other stakeholders.

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

This information is provided throughout the participant's involvement with the PIHP. It starts from the time that the participant approaches the PIHP for services and is provided with information regarding options for participant direction. Participants are to be provided with information about the principles of self-determination and the possibilities, models and arrangements involved. The PCP process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Self-determination arrangements begin when the PIHP and the participant reach an agreement on an individual plan of service, the funding authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each participant (or his or her legal representative) who chooses to direct his or her services and supports signs a Self-Determination Agreement with the PIHP 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 informal supports can include agents designated under a power of attorney or other identified persons participating in the PCP process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the participant. Moreover, the waiver service definition of the fiscal intermediary includes the following safeguard: Fiscal Intermediary Services may not be authorized for use by a participants representative where that representative is not conducting tasks in ways that fit the participants preferences and/or do not promote achievement of the goals contained in the persons plan of services so as to promote independence and inclusive community for the participant or when they are acting in a manner that is in conflict with the interests of a participant. In the event the representative is working counter to the participants interests, the supports coordinator or other chosen qualified provider 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
Goods and Services	☒	☒
Community Living Supports	☒	☒
Enhanced Pharmacy	☐	☒
Supported Employment	☒	☒
Respite	☒	☒
Supports Coordination (Authority Change Effective 10/1/2019)	☐	☒
Personal Emergency Response System	☐	☒
Overnight Health and Safety Support	☒	☒
Non-Family Training	☒	☒
Private Duty Nursing	☒	☒
Family Training	☒	☒
Out-of-Home Non-Vocational Habilitation	☒	☒
Prevocational Services	☒	☒

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

○ **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:

A fiscal intermediary (FI) is a neutral and independent legal entity that acts as the fiscal agent of the PIHP or the PIHP contracted network provider for the purpose of assuring fiduciary accountability for the funds authorized to purchase the services and supports in the child's/participant's IPOS. The FI receives the funds; makes payments as authorized by the family to providers of services and supports; and acts as an employer agent when the family directly employs workers. A FI may also provide a variety of supportive services that assist families in using the Choice Voucher/self-determination and managing their own supports. FI entities include: accountants and accounting firms, financial advisors / managers, financial management firms, attorneys, and advocacy and human services agencies.

The PIHP or the PIHP contracted network provider offers the participant or legal guardian a choice among available FI entities that meet the qualifications for this provider type. If the consumer's representative identifies a qualified FI not currently on the provider panel, that FI may apply to the PIHP or contracted network provider to be included on the provider panel. A contract between the PIHP contracted network provider and the FI is developed and signed that outlines the roles, responsibilities, basis and process for payment.

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

The contract between the PIHP and the FI stipulates the conditions of the agreement including the role and responsibility of the FI and how the FI is compensated for the financial management services it provides. The FI gets compensated through via the PIHP 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:

The FI must designate a liaison person who will be the primary contact person and have responsibility for monitoring and ensuring that the terms of the contract between the FI and the CMHSP are fulfilled. Activities include:

1.To receive, safeguard, manage and account for funds provided by the PIHP on behalf of each consumer and maintain complete and current financial records and supporting documentation verifying expenditures paid by the FI and a chart of accounts.

2. To assist consumers and their representatives to understand billing and documentation responsibilities.

3. To perform the financial administrative duties of employer and provide employer agent services to the consumer and his/her representative directly employing staff or contracting with clinical service providers. The FI must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the PIHP/CMHSP and the consumer or consumer's representative must provide copies of all required employment documents including the Medicaid Provider Agreement to the FI.

4. To disburse funds to vendors and other providers of services and supports as directed by each consumer or consumer's representative for the services and supports selected by the consumer or consumer's representative and in accordance with the consumer's individual plan of services, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the consumer or consumer's representative.

5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the FI on behalf of each consumer. These records must be retained for seven years from the start of FI services.

6. To record and maintain a monthly report of services and expenditures for each consumer to keep the PIHP/CMHSP and the consumer or consumer's representative informed of utilization and expenditures for services.

7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by the consumer or consumer's representative and/or the PIHP/CMHSP.

8. To flag for the CMHSP and the consumer or consumer's representative deviations in provision of services authorized in accordance with the consumer's individual plan of services. 9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.

10. To make records regarding consumers available to the PIHP/CMHSP (on behalf of the State Medicaid Agency) as requested and to allow each consumer or consumer's representative access to his or her own records.

11. To commission a full financial audit of the FI's books and records as required by the PIHP/CMHSP and/or MDHHS.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **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) MDHHS requires that PIHP/CMHSPs develop and implement a plan for assessing and monitoring FI performance that involves participants, participants' representatives and their allies in the assessment and monitoring. The plan should include a performance review process at least annually. Elements of the plan for assessing and monitoring FI performance must minimally include:

1. Fulfillment of FI Agreement requirements;

2. Competency in safeguarding, managing and disbursing funds;

3. Ability to indemnify the CMHSP pursuant to FI agreement requirements;

4. Evaluation of consumer feedback and experience with and satisfaction of FI performance with alternate methods for collecting data from consumers;

5. Involvement of consumers and their allies in the development and implementation of the FI arrangement; and

6. Performing an audit of a sample of service utilization and expenditure reports.

(b) The PIHP/CMHSPs are responsible for this monitoring. Compliance with the requirement is included in the Quality Management Program (QMP) site review process.

(c) The FI performance review must be conducted at least 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:

Specific options for participant direction are addressed through the person-centered planning process (PCP), which is mandated in the Michigan Mental Health Code. Each consumer develops an Individual Plan of Service (IPOS) through the PCP process, which involves his or her family and friends and a supports coordinator or other qualified provider (such as an independent supports broker). For minor children and their families, this planning process includes a family-driven/youth-guided practice that builds upon the child's capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the child and the family and involves the participation of the child, family and friends. This process results in an IPOS for the child that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

When an individual expresses interest in self-directing services, the supports coordinator (or other person selected by the participant's representative) will assist the person in gaining an understanding about self-directed services and how those options might work for the consumer. This includes providing information regarding the responsibilities, liabilities and benefits of these options prior to the PCP process. The IPOS will include the waiver services needed by and appropriate for the person. A budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The person or their representative will be informed of qualified fiscal intermediaries (FI) on contract with the PIHP/CMHSP.

Depending on the need of the individual, supports coordinator may provide a variety of information and assistance related to implementing participant direction. This can include helping to develop job descriptions and ads (in a variety of formats), and recruiting candidates to interview through job ads, worker registries and other sources. When not delegated to the FI, the CMHSP is responsible for verifying staff qualifications and working through any issues with the criminal background checks with the family. When staff are hired, the supports coordinator may troubleshoot staff performance problems or-in the case of purchase of service arrangements for clinical service providers-the case manager may troubleshoot services, eg., scheduling.

☒ **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
Enhanced Medical Equipment and Supplies	☐
Goods and Services	☐
Community Living Supports	☐
Enhanced Pharmacy	☐
Supported Employment	☐
Environmental Modifications	☐
Respite	☐
Fiscal Intermediary	☒
Supports Coordination (Authority Change Effective 10/1/2019)	☐
Personal Emergency	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Response System	
Overnight Health and Safety Support	☐
Non-Family Training	☐
Private Duty Nursing	☐
Family Training	☐
Out-of-Home Non-Vocational Habilitation	☐
Prevocational Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

A variety of options for independent advocacy are available. These options include: Utilizing a network of allies in the PCP process, using an Independent Facilitator to facilitate the planning process and retaining an independent supports broker for assistance throughout the planning and implementing the individual plan of service and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what will work best for him/her, are consistent with his/her needs and reflect the participant's circumstances. The supports broker helps the participant explore the availability of community services and supports, access housing and employment, and makes the necessary arrangements to link the participant with those supports. Supports brokerage services offer practical skills training to enable participants to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving. When a participant uses an independent supports broker, the supports coordinator or supports coordinator assistant has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. Authorization of the IPOS and individual budget cannot be delegated to an individual advocate by the PIHP.

An Independent Facilitator should be someone trusted by the consumer or his/her representative. (For children, the Independent Facilitator cannot be the consumer's representative, as Independent Facilitators do not decide what will be paid for in the plan, authorize services and supports, or benefit from the outcome of the plan.) If the consumer or his/her representative would like assistance in finding an Independent Facilitator, they can ask their case manager, other service provider or an advocacy agency to provide a list of names and resumes of facilitators.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The participant has the freedom to modify or terminate his or her arrangements that support self-determination at any time. The most effective method for making changes is through the person-centered / family-driven / youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a consumer to terminate participant direction does not alter the need for services as identified in the IPOS. Upon termination of participant direction, the PIHP/CMHSP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP/CMHSP.

The Self-Determination Policy and Practice Guideline sets forth the procedure for the PIHP/CMHSP to follow. The Self Determination Agreement defines the responsibilities of the parties regarding participation and is in effect until it is changed or ended. Either party can initiate a change or end to the agreement by providing written notice to the other party. The PIHP/CMHSP must respond to any such notice within seven (7) working days.

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 PIHP or CMHSP may involuntarily terminate participant direction when the health and welfare of the participant is in jeopardy or other serious problems are resulting from the participants failure in directing services and supports. The Self-Determination Policy and Practice Guideline sets forth the procedure for the PIHP to follow, and provides direction as follows: Prior to the [PIHP] terminating an agreement, and unless it is not feasible, the PIHP shall inform the participant of the issues that have led to the decision to consider altering or discontinuing the arrangement in writing, and provide an opportunity for problem resolution. Typically, the person-centered planning process will be used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found. In any instance of discontinuation or alteration of a self-determination arrangement, the local grievance procedure process may be used to address and resolve the issues. The decision of the PIHP to terminate participant direction does not alter the services and supports identified in the individual plan of service. In that event, the PIHP has an obligation to take over responsibility for providing those services through its network of qualified providers.

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		1435
Year 2		1507
Year 3		1582
Year 4		1661
Year 5		1744

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:

In the Agency with Choice model, participants serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as AWC provider) serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing workers compensation insurance). In the Agency with Choice model, participants may get help with selecting their workers (for example, the AWC provider may have a pool of workers available for consideration by participants). The AWC provider may also provide back-up workers when the participants regular worker is not available. Like traditional staffing agencies, the AWC provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that participants directly employing workers cannot provide. The Agency with Choice model is also an important option for participants who do not want to directly employ workers or who want to transition into direct employment.

☒ **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.

☒ **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:

Not applicable. Same as c-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **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*:

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

Specify:

1. Execute and terminate purchase of service agreements with clinical service providers.
2. Authorize payment for contracted clinical service providers

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.

An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the IPOS (SD Guideline II.C.). Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP) (SD Guideline II. A.). Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.

Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the IPOS, after a IPOS that meets the participants needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year).

Once the IPOS is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the participant, the mental health agency (PIHP or designee), and others participating in the PCP process.

This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Workers Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. The individual budget must include the fiscal intermediary fee if a fiscal intermediary is utilized.

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a fiscal intermediary be used.

Fiscal intermediary is a waiver service and is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from $75.00 to $125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.

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 PIHP include written information on the development of the individual budget. During the planning process, a participant is to be provided clear information and 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 IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the participant and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the participant to implement the plan and the individual budget. The budget will be 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 PIHP. The participant's plan is also attached to the agreement.

The participant's supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant) are expected to provide assistance to the participant in understanding the budget and how to utilize it. In situations where the participant also has an independent supports broker, the broker will assist the participant to understand and apply the budget. The participant may seek an adjustment to the individual budget by requesting this from their supports coordinator or other chosen qualified provider. The supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant) will be expected to assist the participant to convene a meeting including the participant's chosen family members and allies, and to assure facilitation of a PCP process to review and reconsider the budget. A change in the budget is not effective unless the participant and the PIHP have agreed to the changes.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The amount of the individual budget must be sufficient to provide a defined amount of resources. It must also be written to allow flexibility in its use, which means that a participant can decide when services and supports are used and make some adjustments between budget line items. The SD Guideline describes types of flexibility (SD Guideline II.E.4):

Adjustments that do not require a Modification to the Individual Budget:

Unless an adjustment deviates from the goals and objectives in the participant's IPOS, the participant is not required to obtain permission from the mental health agency (PIHP or designee) or provide advance notification of an intended adjustment. "The [participant] may adjust the specific application of CMHSP-authorized funds within the budget between budgetary line items and/or categories in order to adjust his/her specialty mental health services and supports arrangements as he or she deems necessary to accomplish his/her IPOS." (SD Guideline II.E.4.a.) The IPOS must be written in a way that contemplates and plans for the manner in which the participant may use the services and supports. Amounts, scopes and durations may be written in ranges or a length of time that makes flexibility possible (a month or a quarter). Services and supports that are similar and may be substituted for one another should be identified as well as services and supports for which there is no substitution. Adjustments in this manner should be communicated to the mental health agency (PIHP or designee) in a timely manner.

Adjustments that Require a Modification to the Individual Budget:
Sometimes, a participant wants to make an adjustment that fundamentally alters the IPOS (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized). If the adjustment "does not serve to accomplish the direction and intent of the person's IPOS, then the IPOS must be appropriately modified before the adjustment may be made." (SD Guideline II.E.4.d). In this situation, a modification can often be made over the phone between the participant and his or her supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant). The change should be accomplished as expeditiously as possible. Larger changes may need to be made through the PCP process.

The mental health agency (PIHP or designee) must provide the participant with information on how to request a Medicaid Fair Hearing when the participant's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment.

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:

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. Most participants use FMS through a fiscal intermediary even if they only contract with providers already under contract with the PIHP; however, there is no requirement that they do so.

The funds in an individual budget are transferred to the fiscal intermediary, which handles payment for services and supports in the IPOS upon receipt of invoices and timesheets authorized by the participant. The fiscal intermediary provides both the participant and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or underutilization identified in the report can be addressed by the supports coordinator (or other chosen qualified provider) and participant informally or through the PCP process.

The supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) is responsible for assisting the participant in implementing the individual budget and arrangements, including understanding the budget report. A participant can use an independent supports broker to assist him or her in implementing and monitoring the IPOS and budget. When a participant uses an independent supports broker, the supports coordinator (other qualified provider selected by the participant) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the IPOS and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee.

If using FMS through a fiscal intermediary, the supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the participant, the supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report. If the participant does not use a fiscal intermediary because he or she only contracts with providers already under contract with the PIHP, the PIHP must provide a monthly budget report to the participant and supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) so the participant can effectively manage his or her budget and thereby, exercise budget authority.

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 State has established a grievance system that is compliant with 42 CFR 431 Subpart F through contract agreement with each PIHP. The Grievance and Appeal Technical Requirement is Attachment 6.3.1.1 of the MDHHS/PIHP contract.

The notice of action to the beneficiary or his/her legal representative must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

The PIHPs are required to provide timely and adequate notice of any Adverse Benefit Determination. The content of the notice must meet the following requirement:
- Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;
- Description of Adverse Benefit Determination;
- The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
- Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
- Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
- Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
- Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";
- Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
- An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

The Adverse Benefit Determination Notice allows for the opportunity for internal review with the PIHP prior to the individual requesting a State Fair Hearing in some situations.
- The PIHP 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.

Appeal Resolution Notice:
- The notice of resolution must include the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
  i. Right to request a state fair hearing, and how to do so;
  ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
  iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

If a beneficiary not enrolled in the HSW requests to apply for the HSW, the beneficiary must be given the choice of home and community-based waiver services as an alternative to the level of care provided in an ICF/IID by the PIHP. Evidence that the PIHP offered this choice to the beneficiary is documented in the HSW eligibility certification form. If the PIHP does not offer the choice between home and community-based services instead of the level of care offered by an ICF/IID, the PIHP must give adequate notice to the beneficiary or legal representative (if applicable) per the process described above.

Once the HSW application has been submitted to MDHHA-BHDDA for review, if the beneficiary is determined to not meet eligibility requirements for the HSW, an adequate notice is sent to the beneficiary and legal representative (if applicable) by the MDHHS-BHDDA Federal Compliance Section Manager. This notice follows the process described above.

Once a beneficiary has enrolled in the HSW, the participant may receive adequate or advance notice, depending on the decision related to their HSW or other Medicaid mental health services.

Upon completion of the development of the individual plan of services (IPOS) through the person-centered planning process, the beneficiary or his legal representative is provided adequate notice of action at the time of the signing that he or she may file a

request for a fair hearing if he or she subsequently disagrees with the scope, duration or intensity of authorized services. Adequate notice of action is also provided when there is a decision by the PIHP to deny or limit authorization for services requested. Notice is provided to the beneficiary or his/her legal representative on the same date as the action takes effect.

PIHP policies and procedures vary as to upon whom the responsibility is placed to notify beneficiaries or their legal representatives of an adverse action, e.g. Utilization Management, Customer Services, person designated in the plan of service as responsible for assuring that committed services/supports are delivered. (MDHHS Admin. Rule 330.7199)

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy. The MDHHS Federal Compliance Section also monitors Fair Hearing Requests and Decisions by the Tribunal for HSW participants and takes action with the PIHP when necessary to assure HSW services are provided as specified in policy.

All notices of action which include information on the opportunity to request a State fair hearing are maintained in appropriate PIHP administrative files and a copy in the beneficiarys record.

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.

a) The State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 10 IHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.1.1 of the MDHHS/PIHP Contract.

b) Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, such as a denial, termination, or reduction of a service, and those challenging anything else, such as a beneficiary's dissatisfaction with service, e.g., quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary. A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

BEBEFICIARY APPEALS:

Beneficiary Appeals are initiated by notice of an adverse action. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal.
Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:
- The Enrollee has 60 calendar days from the date of the notice of Adverse Benefit Determination to request an Appeal. 42 CFR 438.402(c)(2)(ii).
- The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. 42 CFR 438.402(c)(3)(ii).
- If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee’s benefits if all of the following occur: 42 CFR 438.420
  1.The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); 42 CFR 438.402(c)(2)(ii);
  2.The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). 42 CFR 438.420(a); and
  3. The period covered by the original authorization has not expired.

When a beneficiary or his/her legal representative requests an Appeal, the PIHP is required to:
- Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR 438.406(a).
- Acknowledge receipt of each Appeal. 42 CFR 438.406(b)(1).
- Maintain a record of appeals for review by the State as part of its quality strategy. 42 CFR 438.416.
- Ensure that the individual(s) who make the decisions on Appeals: 42 CFR 438.406(b)(2).
  a) Were not involved in any previous level of review or decision- making, nor a subordinate of any such individual;
  b) When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee’s condition or disease.
  c) Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; 42 CFR 438.406(b)(4).
- Provide the Enrollee and his/her representative the Enrollee’s case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. 42 CFR 438.406(b)(5).
- Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; 42 CFR 438.406(b)(6).
- Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

Appeal Resolution Notice:
- The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. 42 CFR 438.408(d)(2).
- When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
  i.Right to request a state fair hearing, and how to do so;
  ii.Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
  iii.Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

The Notice of Disposition of Appeal must be provided within the following timeframes:
Standard Resolution: The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP receives the Appeal.

Expedited Resolution: If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72-hours after the PIHP receives the request for expedited resolution of the Appeal. 42 CFR 438.408. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

The PIHP may extend the notice of disposition timeframe by up to 14 calendar days if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the beneficiary's interest.

If the PIHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. The PIHP makes reasonable efforts to give the beneficiary prompt oral notice of the denial, and give the beneficiary follow up written notice within two (2) calendar days.

BENEFICIARY GRIEVANCES:
Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". Generally:
1. Enrollees must file Grievances with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of Grievances.
2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. 42 CFR 438.402(c)(2)(i).
3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution

For each grievance filed by a beneficiary, the PIHP is required to:
1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR 438.406(a).
2. Acknowledge receipt of the Grievance. 42 CFR 438.406(b)(1).
3. Maintain a record of grievances for review by the State as part of its quality strategy.
4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. 42 CFR 434.32
5. Ensure that the individual(s) who make the decisions on the Grievance:
  a.Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. 42 CFR 438.406(b)(2)(i).
  b.When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

c.Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination

STATE FAIR HEARING APPEAL PROCESS:

- Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:
  - After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. 42 CFR 438.408(f)(1);
  - When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in 42 CFR 438.408. 42 CFR 438.408(f)(1)(i).
- The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). 42 CFR 438.408(f)(1)(ii).
- The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.
- Enrollees are given 120 calendar days from the date of the applicable notice of resolution to file a request for a State Fair Hearing. 42 CFR 438.408(f)(2).

The requirements are specified in the MDHHS/PIHP contract in Attachment 6.3.1.1.

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 MDHHS-BHDDA requires reporting on the following critical events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of consumer. Allegations of abuse, exploitation and neglect are also reported to the local Community Mental Health Services Program (CMHSP) Office of Recipient Rights (ORR). Definitions follow after the description of the system for reporting.

There are several systems of reporting that are involved in assuring participant safeguards, including the Immediate Event Reporting, sentinel event analysis and reporting and the Event Reporting System by PIHPs and CMHSPs; the local CMHSP ORR reporting to other state agencies, such as the Department of Licensing and Regulatory Affairs, Child Protective Services (CPS), or Adult Protective Services (APS), and involvement by local law enforcement.

MDHHS-BHDDA requires the PIHPs and CMHSPs to report critical incident data and related information as measures of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including HSW participants.

EVENT REPORTING: Attachment P7.7.1.1. of the MDHHS/PIHP contract requires the PIHP to report directly to MDHHS when any of the following egregious events occur: any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation (report to MDHHS electronically within 48 hours of death or PIHP's notification of death), relocation of a consumer's placement due to licensing suspension or revocation (report to MDHHS telephonically or other forms of communication within five business days), conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of his or her job duties or responsibilities (report to MDHHS telephonically or by other forms of communication within five business days) and an occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours (report to MDHHS telephonically or by other forms of communication within five business days). The CMHSP is responsible to assure the immediate health and welfare of the HSW participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident.

CRITICAL INCIDENT REPORTING SYSTEM (CIRS): The CIRS enables MDHHS to receive data on individual consumers within specified timeframes, depending on the type of event. People enrolled under the HSW are a reportable population in the CIRS. Attachment P7.7.1.1 the CIRS requires the PIHP to report the following events to MDHHS-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. Timeframes for reporting the five specified events in the CIRS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the CMHSP attempts to determine whether the death was due to suicide. In that case the submission is due within 30 days of the end of the month in which CMHSP determined the death was not due to suicide.

Emergency medical treatment due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

SENTINEL EVENT: Any provider of waiver services report incidents, such as an injury or the use of physical management permitted for intervention in an emergency, on an incident report form that is submitted to the CMHSP. The CMHSP is responsible to assure the immediate health and welfare of the participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident. The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel event and is related to practice of care as described in G-1-d. If the incident if a sentinel event, the CMHSP must undertake a process that begins with a root cause analysis and ends with quality improvement activities. Depending on the type of

incident, it may also be required to be reported on the CIRS through the PIHP to MDHHS. The local CMHSP ORR would also receive a copy of the incident report and may also investigate as described in the CMHSP ORR section in G-1-d. If the CMHSP ORR substantiates a rights violation related to abuse, including exploitation, or neglect, the ORR makes recommendations for remediation to the CMHSP director. The local CMHSP ORR remediation may become part of the remediation by the PIHP of a sentinel event.

OFFICE OF RECIPIENT RIGHTS: Allegations of abuse (including exploitation) and neglect are reported to the local CMHSP ORR through the incident report forms and/or recipient rights complaint forms. Any person employed by the MDHHS, each CMHSP, each licensed hospital, and each service provider under contract with the department, such as a PIHP or any of its subcontractors, has a duty to report any suspected abuse and/or neglect to the local ORR. Michigan law and rules require the mandatory reporting of recipient rights complaints in a timely manner to the CMHSP ORR. CMHSP policies further specify that reports of rights violations are immediately reported to their ORR. Reporting may be done in writing or by phone or by other means of communication, such as fax. If the ORR substantiates a rights violation related to abuse, including exploitation or neglect, the ORR makes a recommendation for remediation to the CMHSP director.

Certain situations involving suspected abuse and neglect must also be reported to law enforcement, CPS or APS. The Michigan Mental Health Code requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) “immediately shall make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made, and with the chief administrator of the facility or agency responsible for the recipient (330.1723).” Michigan’s Child Protection Law requires the following with regard to reporting suspected child abuse or neglect to MDHHS CPS for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) “immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623).” Michigan’s Social Welfare Act requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) “who suspects or has reasonable cause to believe that an adult has been abused, neglected, or exploited shall make immediately, by telephone or otherwise, an oral report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having or believed to have occurred. After making the oral report, the reporting person may file a written report with the county department [400.11(a)].”

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where participants live in licensed settings, Michigan law and rules (for example, R 400.14311 for small licensed AFC homes) require the licensee to complete an Incident/Accident Report (a copy of which is forwarded to the CMHSP ORR) and to make a reasonable attempt to contact the participant’s designated representative and responsible agency by telephone and follow the attempt with a written report to the designated representative, responsible agency and the adult foster care licensing division within 48 hours. The incident/accident report from the licensee is provided to the CMHSP, the responsible agency, which would assure the immediate health and welfare of the participant, as well as that of any other mental health recipients in the home. A licensee is required to report any of the following:

a) The death of a participant.
b) Any accident or illness that requires hospitalization.
c) Incidents that involve any of the following:
  i.Displays of serious hostility.
  ii.Hospitalization.
  iii.Attempts at self-inflicted harm or harm to others.
  iv.Instances of destruction to property.
d) Incidents that involve the arrest or conviction of a participant as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.

(2) An immediate investigation of the cause of an accident or incident that involves a participant, employee, or visitor

shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
(3) If a participant is absent without notice, the licensee or direct care staff shall do both of the following:
a)Make a reasonable attempt to contact the participant's designated representative and responsible agency.
b)Contact the local police authority.
(4) A licensee shall make a reasonable attempt to locate the participant through means other than those specified in subrule (3) of this rule.
(5) A licensee shall submit a written report to the participant's designated representative and responsible agency in all instances where a participant is absent without notice. The report shall be submitted within 24 hours of each occurrence.
(6) An accident record or incident report shall be prepared for each accident or incident that involves a participant, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
(a) The name of the person who was involved in the accident or incident.
(b) The date, hour, place, and cause of the accident or incident.
(c) The effect of the accident or incident on the person who was involved and the care given.
(d) The name of the individuals who were notified and the time of notification.
(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
(f) The corrective measures that were taken to prevent the accident or incident from happening again.

Members of the general public may also make reports of incidents of alleged abuse, neglect, exploitation or other concerns. Contact information for local community mental health services programs is available on each CMHSP's website and phone numbers are listed in the phone book. Contact information for the local offices of recipient rights is located on the state ORR's web page.

DEFINITIONS:
Definitions of Abuse and Neglect (MDHHS Administrative Rule 330.7001):

Abuse is divided into three categories, Abuse Class I, Abuse Class II and Abuse Class III. Neglect is also divided into three categories, Neglect Class I and Neglect Class II and Neglect Class III. Abuse Class I and II and Neglect Class I and II are required to be reported to MDHHS on a semi-annual basis as each involves some level of physical or emotional harm to the recipient or involves sexual abuse.

"Abuse class I" means a nonaccidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient. "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
"Sexual abuse" means any of the following:
i. Criminal sexual conduct as defined by section 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.

"Abuse class II" means any of the following:
i. A non accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to nonserious physical harm to a recipient.
ii. The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
iii. Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
iv. An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
v. Exploitation of a recipient by an employee, volunteer, or agent of a provider.

"Emotional harm" means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

"Exploitation" means 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.
"Nonserious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.

"Neglect class I" means either of the following:
i. 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 and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.
ii. The failure to report apparent or suspected abuse Class I or neglect Class I of a recipient.

"Neglect class II" means either of the following:
i. 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, rules, policies, guidelines, written directives, procedures, or individual plan of service and that cause or contribute to non serious physical harm or emotional harm to a recipient.
ii. The failure to report apparent or suspected abuse Class II or neglect Class II of a recipient.

Definitions for Sentinel Events:
Sentinel event: Is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Definitions for Critical Incident Reporting System (CIRS):
-“Suicide” - a Consumer’s death shall be reported as a suicide when either one of the following two conditions exists:
a.The CMHSP serving the consumer determines, through its death review process, that the consumer’s death was a suicide, or
b.The official death report (i.e., coroner’s report) indicates that the consumer’s death was a suicide

-“Non-suicide Death” - any death, for consumers in the reportable population, that was not otherwise reported as a suicide. The reportable population includes any HSW participant.

-“Emergency Medical Treatment due to Injury or Medication Error” - Situations where an injury to a consumer or a medication error results in face-to-face emergency treatment being provided by medical staff. Any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms should be reported, provided the treatment was sought due to an injury or medication error.

-“Medication error” is defined as a situation where a mistake is made when a consumer takes prescribed medication (i.e., incorrect dosage taken, prescription medication taken that is not prescribed, medication taken at wrong time, medication

used improperly), or a situation where non-prescription medication is taken improperly.

-“Injury” is defined as bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones.

-“Hospitalization due to Injury or Medication Error” - Admission to a general medical facility due to Injury or Medication Error. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

-“Arrest” - Situations where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody, are not considered to be an arrest.

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.

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDHHS entitled “YOUR RIGHTS When Receiving Mental Health Services in Michigan” at the time of admission into services and periodically thereafter. The HSW participant’s supports coordinator will provide information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of HSW services and as often as needed by the participant or the informal caregivers, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Code: “… applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients. From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Code mandated protections from abuse, neglect, and exploitation, and the 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.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the CMHSP, have rights booklets available in public areas for consumers, guardians, care-givers, etc. The booklet describes the various rights afforded the individual under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDHHS Administrative Rules as well as contact information for the CMHSP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipient’s rights have been violated, including the right to be free from abuse or neglect.

Attachment P. 6.3.1. of the MDHHS-BHDDA/PIHP contract requires that each PIHP must have a Customer Services Unit that provides information about mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a participant. The Customer Services Unit may also, upon request of the participant, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.
The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients’ rights. CMHSP ORRs conduct rights informational sessions for consumers, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Consumer, and Home and Community Based Waiver Conferences, all of which include participants and/or their families. These conferences provided Recipient Rights training that describe consumer rights and the complaint resolution and appeal process.

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.

Critical incidents may be investigated by the CMHSP ORR, the PIHP, the CMHSP, as well as by law enforcement or other state agencies as applicable depending on the nature of the incident.

EVENT REPORTING: Per attachment P 7.7.1 of the MDHHS/PIHP Contract, following event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service. The written report will include beneficiary information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP's plan for monitoring to assure any quality improvement actions are implemented.

SENTINEL EVENT: The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel events and are related to practice of care. Depending on the type of incident, it may also be required to report on the CIRS to MDHHS. In the MDHHS/PIHP contract, attachment P7.9.1 requires that each PIHP's Quality Assessment Performance Improvement Plan (QAPIP) addresses sentinel events. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

All unexpected deaths (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect) of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:
-Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
-Involvement of medical personnel in the mortality reviews
-Documentation of the mortality review process, findings, and recommendations
-Use of mortality information to address quality of care
-Aggregation of mortality data over time to identify possible trends.

Per the MDHHS/PIHP Contract Attachment P 1.4.1, physical management, permitted for intervention in emergencies only, is considered a critical incident that must managed and reported according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in Attachment P 1.4.1 as "a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDHHS requires PIHPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the PIHP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. [excerpt from MDHHS/PIHP contract Section 6.1].

CRITICAL INCIDENT REPORTING SYSTEM: The CIRS requires the CMHSP to report the following events through the PIHP to MDHHS-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. CMHSPs will submit data through the PIHP to MDHHS- BHDDA via the CIRS. Incidents reported in the CIRS would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the CIRS, such as a death or injury, could result in a criminal investigation or referral to Child or Adult Protective Services. All events are included in aggregate trend and analysis reports. Events that are

considered priorities, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example), are reviewed through the MDHHS internal process. During biennial on-site reviews, MDHHS-BHDDA verifies the process for Critical Incident Reporting is being implemented per MDHHS policy. If it is not, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP. Section G-1-b of this application defines incidents and identifies time lines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP affiliates of the PIHPs shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the participant within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion of the office of recipient rights and the action or plan of action to remedy a violation to the complainant, recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights. Information gathered from investigations is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDHHS to CMHSPs. Aggregate data are shared with MDHHS-BHDDA, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child or adult, MDHHS – CPS or APS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring participant safety. The CMHSP ORR is responsible for investigating rights violations. The Department of Licensing and Regulatory Affairs is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above. Local DHS offices must have signed agreements with their respective CMH boards and AFC licensing to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating and sharing information are in the Adult Services Manual (DHS-ASM 256).

If, during a QMP on-site visit, the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

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.

EVENT NOTIFICATION: Events requiring "immediate notification", as identified in G-1-b, are considered egregious events and are reviewed through the MDHHS internal process. If it is determined that the event is for an HSW participant, immediate follow up by MDHHS staff will occur.

Critical Incident Reporting System (CIRS): The CIRS will allow MDHHS to better monitor the types of events which occur in particular populations, such as the ability to monitor incidents for HSW participants. Since individual consumer identification will be included with each event, MDHHS can look for potential trends by comparing reportable events to data already existing in the Quality Improvement/Encounter files. MDHHS will oversee that the PIHP delegated responsibility for critical incident management for the waiver population by measuring the rate of critical incidents for HSW participants. After establishing a baseline "penetration" rate, MDHHS will set targets for reductions in the rate of critical incidents that will result from systems improvement strategies identified in Appendix H and oversight of critical incidents.

MDHHS staff reviews the critical incident data for outliers and may contact the PIHP or CMHSP when concerns arise. Technical assistance, consultation, and referrals for additional follow-up or training are provided as required. On-site follow-up on reported events takes place at a maximum during MDHHS biennial site reviews. More frequent reviews by MDHHS staff may be required in addition to site reviews, depending on the situation. During site reviews, MDHHS staff examine the PIHP’s incident reporting process, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of reportable event would re-occur. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP within 30 days. The corrective action plan is reviewed by MDHHS. If the submitted plan is satisfactory, it is formally approved. Any less than satisfactory plan would be returned to the PIHP for revision and the process for review and approval by MDHHS would be repeated until a satisfactory plan is achieved. MDHHS conducts an on-site review to assess the efficacy of the plan of correction approximately one year after the full review was conducted. This state oversight by the QMP assures the PIHP has the necessary processes in place for participant safeguards.

OFFICE OF RECIPIENT RIGHTS: On a semi-annual basis, local CMHSP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local Rights office, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including HSW participants. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature.

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 requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Program contract between MDHHS-BHDDA and the PIHPs; the Agreement Between MDHHS-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA)is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

(2)A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a)Use any form of punishment.
(b)Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c)Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d)Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.

○ **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:

◉ **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.

The Michigan Mental Health Code 330.1726 requires (in part):
- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the person's individual plan of services. The Michigan Mental Health Code 330.1744 requires (in part):
- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.

MDHHS Administrative Rules 330.7199 requires (in part):
-The plan [of services and supports] shall identify, at a minimum, all of the following:
Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

The MDHHS contract with the PIHPs and CMHSPs includes Attachment P 1.4.1 MDHHS Standards for Behavior Treatment Plan Review Committees, which addresses the use of restraint, seclusion, intrusive and restrictive interventions.

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained in Attachment P 1.4.1, including those for its appointment, duties, and functions. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. The Committee shall be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. The Committee shall meet as often as needed. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.

The function of the committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
   •Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative

association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.

•Physical management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.

•Restraint: The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support

•Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means

2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.

•Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

•Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

•Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

3.Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

•Positive behavioral supports: A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

4.For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

5.Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

6.As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
1.Dates and numbers of interventions used.
2.The settings (e.g., individual's home or work) where behaviors and interventions occurred
3.Observations about any events, settings, or factors that may have triggered the behavior.
4.Behaviors that initiated the techniques.
5.Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
6.Description of positive behavioral supports used.
7.Behaviors that resulted in termination of the interventions.
8.Length of time of each intervention.
9.Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

The use of physical management would also generate an incident report that is reviewed by the CMHSP ORR. If after investigation by the CMHSP ORR, it is determined that staff used physical management (1) when there is not an imminent risk of harm to the recipient or others, (2) if the physical management used is not in compliance with the techniques approved by the CMHSP, (3) the physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service, and/or (4) physical management is used when other lesser restrictive measures were possible but not attempted immediately before the use of physical management, the CMHSP ORR will substantiate Abuse Class II Use of Unreasonable Force, against the staff. The Michigan Mental Health Code mandates that disciplinary action for any substantiated abuse or neglect.

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:

MDHHS monitors the critical incident reporting through the CIRS. Any death or injury requiring emergency treatment or hospitalization that resulted from the use of physical management would be reported within the timeframes specified in G-1-d.

In addition to monitoring critical incident reporting, MDHHS-BHDDA oversees the activities of the CMHSP Behavior Treatment Plan Review Committees through biennial Site Reviews and more frequent oversight if issues or critical incidents related to the use of restrictive interventions are noted. If critical incidents are reported related to the use of physical management, MDHHS-BHDDA may require the PIHP and CMHSP staff to receive training in positive behavioral supports, as well as recommend other approaches or strategies as appropriate. The data on the use of intrusive and restrictive techniques from CMHSP Behavior Treatment Plan Review Committees must be available for MDHHS review.

The Site Review Team verifies that the process for the Behavior Treatment Plan Review Committees is being implemented per MDHHS policy. If the process is not being implemented per MDHHS policy, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDHHS review.

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 requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Program contract between MDHHS-BHDDA and the PIHPs; the Agreement Between MDHHS-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

(2)A licensee, direct care staff, the administrator, members of the household,
volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a)Use any form of punishment.
(b)Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c)Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d)Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.

○ **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.

The PIHPs and their affiliated CMHSPs 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]. The participant’s individual plan of services and supports must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the participant’s planning team [as authorized by the participant], and all provider staff with medication administration/self- administration assistance/monitoring responsibilities. This helps all within the participant’s planning/service/support network to know when to request a formal medication review outside those scheduled within the plan. Supports coordinators’ 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. Supports coordinators average one face-to-face visit per month with HSW participants.

The PIHP/CMHSP medications monitoring procedure, called a Medication Review, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the participant’s individual plan of services and supports. The average frequency of Medication Reviews performed for those participants who required them is approximately once per quarter.

Michigan’s Department of Licensing and Regulatory Affairs licenses and certifies Adult Foster Care that provide specialized residential services. A significant number of HSW participants reside in this type of setting. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. DHS licensing inspections occur every two years, as well as conducting special investigations when needed.

Any use of behavior modifying medications requires specific approval of a Behavior Treatment Plan Review Committee. These requirements are outlined in contracts with the PIHPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDHHS for HSW participants on a quarterly basis.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the PIHP must follow-up to address the participant’s health and welfare as applicable, report through the critical incident reporting system (CIRS) and conduct a sentinel event investigation.

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.

In addition to the state requiring the PIHP/CMHSP precautions outlined in G-3-a.i, the state's specialized residential certification rule R330.1806(2)(e) requires that "all staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas. . .proper precautions and procedures for administering prescriptive and non-prescriptive medications." In addition to the regular Medication Reviews by the PIHP/CMHSP medical professionals specified in the plan, supports coordinators and others are trained to spot signs and symptoms of potentially harmful practices and can request an unscheduled Med Review and a planning meeting to address any confirmed issues.

The CIRS captures individually identifiable medication errors for HSW participants that required emergency medical treatment or hospitalization. When a hospitalization or emergency medical treatment due to medication error is reported for a HSW participant, MDHHS staff follow-up with the PIHP including requiring a plan of correction from the PIHP/CMHSP to ensure the cause of the medication error is identified and remediated.

During biennial QMP site reviews of the PIHPs, MDHHS-BHDDA staff on the site review team evaluate residential service provider compliance with staff training and incident reporting requirements, as well as the PIHP's monitoring and follow-up of medication errors. In addition, the site reviews evaluate compliance with Behavior Treatment Plan Committee. If a potentially harmful practice is identified at any level, the PIHP works with the provider to correct the practice. If a residential provider does not cooperate toward correction, the PIHP may file a complaint with MDHHS, and per rule R330.1804: (2) Upon receipt of a complaint regarding the provision of specialized program services, the department shall conduct a review within 30 days to determine whether these rules have been violated. The department shall issue a written report of its findings and provide a copy to the department of human services, the complainant, the facility, and the placing agency; (3) The department shall issue a complaint against a facility if rule violations warrant; (4) Failure of the licensee to fully cooperate with the department in connection with inspections and investigations is a ground for the denial, suspension, or revocation of, or refusing to renew, a facility's certification. Non-cooperation from non-residential providers can result in the PIHP revoking their contracts/removing them from their waiver services provider panel.

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).

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 recipients individual plan of service and based upon the recipients 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.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

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

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

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Providers responsible for medication administration are required to record medication errors as noted in G-3-c.i above in Administrative Rule 330.7158 (7). PIHPs must report certain medication errors to MDHHS-BHDDA per the MDHHS-BHDDA/PIHP and CMHSP contracts.

"Medication errors" mean: 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. AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which participants have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDHHS-MHSA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur.

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.

MDHHS will monitor the critical incidents related to medication errors through the CIRS to monitor for trends and outliers. MDHHS may require the PIHP to receive additional technical assistance or training as a result of CIRS data.

On-site follow-up on reported critical incidents regarding medication errors takes place at a maximum during QMP biennial site reviews. During these site reviews, MDHHS-BHDDA staff verifies the PIHP's process for Critical Incident Reporting is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP and additional follow-up by MDHHS 90 days after the corrective action plan has been approved.

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 substantiated abuse and neglect events reported for waiver participants that are remediated. Numerator: Number of substantiated abuse and neglect events reported for waiver participants that are remediated. Denominator: All substantiated abuse and neglect events reported for waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDHHS Office of Recipient Rights

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: Semi-annually

Performance Measure:
Number and percent of participants who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants who received information and education in the prior year. Denominator: Number of participants sampled.

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period.	

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 critical incidents reported within timeframe as required by MDHHS/PIHP contract. Numerator: Number of critical incidents reported for HSW participants within timeframe as required by MDHHS/PIHP contract. Denominator: all critical incidents reported for HSW participants.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Critical Incident Reports

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**	☐ **Annually**

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

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 enrollees requiring emergency medical treatment due to medication error. Numerator: Number of enrollees requiring emergency medical treatment due to medication error. Denominator: all enrollees with reported incidents of emergency medical treatment for injuries or medication errors

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:

#and% of enrollees requiring hospitalization d/t injury related to the use of physical management (PM) where remediation was complete to avoid future incidents of this type.N:#of enrollees requiring hospitalization d/t injury related to the use of PM where remediation was complete to avoid future incidents of this type.D:#of enrollees requiring hospitalization d/t injury related to the use of PM.

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 enrollees requiring hospitalization due to medication error.
Numerator: Number of enrollees requiring hospitalization due to medication error.
Denominator: all enrollees with reported incidents of hospitalization for injuries or medication errors

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**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state 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 records being reviewed where the Behavior Treatment Plan Review Committees (BTPRC) policy was followed. Numerator: Number of records being reviewed where the BTPRC policy was followed. Denominator: Number of records reviewed with Behavioral Treatment Plan.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: bi-ennial, statewide data gathered across two-year time period	

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 records being reviewed where the waiver participants received health care appraisal. Numerator: number of records being reviewed where the waiver participants received health care appraisal . Denominator: number of records 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample.
	☒ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

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:

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 will analyze a 100% of all reported critical incidents involving HSW participants from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS including who required hospitalization due to an injury related to use of physical management or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDHHS and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies.

MDHHS also has regular meetings with LARA Licensing staff to identify issues of concern related to people living in licensed settings.

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 an incident is reported to the CMHSP ORR or CMHSP, the system described in this Appendix would require the following steps be taken. Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the participant’s rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

If an egregious event is reported through the Event Notification or through other sources, MDHHS may follow-up through a number of different approaches, including sending a site reviewer or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a QMP on-site visit, if the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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.

The Quality Improvement Council (QIC)has primary responsibility for identifying and prioritizing needs related to the Quality Improvement Strategy (QIS), which would include changes to HSW quality processes as applicable. The Quality Improvement Council meets every other month basis to review data and information from numerous sources, such as site review findings, 372 reports, state-level workgroups for practice improvement, EQR standard and special project reports, legislative reports, and QAPIP and PIP activities. The QIC determines where there are needs for system improvement and makes recommendations to MDHHS to incorporate into system improvement activities. The timeframe for incorporating changes is dependent on whether it is an issue requiring immediate enactment which would be addressed through policy changes or an amendment to the MDHHS/CMHSP and MDHHS/PIHP contracts. Otherwise, changes to the QIS are generally implemented in conjunction with the annual contracts between MDHHS and the PIHPs and CMHPS.

The Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the Michigan 1115 Behavioral Health Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), and the Waiver for Children with Serious Emotional Disturbance (SEDW). The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of fund source. The MDHHS QMP Site Review team conducts comprehensive biennial reviews at each PIHP (and affiliate CMHSPs). During the alternate years, QMP staff visit PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of §1915(c) waiver participants are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews. In addition to identifying individual issues that are addressed in remediation, the QMP findings are also used for identifying trends to implement systems improvements. This site visit strategy covers all consumers served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; follow up on reported critical incidents regarding medication errors and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDHHS policy and procedures, including utilizing person centered/family centered planning
• is updated at least annually

Clinical record reviews are also completed to determine that participants are afforded choice between waiver services and institutional care and between/among service providers and that services are provided as identified in the IPOS.

QMP staff conducts consumer interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with consumers who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the waivers.

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDHHS in 30 days. MDHHS reviews and approves the plan of correction and evidence of remediation of issues is to be provided to MDHHS by the PIHP within 90 days after

approval of the plan. Follow-up review is conducted approximately 90 days after the approval of the plan. Results of the MDHHS on-site reviews are shared with MDHHS BHDDA management team, the Quality Improvement Council (QIC), and QMP staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QAPIP has been developed with the input of consumers and the Mental Health QIC. Michigan's QAPIP is revised with the Michigan 1115 Behavioral Health Demonstration and reflects the activities, concerns, input or recommendations from the MDHHS's Encounter Data Integrity Team (EDIT), EQR activities and the terms and conditions from CMS' previous waiver approvals. The QMP Site Review Protocol is reviewed and revised to address changes in policy resulting from trends or system improvements.

The existing infrastructure in Michigan includes Michigan 1115 Behavioral Health Demonstration to allow Michigan to provide mental health services not otherwise covered under the State Plan through a managed care delivery system. The concurrent §1115/1915(c) waivers enables Michigan to use Medicaid managed care program features such as quality improvement performance plans and external quality reviews as important parts of effective monitoring of the HSW.

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the Quality Assessment and Performance Improvement Programs. These elements were required as part of the AFP (2002) and are now part of the MDHHS/PIHP contracts and they are reviewed by MDHHS staff and/or the EQR process. While a review of the following three areas is not specific to the HSW, it assures overall quality services for all consumers.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. MDHHS-BHDDA contracts with Health Services Advisory Group (HSAG) to conduct the EQR. The EQR consists of desk audits of PIHP documents, on-site visits to PIHPs or both. One EQR component addresses PIHP compliance to BBA requirements. The other two EQR activities involve validation of PIHP performance improvement projects and performance indicators.

The EQR address requirements for customer services: staff who are knowledgeable about referral systems to assist individuals in accessing services, a range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network, performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP, focus of customer services is customer satisfaction and problem avoidance, assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications, and the relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews the process, information to recipients and contractors, method for filing, provision of assistance to consumers, process for handling grievances, record- keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDHHS. MDHHS uses its Appeals and Grievances database to track the trends of the types of requests for fair hearing and their resolution, to identify PIHPs that have particularly high volumes of appeals, to identify themes, such as appeals related to a specific service and to address any trends that are noted through training, policy clarification, or other methods. MDHHS also has regular meetings with the Administrative Tribunal to address trends and identify solutions.

Quality Assessment and Performance Improvement Programs: The MDHHS contracts with PIHPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors the PIHP implementation of their local QAPIP plans that must include the required standards. QMP site reviews include review of implementation of standards for sentinel events and credentialing of providers. MDHHS-BHDDA collects data for performance indicators and performance improvement projects as described in b.i. below.

In addition to the QMP strategies implemented for all consumers, the HSW staff review all applications and monitor the timeliness of re-certifications by way of the web-based HSW database. The HSW staff may participate in QMP site reviews of clinical and administrative records or provide technical consultation as requested by the Site Review Team during a PIHP/CMHSP review.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to PIHPs and CMHSPs during quarterly webinars; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure Quality Improvement Project is being implemented; and identifying topics for technical assistance webinars or conferences at both state and local levels to address systemic issues.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: The QIC meets every other month. For the PIHPs/CMHSPs and MDHHS, QI activities are on-going.

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.

MDHHS-BHDDA uses performance indicators to measure the performance of the PIHP/CMHSP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data collected for performance indicators can be identified at the individual HSW participant level if necessary.

Indicators are used to alert MDHHS-BHDDA of systemic issues and PIHP/CMHSP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter data located in MDHHS's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDHHS and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDHHS web site. Results of the performance indicators are shared with MDHHS-MHSA management team, the QIC and HSW staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Participant level demographic data are reported monthly for each individual. Demographic data housed in the Behavioral Health Treatment Episode Data Set (BH-TEDS) is used for identifying the residential living arrangement for HSW participants, which is used in calculating the HSW capitation payment. A significant amount of work was done between MDHHS- BHDDA Federal Compliance Section and the PIHPs to identify the process and challenges with demographic data used by the HSW for payment calculations. The process for assigning a residential living arrangement code was incorporated into the HSW web-based database, which must be in agreement with the demographic data submitted by the PIHP before enrolling a HSW participant. This process improvement has significantly increased the accuracy and timeliness of demographic data submissions for HSW participants in particular. Aggregate data from the encounter data system are shared with the MDHHS-BHDDA management team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the HSW participant level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDHHS to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDHHS-BHDDA management team, the EDIT, and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Critical Incidents are reported, reviewed, investigated and acted upon at the local level by each PIHP for all HSW participants, as well as the following groups: beneficiaries receiving Targeted Case Management, participants enrolled in the CWP and the SEDW, and those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDHHS semi-annually. Aggregate data are shared with MDHHS-BHDDA management team, the QIC and staff from the Federal Compliance Section. Information is used by MDHHS to take contract action as needed, becomes the focus of on-site reviews conducted by MDHHS, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP Offices of Recipient Rights (ORR) report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature. Data collection improvements distinguish Medicaid consumers from other individuals served. Information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDHHS-MHSA BHDDA management team, the QIC, and staff from Federal Compliance Section . Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

The EQR process checks for PIHP policy and processes and evidence that those policies and processes are being implemented. Although the data is not necessarily specific to the HSW, because HSW participants represent a significant percentage of the Medicaid beneficiaries who have intellectual/developmental disabilities, the findings of PIHP performance are considered a valid data source for assuring the PIHP policies and procedures in the 13 areas are met. This data source is also used to identify areas for system design change and improvements.

The MDHHS-BHDDA staff collaborates with the Quality Improvement Council to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and stakeholder concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDHHS; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDHHS performance improvement project reports are shared with MDHHS-BHDDA management team, the QIC and HSW staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDHHS-BHDDA staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the QMP on-site reviews and the EQRs are shared with MDHHS-BHDDA management team and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Consolidated Reporting:

The MDHHS system improvement strategy encompasses 1915(i) SPA with the following three 1915(c)’s waivers: Children’s Waiver program, Habilitation Supports Waiver, and Waiver for Children with Serious Emotional Disturbances.
MDHHS designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the available the 1915(c) services waiver options and the 1915(i) state plan. this is evident in the following components;
A) participant services-all 1915(c) waivers and the 1915(i) offer similar services to participants to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve an individual’s goals of community inclusion and participation, independence, recovery, or productivity.
B) participant safeguards-all 1915(c) waivers and the 1915 (i) follow the same participant safeguards outlined throughout the individual waiver and ispa applications.
C) quality management: the information below outlines the approach which is the same or similar across 1915(c) waivers and the 1915 (i).

The quality management approach is the same or similar across waivers and the 1915 (i):
a) methodology for discovering information: the state draws from several tools to gather data and measure individual and system performance. tools utilized include the record review protocol, the CHAMPS, web-based database called the Waiver Support Application, and a critical incident reporting system across all waivers and 1915 (i) participants.
b) manner in which individual issues are remedied: MDHHS is the single state agency responsible for establishing the components of the quality improvement strategy which includes the remediation of all waiver and 1915 (i) issues at an individual level and all actions and timelines are recorded and tracked through annual monitoring activities.
c) process for identifying and analyzing trends/patterns: data gathered from the record reviews will be used initially to foster improvements and provide technical assistance at the agency whose records are being reviewed. annually, this data will be compiled to look for systemic trends and areas in need of improvement and published in the state’s annual report. Using encounter data, measure penetration rates of beneficiaries who access services at the PIHP level to determine a baseline, median, and negative statistical outliers. the state will track and trend critical incidents that involve beneficiaries at the PIHP level: baseline, then identify negative statistical outliers.

and track and trend requests for Medicaid fair hearing by beneficiaries, and track and trend by PIHP the fair hearing decisions that are found in favor of the beneficiary.
d) majority of the performance indicators are the same: the majority of the performance measures associated with CMS assurances are the same.

The provider network is the same across the 1915(c) waiver programs and the 1915(i). All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(c) waiver programs and the 1915(i) are required to meet the same training and background check requirements according to policy in order to furnish HCBS.

Provider oversight is the same across the 1915(c) waiver programs and the 1915(i) and all services are included in the consolidated reporting.

Sampling Methodology for Consolidated Reporting:
Pulling a statistically significant sample from the total population of all 1915(c) waivers (HSW, CWP and SEDW) and 1915(i)SPA operated by the MDHHS/BHDDA. This is based on a 5% margin of error, a 95% confidence level, and a response distribution of 50%. The state then stratifies the sample for each specific waiver by drawing at least a minimum number of records for each waiver. The stratification standards the state uses for minimum sampling is 10% margin of error, 95% confidence level, and a response distribution of 50%.

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

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIC would address QI strategies and systems improvements required for the HSW, as well as all the waiver populations served by Michigan's mental health system. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDHHS-BHDDA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the BHDDA could amend the contract. Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to BHDDA upper management team to revise the QIS. The final decision on changes to the QIS is made by the BHDDA upper management team.

The MDHHS-BHDDA leadership meets regularly with the PIHP and CMHSP directors and quality improvement strategies may be discussed during the course of those meetings. Feedback from the group is used to help evaluate the QI process and identify opportunities for improvements to MDHHS-BHDDA management team and the QIC.

In addition, as described in H-1-a-i above, trend patterns identified through a number of quality activities have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference, quarterly technical assistance webinars and identifying topics for technical assistance calls at both state and local levels to address systemic issues.

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):*

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).*

The Habilitation Supports Waiver operates concurrently with the Michigan 1115 Behavioral Health Demonstration. The HSW capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDHHS/PIHP contract includes requirements for PIHPs to complete independent audits.

b) Pursuant to the MDHHS/PIHP and MDHHS/CMHSP contracts, PIHPs and CMHSPs must submit to MDHHS a Financial Statement Audit and a Compliance Examination Report conducted in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements 10 and the CMH Compliance Examination Guidelines attached to the MDHHS/PIHP and MDHHS/CMHSP contracts.

The annual independent financial audit must clearly indicate the operating results for the reporting period and financial position of the PIHP at the end of the fiscal year. The Financial Statement Audit must be conducted in accordance with Generally Accepted Auditing Standards.

The annual CMHSP Compliance Examination requires that an independent auditor examine compliance issues related to contracts between PIHPs and the MDHHS to manage the concurrent §1115 and the 1915(c) waiver programs as well as general fund and Mental Health Block Grant funds. PIHPs must assure that compliance issues are monitored by either requiring their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs, or require the affiliated CMHSPs to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. The CMH Compliance Examination does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit.

The PIHP must submit to MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA- compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: whether services claimed were listed in the Michigan Medicaid Provider Manual; whether services were identified in the person-centered plan; and verification of documentation that services claimed were actually provided. Sampling methodologies are used to conduct the Medicaid services verification reviews, which cover all Medicaid-reimbursed services. A report, known as the "Medicaid Services Verification Report", is submitted to and reviewed by MDHHS's Division of QMP annually. Although the report does not specifically look at HSW services, because HSW enrollees represent a sizable proportion of people served who have intellectual/developmental disabilities, the report is used to note overall trends.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $750,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to PIHPs. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the HSW Managed Care benefit plan. This process uses edits to assure only the PIHPs that have a contract with the State are provided the capitation payment for the HSW. Each PIHP 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 PIHP. This process includes verifying the participant's Medicaid eligibility and HSW benefit plan. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PIHP 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 PIHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the HSW during a given month when the PIHP 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 HSW but the PIHPs received capitation payments due to data lags in the 834 process.

MDHHS has developed a report in the HSW database to monitor participants who are not receiving any HSW services.

Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's participants.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDHHS Office of Audit and the MDHHS-BHDDA Bureau of Community Mental Health Services review the reports, issue management decisions, and follow-up as needed.

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 capitation payments made to the PIHP only for HSW participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHP for HSW participants with active Medicaid eligibility. Denominator: All capitation payments for HSW participants sampled.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
CHAMPS

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 =* *95*
☐ ***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 HSW encounters submitted to MDHHS with all required data elements. Numerator: Number of HSW encounters submitted to MDHHS with all required data elements. Denominator: Number of encounters submitted to MDHHS for HSW participants sampled.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Data Warehouse

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 =* *95*
☐ ***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***

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:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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 to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Number of capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS for HSW participants sampled.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
CHAMPS

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 =* *95*
☐ ***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):*

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

The QMP Site Review includes an examination of the participant's IPOS and the supporting documentation that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS.

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.*

MDHHS-BHDDA has developed a report in the HSW database to track and monitor the HSW participants not receiving HSW services on a quarterly basis. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's participants. For active HSW participants not receiving HSW services in three consecutive months, MDHHS Federal Compliance Manager will provide phone consultations with the PIHP and may recommend disenrollment from the HSW.

MDHHS Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. When irregularities are found, the PIHP must submit a Corrective Action Plan. The MDHHS Office of Audit or MDHHS-BHDDA Bureau of Community Mental Health issues a management decision regarding whether the corrective action plan is sufficient to address the issues. If the plan is not sufficient to correct the issue, it would be addressed in the management decision letter as to why the corrective action plan is not sufficient and what further corrective action is required. Follow-up by MDHHS requires the PIHP to report on the current status toward correction and implementation of the plan. In addition to this process, the MDHHS- BHDDA Division of Program Development, Consultation, and Contracts may provide technical assistance to PIHPs to help in correcting financial irregularities and assuring fiscal integrity in accordance with OMB Circular A-87.

The PIHP/CMHSP and other qualified/approved community-based mental health and developmental disability services providers monitor claims through the services verification review process described above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff follows up with the provider on actions taken to correct and monitor identified deficiencies. If an identified problem rises to a level of fraud and abuse, the PIHP/CMHSP is required to report the finding to the MDHHS Medicaid Fraud Unit for investigation and follow-up. If it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

If the QMP site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDHHS-BHDDA.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

This §1915(c) waiver operates concurrently with the Michigan 1115 Behavioral Health Demonstration. Please refer to the Michigan's §1115 Waiver application and associated materials.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The PIHP contracted providers submit HSW services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDHHS/PIHP contract requirements.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020, or January 1, 2021 if Michigan receives approval of a good faith effort exemption request, and for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

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.)

a) For this waiver, the PIHP incurs certified public expenditures (and is a CMHSP, which is a local government agency).
b)The PIHPs collect and calculate actual cost data and attest to the fact that the data reporting is accurate. Costs are reported through various financial documents both throughout the fiscal year and at the close of the fiscal year and are subject to annual auditing to assure that the CPE is based on total computable costs for the concurrent 1115/1915(c) waiver.
c)Expenditures are based on eligibility, reporting of encounters for the provision of valid waiver services and the cost for providing those services. CHAMPS verifies eligibility. Annual audit compliance exams are used to verify that the CPE are properly identified, categorized, distributed, and reported by fund source are eligible for FFP. MDHHS reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

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:*

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the participants enrolled in this waiver program.

a) These capitation payments are made only after the each participants active Medicaid eligibility has been verified through CHAMPS. Per the performance measure in the QIS for this appendix, a representative random sample of all HSW participants is reviewed to assure that capitation payments are made only for HSW participants with active Medicaid eligibility.

b) The QMP Site Review Team reviews a proportionate random sample of HSW participants during each comprehensive full review. This review includes an examination of the participant's IPOS and the supporting documentation (e.g., progress notes, time sheets, claims from providers to the PIHP, or any other relevant evidence) that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.

c) MDHHS Federal Compliance Section developed a report in the HSW database to track and monitor the HSW participants not receiving HSW services on a quarterly basis. Report will look at HSW encounters submitted by the PIHP. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's participants. For active HSW participants not receiving HSW services in three consecutive months, MDHHS Federal Compliance Manager will provide phone consultations with the PIHP and may recommend disenrollment from the HSW.

Section 7.8.2 of the MDHHS/PIHP contract specifies the Claims Management requirements incumbent upon the PIHPs and the providers within their networks. It is the encounter and cost data governed by these claims management requirements that constitutes the data basis from which the States actuary develops the capitation rates for this waiver programs participants.

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:

As noted in I-1, the HSW database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the HSW database to CHAMPS. If the HSW participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the HSW benefit plan is opened. If the HSW participant is non-Medicaid eligible, notification is sent back to the HSW database advising that a particular record did not process for payment and must be resubmitted next cycle. If the HSW benefit plan is open, the PIHP receives an electronic member file (834) containing HSW enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the HSW participant has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the HSW capitation payments are made by MDHHS to the PIHPs accounts and a payment record (820) is issued to the PIHP.

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.

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:

PIHPs are the lead CMHSPs, which are local governmental entities. The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers, the full array of this waiver's services.

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:

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1115/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

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 MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1115/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

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.***

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:

Section 428 of the current year Appropriation Act states: Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

a) County governments have the authority to levy taxes. CMHSPs may receive county appropriations or other revenues described below.

b) Per the MDHHS/CMHSP contract, the sources of other revenue are described in Section 7.0 Contract Financing. The revenue sources include county appropriations, other appropriations and service revenues, gifts and contributions, special fund account, investment interest, and other revenues for mental health.

c) The mechanism used to transfer funds to the Medicaid Agency is an intergovernmental transfer, specifically the PIHP shall provide to MDHHS on a quarterly basis the PIHP obligation for local funds as a bon fide source of match for Medicaid

☒ ***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:

not applicable

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:*

The requirement to exclude room and board costs from Medicaid payments is stated in the Michigan Medicaid Provider Manual, as well as within the MDHHS Contract with the PIHPs. The PIHPs pay for HSW services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

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: ICF/IID

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	53176.86	21986.70	75163.56	113807.84	12742.90	126550.74	51387.18
2	54096.38	22755.20	76851.58	116653.04	13061.47	129714.51	52862.93
3	55190.45	23551.63	78742.08	119569.36	13388.01	132957.37	54215.29
4	56299.25	24375.94	80675.19	122558.60	13722.71	136281.31	55606.12
5	57611.52	25229.09	82840.61	125622.56	14065.78	139688.34	56847.73

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:
		ICF/IID
Year 1	*8268*	*8268*
Year 2	*8268*	*8268*
Year 3	*8268*	*8268*
Year 4	*8268*	*8268*
Year 5	*8268*	*8268*

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) has been projected based on actual experience from recent historical experience, reflecting year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count. The ALOS is calculated based on actual experience through September 2018 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the 5-year renewal period are based on projected changes in enrollees over the waiver period and reflecting slightly shorter stays if more people phase into the waiver than phase out in a given year

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 base experience from the previously filed and approved waiver amendment has been updated to reflect SFY 2018 experience. Factor D for the new 5-year waiver period for the renewal (October 1, 2019 through September 30, 2024) was projected from SFY 2018 of the current period data in the following manner:

- *Base number of users was calculated by determining the allocated number of users from the historical experience. The percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the 5-year renewal period. Therefore, a projected number of users for WY 1 represents projected experience for SFY 2019 multiplied by the change in unduplicated participant count from to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology.*
- *Baseline average units per user was calculated by adjusting the historical experience of average units per user by projected growth in the ALOS. Therefore, a projected average units per user was developed by taking actual experience and multiplying by the change in ALOS to projected future time periods. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected WY 5 average units per user multiplied by the estimated change in ALOS.*
- *Baseline average cost per unit values were calculated by adjusting the historical experience of unit cost through SFY 2018. Using the total expenditures by waiver service developed from the allocation process and dividing by the total number of units, the cost per unit was established for most of the services in the various waiver programs. Factor D was trended at a rate of 2.0% per year.*

Additionally, Factor D for Waiver Years 1 through 5 were adjusted to include the following services:

- *Non-family training services:*
  - *Cost Assumptions:*

Number of users – we estimate the number of users to be 50% of those residing in a licensed residential setting (identified as those who received H2016).

Average units per user – we are assuming the same number of units per user will be provided to HSW users as was reflected in the historical CWP experience

Cost per unit – we are assuming the same cost per unit will be observed for HSW as was reflected in the historical CWP experience.

- *Fiscal intermediaries services:*
  - *Cost Assumptions:*

Number of users: HSW - we estimate the number of users to be 1,620 in WY 1 based on the number of HSW users who receive fiscal intermediary services through the b(3) benefit, with a 5% trend for each successive year.

Average units per user – we are assuming the same number of units per user will be provided to HSW users as was reflected in the historical CWP experience

Cost per unit – we are assuming the same cost per unit will be observed for HSW as was reflected in the historical CWP experience.

- *Overnight Health and Safety Support:*
  - *Cost Assumptions:*

Number of users – It is estimated to be 100% of the users not in a licensed residential setting for HSW. This information was estimated based on survey information MDHHS received from the community mental health service programs (CMHSPs).

Average units per user – projected Overnight Health and Safety Support dollars are allocated to each program based on the historical CLS and respite dollars experienced. The units per users vary by waiver. The projected cost was estimated based on survey information received from the CMHSPs.

Cost per unit – we estimate the cost to deliver Overnight Health and Safety Support to be 14.86 per hour, or $3.72 per 15 minute unit, based on an independent model build-up of the cost to provide the service. This represents the unit cost for the base experience period. The Year 1 values in Appendix J-2-D represent a trended unit cost for this service.

Community living supports and respite were reduced to reflect the situations where beneficiaries are currently receiving overnight community living supports or overnight respite. The number of beneficiaries currently receiving Overnight Health and Safety Support via community living supports and respite was estimated based on survey information received from the CMHSPs.

Supports Coordination will be moved from 1915(c)HSW to State Plan effective 10/1/19. This authority change will be seamless to HSW participant as they will continue to have access to the service through the State Plan. Since the WMS does not allow users to enter all zeros for an active waiver service. MDHHS has entered one (1) for the estimated participants, average units per user, and .01 for the average cost per unit to illustrate the service being phased out effective 10/1/2019.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The base experience for the Factor D' expenditures from the previously filed and approved waiver amendment has been updated to reflect SFY 2018 experience. Factor D' was trended at a rate of 3.5% per year. We utilized the actual state plan service expenditures from the FFS claims and encounter data. We have also moved both supports coordination, which have historically been included in the Factor D costs, into the Factor D' costs to coincide with MDHHS' transition of this service to the state plan. In the prior Waiver, capitation payments were utilized for those enrolled in managed care programs. This resulted in a material increase in the Factor D' expenditures.

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:*

Estimates of Factor G expenditures for Waiver Years 1 through 5 is based on based on Ohio ICF/IID experience for all ages (OH.0380.R03.05).

Michigan closed the last ICF/IID in 2009. Therefore cannot base our estimates for G on prior experience. After consulting with CMS, MDHHS evaluated and determined that Ohio (H0380.R03.05) projection for factor G and G' was the most appropriate due to the population and the LOC criteria mirroring Michigan's HSW.

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:*

Estimates of Factor G' expenditures for Waiver Years 1 through 5 is based on based on Ohio ICF/IID experience for all ages (OH.0380.R03.05).

Michigan closed the last ICF/IID in 2009. Therefore cannot base our estimates for G' on prior experience. After consulting with CMS, MDHHS evaluated and determined that Ohio (H0380.R03.05) projection for factor G and G' was the most appropriate due to the population and the LOC criteria mirroring Michigan's HSW.

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	
Out-of-Home Non-Vocational Habilitation	
Prevocational Services	
Respite	
Supported Employment	
Supports Coordination (Authority Change Effective 10/1/2019)	
Enhanced Medical Equipment and Supplies	
Enhanced Pharmacy	
Fiscal Intermediary	
Goods and Services	
Community Living Supports	

Waiver Services	
Environmental Modifications	
Family Training	
Non-Family Training	
Overnight Health and Safety Support	
Personal Emergency Response System	
Private Duty Nursing	

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
Out-of-Home Non-Vocational Habilitation Total:							35475350.55
Out-of-Home Non-Vocational Habilitation	☒	15 minutes	1489	5477.00	4.35	35475350.55	
Prevocational Services Total:							3909009.79
Hour	☒	Hour	379	679.00	15.19	3909009.79	
Respite Total:							3349038.89
Respite, out-of-home setting	☒	Day	131	16.00	118.75	248900.00	
Respite, 15 minutes	☒	15 minutes	934	1139.00	2.85	3031904.10	
Respite, in-home setting	☒	Day	69	13.00	76.07	68234.79	
Supported Employment Total:							2689272.32
Supported Employment	☒	15 minutes	496	721.00	7.52	2689272.32	
Supports Coordination							0.01

GRAND TOTAL:	439666312.39
Total: Services included in capitation:	439666312.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	53176.86
Services included in capitation:	53176.86
Services not included in capitation:	
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Authority Change Effective 10/1/2019) Total:							
Supports Coordination (Authority Change Effective 10/1/2019)	☒	15 minutes	1	1.00	0.01	**0.01**	
Enhanced Medical Equipment and Supplies Total:							**469524.40**
Durable medical equipment, miscellaneous	☒	Item	428	1.00	553.05	**236705.40**	
Personal care item, not otherwise specialized	☒	Item	54	3.00	217.40	**35218.80**	
Specialized supply, not otherwise specified, waiver	☒	Item	56	3.00	370.73	**62282.64**	
Specialized medical equipment, not otherwise specified, waiver	☒	Item	60	3.00	253.01	**45541.80**	
Vehicle modifications, waiver	☒	Item	19	1.00	4725.04	**89775.76**	
Enhanced Pharmacy Total:							**508656.40**
Enhanced Pharmacy	☒	Item	778	14.00	46.70	**508656.40**	
Fiscal Intermediary Total:							**1938978.00**
Fiscal Intermediary	☒	Encounter	1620	10.00	119.69	**1938978.00**	
Goods and Services Total:							**5514.96**
Goods and Services	☒	Item	3	2.00	919.16	**5514.96**	
Community Living Supports Total:							**301280305.64**
CLS per diem - licensed	☒	Day	4333	327.00	129.91	**184068309.81**	
CLS per 15	☒					**34381948.79**	

GRAND TOTAL:	**439666312.39**
Total: Services included in capitation:	439666312.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**53176.86**
Services included in capitation:	53176.86
Services not included in capitation:	
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
minutes		15 minutes	2441	4529.00	3.11		
CLS per diem - unlicensed	☒	Day	2098	304.00	129.87	82830047.04	
Environmental Modifications Total:							309084.84
Environmental Modifications	☒	Service	36	1.00	8585.69	309084.84	
Family Training Total:							189324.56
Family Training	☒	Encounter	167	8.00	141.71	189324.56	
Non-Family Training Total:							812191.60
Non-Family Training	☒	Encounter	2167	5.00	74.96	812191.60	
Overnight Health and Safety Support Total:							78213319.20
Overnight Health and Safety Support	☒	15 minutes	3935	5136.00	3.87	78213319.20	
Personal Emergency Response System Total:							1551326.41
PERS installation & testing	☒	Encounter	3	1.00	627.47	1882.41	
PERS monthly monitoring	☒	Month	104	10.00	1489.85	1549444.00	
Private Duty Nursing Total:							8965414.82
PDN by RN	☒	Hour	17	1482.00	42.67	1075027.98	
PDN by LPN	☒	Hour	19	1994.00	33.94	1285850.84	
PDN by RN or LPN, per 15 min	☒	15 minutes	80	8511.00	9.70	6604536.00	

GRAND TOTAL:	439666312.39
Total: Services included in capitation:	439666312.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	53176.86
Services included in capitation:	53176.86
Services not included in capitation:	
Average Length of Stay on the Waiver:	340

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
Out-of-Home Non-Vocational Habilitation Total:							36103544.76
Out-of-Home Non-Vocational Habilitation	☒	15 minutes	1489	5461.00	4.44	36103544.76	
Prevocational Services Total:							3974470.67
Hour	☒	Hour	379	677.00	15.49	3974470.67	
Respite Total:							3411066.55
Respite, out-of-home setting	☒	Day	131	16.00	121.13	253888.48	
Respite, 15 minutes	☒	15 minutes	934	1136.00	2.91	3087579.84	
Respite, in-home setting	☒	Day	69	13.00	77.59	69598.23	
Supported Employment Total:							2735306.08
Supported Employment	☒	15 minutes	496	719.00	7.67	2735306.08	
Supports Coordination (Authority Change Effective 10/1/2019) Total:							0.01
Supports Coordination (Authority Change Effective 10/1/2019)	☒	15 minutes	1	1.00	0.01	0.01	
Enhanced Medical Equipment and Supplies Total:							478913.96
Durable medical equipment, miscellaneous	☒	Item	428	1.00	564.11	241439.08	
Personal care item, not otherwise	☒	Item	54	3.00	221.75	35923.50	

GRAND TOTAL:	447268839.92
Total: Services included in capitation:	447268839.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	54096.38
Services included in capitation:	54096.38
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
specialized							
Specialized supply, not otherwise specified, waiver	☒	Item	56	3.00	378.14	63527.52	
Specialized medical equipment, not otherwise specified, waiver	☒	Item	60	3.00	258.07	46452.60	
Vehicle modifications, waiver	☒	Item	19	1.00	4819.54	91571.26	
Enhanced Pharmacy Total:							518785.96
Enhanced Pharmacy	☒	Item	778	14.00	47.63	518785.96	
Fiscal Intermediary Total:							2076580.80
Fiscal Intermediary	☒	Encounter	1701	10.00	122.08	2076580.80	
Goods and Services Total:							5625.24
Goods and Services	☒	Item	3	2.00	937.54	5625.24	
Community Living Supports Total:							306333117.28
CLS per diem - licensed	☒	Day	4333	326.00	132.51	187178060.58	
CLS per 15 minutes	☒	15 minutes	2441	4516.00	3.17	34944672.52	
CLS per diem - unlicensed	☒	Day	2098	303.00	132.47	84210384.18	
Environmental Modifications Total:							315266.40
Environmental Modifications	☒	Service	36	1.00	8757.40	315266.40	
Family Training Total:							193105.44
Family Training	☒	Encounter	167	8.00	144.54	193105.44	
Non-Family Training Total:							828444.10
Non-Family Training	☒	Encounter	2167	5.00	76.46	828444.10	

GRAND TOTAL:	447268839.92
Total: Services included in capitation:	447268839.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	54096.38
Services included in capitation:	54096.38
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Health and Safety Support Total:							**79596983.25**
Overnight Health and Safety Support	☒	15 minutes	3935	5121.00	3.95	**79596983.25**	
Personal Emergency Response System Total:							**1582356.06**
PERS installation & testing	☒	Encounter	3	1.00	640.02	**1920.06**	
PERS monthly monitoring	☒	Month	104	10.00	1519.65	**1580436.00**	
Private Duty Nursing Total:							**9115273.36**
PDN by RN	☒	Hour	17	1478.00	43.52	**1093483.52**	
PDN by LPN	☒	Hour	19	1988.00	34.62	**1307666.64**	
PDN by RN or LPN, per 15 min	☒	15 minutes	80	8486.00	9.89	**6714123.20**	

GRAND TOTAL:	**447268839.92**
Total: Services included in capitation:	447268839.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**54096.38**
Services included in capitation:	54096.38
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

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
Out-of-Home Non-Vocational							**36835373.37**

GRAND TOTAL:	**456314668.93**
Total: Services included in capitation:	456314668.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**55190.45**
Services included in capitation:	55190.45
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:							
Out-of-Home Non-Vocational Habilitation	☒	15 minutes	1489	5461.00	4.53	36835373.37	
Prevocational Services Total:							4054011.40
Hour	☒	Hour	379	677.00	15.80	4054011.40	
Respite Total:							3481190.66
Respite, out-of-home setting	☒	Day	131	16.00	123.55	258960.80	
Respite, 15 minutes	☒	15 minutes	934	1136.00	2.97	3151241.28	
Respite, in-home setting	☒	Day	69	13.00	79.14	70988.58	
Supported Employment Total:							2788799.68
Supported Employment	☒	15 minutes	496	719.00	7.82	2788799.68	
Supports Coordination (Authority Change Effective 10/1/2019) Total:							0.01
Supports Coordination (Authority Change Effective 10/1/2019)	☒	15 minutes	1	1.00	0.01	0.01	
Enhanced Medical Equipment and Supplies Total:							488491.37
Durable medical equipment, miscellaneous	☒	Item	428	1.00	575.39	246266.92	
Personal care item, not otherwise specialized	☒	Item	54	3.00	226.19	36642.78	
Specialized supply, not otherwise specified, waiver	☒	Item	56	3.00	385.70	64797.60	
Specialized medical equipment, not	☒	Item	60	3.00	263.23	47381.40	

GRAND TOTAL:	456314668.93
Total: Services included in capitation:	456314668.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	55190.45
Services included in capitation:	55190.45
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
otherwise specified, waiver							
Vehicle modifications, waiver	☒	Item	19	1.00	4915.93	93402.67	
Enhanced Pharmacy Total:							529133.36
Enhanced Pharmacy	☒	Item	778	14.00	48.58	529133.36	
Fiscal Intermediary Total:							2223927.20
Fiscal Intermediary	☒	Encounter	1786	10.00	124.52	2223927.20	
Goods and Services Total:							5737.74
Goods and Services	☒	Item	3	2.00	956.29	5737.74	
Community Living Supports Total:							312422398.44
CLS per diem - licensed	☒	Day	4333	326.00	135.16	190921339.28	
CLS per 15 minutes	☒	15 minutes	2441	4516.00	3.23	35606085.88	
CLS per diem - unlicensed	☒	Day	2098	303.00	135.12	85894973.28	
Environmental Modifications Total:							321571.80
Environmental Modifications	☒	Service	36	1.00	8932.55	321571.80	
Family Training Total:							196966.48
Family Training	☒	Encounter	167	8.00	147.43	196966.48	
Non-Family Training Total:							845021.65
Non-Family Training	☒	Encounter	2167	5.00	77.99	845021.65	
Overnight Health and Safety Support Total:							81209074.05
Overnight Health and Safety Support	☒	15 minutes	3935	5121.00	4.03	81209074.05	
Personal Emergency Response System							1614000.06

GRAND TOTAL:	456314668.93
Total: Services included in capitation:	456314668.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	55190.45
Services included in capitation:	55190.45
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
PERS installation & testing	☒	Encounter	3	1.00	652.82	**1958.46**	
PERS monthly monitoring	☒	Month	104	10.00	1550.04	**1612041.60**	
Private Duty Nursing Total:							**9298971.66**
PDN by RN	☒	Hour	17	1478.00	44.39	**1115343.14**	
PDN by LPN	☒	Hour	19	1988.00	35.31	**1333729.32**	
PDN by RN or LPN, per 15 min	☒	15 minutes	80	8486.00	10.09	**6849899.20**	

GRAND TOTAL:	**456314668.93**
Total: Services included in capitation:	456314668.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**55190.45**
Services included in capitation:	55190.45
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

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
Out-of-Home Non-Vocational Habilitation Total:							**37567201.98**
Out-of-Home Non-Vocational Habilitation	☒	15 minutes	1489	5461.00	4.62	**37567201.98**	
Prevocational Services Total:							**4136117.96**

GRAND TOTAL:	**465482173.96**
Total: Services included in capitation:	465482173.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**56299.25**
Services included in capitation:	56299.25
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Hour	☒	Hour	379	677.00	16.12	4136117.96	
Respite Total:							3551446.48
Respite, out-of-home setting	☒	Day	131	16.00	126.02	264137.92	
Respite, 15 minutes	☒	15 minutes	934	1136.00	3.03	3214902.72	
Respite, in-home setting	☒	Day	69	13.00	80.72	72405.84	
Supported Employment Total:							2845859.52
Supported Employment	☒	15 minutes	496	719.00	7.98	2845859.52	
Supports Coordination (Authority Change Effective 10/1/2019) Total:							0.01
Supports Coordination (Authority Change Effective 10/1/2019)	☒	15 minutes	1	1.00	0.01	0.01	
Enhanced Medical Equipment and Supplies Total:							498260.05
Durable medical equipment, miscellaneous	☒	Item	428	1.00	586.90	251193.20	
Personal care item, not otherwise specialized	☒	Item	54	3.00	230.71	37375.02	
Specialized supply, not otherwise specified, waiver	☒	Item	56	3.00	393.41	66092.88	
Specialized medical equipment, not otherwise specified, waiver	☒	Item	60	3.00	268.49	48328.20	
Vehicle modifications, waiver	☒	Item	19	1.00	5014.25	95270.75	
Enhanced Pharmacy Total:							539698.60

GRAND TOTAL:	465482173.96
Total: Services included in capitation:	465482173.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	56299.25
Services included in capitation:	56299.25
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Pharmacy	☒	Item	778	14.00	49.55	539698.60	
Fiscal Intermediary Total:							2381437.50
Fiscal Intermediary	☒	Encounter	1875	10.00	127.01	2381437.50	
Goods and Services Total:							5852.52
Goods and Services	☒	Item	3	2.00	975.42	5852.52	
Community Living Supports Total:							318614092.20
CLS per diem - licensed	☒	Day	4333	326.00	137.86	194735245.88	
CLS per 15 minutes	☒	15 minutes	2441	4516.00	3.29	36267499.24	
CLS per diem - unlicensed	☒	Day	2098	303.00	137.82	87611347.08	
Environmental Modifications Total:							328003.20
Environmental Modifications	☒	Service	36	1.00	9111.20	328003.20	
Family Training Total:							200907.68
Family Training	☒	Encounter	167	8.00	150.38	200907.68	
Non-Family Training Total:							861924.25
Non-Family Training	☒	Encounter	2167	5.00	79.55	861924.25	
Overnight Health and Safety Support Total:							82821164.85
Overnight Health and Safety Support	☒	15 minutes	3935	5121.00	4.11	82821164.85	
Personal Emergency Response System Total:							1646279.24
PERS installation & testing	☒	Encounter	3	1.00	665.88	1997.64	
PERS monthly monitoring	☒	Month	104	10.00	1581.04	1644281.60	
Private Duty Nursing Total:							9483927.92

GRAND TOTAL:	465482173.96
Total: Services included in capitation:	465482173.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	56299.25
Services included in capitation:	56299.25
Services not included in capitation:	
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PDN by RN	☒	Hour	17	1478.00	45.28	1137705.28	
PDN by LPN	☒	Hour	19	1988.00	36.02	1360547.44	
PDN by RN or LPN, per 15 min	☒	15 minutes	80	8486.00	10.29	6985675.20	
					GRAND TOTAL:		465482173.96
					Total: Services included in capitation:		465482173.96
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		8268
					Factor D (Divide total by number of participants):		56299.25
					Services included in capitation:		56299.25
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		339

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
Out-of-Home Non-Vocational Habilitation Total:							38411241.63
Out-of-Home Non-Vocational Habilitation	☒	15 minutes	1489	5477.00	4.71	38411241.63	
Prevocational Services Total:							4230686.04
Hour	☒	Hour	379	679.00	16.44	4230686.04	
Respite Total:							3630492.19
Respite, out-of-home setting	☒	Day	131	16.00	128.54	269419.84	
Respite, 15 minutes	☒	15 minutes	934	1139.00	3.09	3287222.34	
					GRAND TOTAL:		476332014.51
					Total: Services included in capitation:		476332014.51
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		8268
					Factor D (Divide total by number of participants):		57611.52
					Services included in capitation:		57611.52
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite, in-home setting	☒	Day	69	13.00	82.33	73850.01	
Supported Employment Total:							2910994.24
Supported Employment	☒	15 minutes	496	721.00	8.14	2910994.24	
Supports Coordination (Authority Change Effective 10/1/2019) Total:							0.01
Supports Coordination (Authority Change Effective 10/1/2019)	☒	15 minutes	1	1.00	0.01	0.01	
Enhanced Medical Equipment and Supplies Total:							508225.86
Durable medical equipment, miscellaneous	☒	Item	428	1.00	598.64	256217.92	
Personal care item, not otherwise specialized	☒	Item	54	3.00	235.32	38121.84	
Specialized supply, not otherwise specified, waiver	☒	Item	56	3.00	401.28	67415.04	
Specialized medical equipment, not otherwise specified, waiver	☒	Item	60	3.00	273.86	49294.80	
Vehicle modifications, waiver	☒	Item	19	1.00	5114.54	97176.26	
Enhanced Pharmacy Total:							550481.68
Enhanced Pharmacy	☒	Item	778	14.00	50.54	550481.68	
Fiscal Intermediary Total:							2550839.50
Fiscal Intermediary	☒	Encounter	1969	10.00	129.55	2550839.50	
Goods and Services Total:							5969.58

GRAND TOTAL:	476332014.51
Total: Services included in capitation:	476332014.51
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	57611.52
Services included in capitation:	57611.52
Services not included in capitation:	
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services	☒	Item	3	2.00	994.93	5969.58	
Community Living Supports Total:							326049782.82
CLS per diem - licensed	☒	Day	4333	327.00	140.62	199243212.42	
CLS per 15 minutes	☒	15 minutes	2441	4529.00	3.36	37145771.04	
CLS per diem - unlicensed	☒	Day	2098	304.00	140.58	89660799.36	
Environmental Modifications Total:							334563.12
Environmental Modifications	☒	Service	36	1.00	9293.42	334563.12	
Family Training Total:							204929.04
Family Training	☒	Encounter	167	8.00	153.39	204929.04	
Non-Family Training Total:							879151.90
Non-Family Training	☒	Encounter	2167	5.00	81.14	879151.90	
Overnight Health and Safety Support Total:							84680570.40
Overnight Health and Safety Support	☒	15 minutes	3935	5136.00	4.19	84680570.40	
Personal Emergency Response System Total:							1679204.00
PERS installation & testing	☒	Encounter	3	1.00	679.20	2037.60	
PERS monthly monitoring	☒	Month	104	10.00	1612.66	1677166.40	
Private Duty Nursing Total:							9704882.50
PDN by RN	☒	Hour	17	1482.00	46.19	1163710.86	
PDN by LPN	☒	Hour	19	1994.00	36.74	1391931.64	
PDN by RN or LPN, per 15 min	☒	15 minutes	80	8511.00	10.50	7149240.00	

GRAND TOTAL:	476332014.51
Total: Services included in capitation:	476332014.51
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	8268
Factor D (Divide total by number of participants):	57611.52
Services included in capitation:	57611.52
Services not included in capitation:	
Average Length of Stay on the Waiver:	340