Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 14, 2011

Stephen Fitton, Director
Medical Services Administration
Michigan Department of Community Health
Capitol Commons
400 South Pine
Lansing, Michigan 48909

Dear Mr. Fitton

I am pleased to inform you that your request to amend Michigan's home and community-based services Waiver for Children with Serious Emotional Disturbances (SEDW) is approved. This waiver is authorized under §1915(c) of the Social Security Act. The amended waiver will continue to serve children with serious emotional disturbances that would otherwise require the level of care provided in an inpatient psychiatric facility for individuals age 21 and under. The amendment will add 2 Community Mental Health Services Programs (CMHSPs) serving 2 new counties and 2 additional counties served by currently approved CMHSPs. This waiver amendment has been assigned control number 0438.R01.03, which should be used in all future correspondence.

In addition, the Michigan Department of Community Health (MDCH) has agreed to submit another amendment to the Waiver for Children with Serious Emotional Disturbances, control number 0438.R01, as well as an initial application for a §1915(b)(4) waiver to address the following changes:

1) An increase in the unduplicated count
2) Identification of an any point in time number
3) Expansion of the geographic service area.
4) Commitment to a concurrent §1915(c) and §1915(b)(4) waiver to come into compliance with §1902(a)(23) of the Act and 42 CFR §431.51

MDCH has agreed to submit these amendments by December 31, 2011, which will provide additional time to continue the ongoing planning process between MDCH and the Michigan Department of Human Services (MDHS) and finalize decisions related to the expansion of the geographic region and unduplicated count at any point in time for the SEDW.

The MDCH has satisfactorily responded to inquires thereby assuring the Centers for Medicare & Medicaid Services (CMS) of the State's accountability for the waiver program. The CMS would request that the State provide the Regional Office with information regarding any changes or updates related to this waiver as soon as any potential change in plans from the above schedule is identified.

Based on the assurances provided, CMS approves this amendment with the effective date of October 1, 2010. This approval is subject to the State's agreement to provide home and community-based services to no more individuals than approved in the waiver amendment.

The CMS looks forward to working with the Michigan Department of Community Health in continuing to administer this waiver. If there are any questions please contact Cathy Song at (312)353-8154 or Catherine.Song1@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Jacqueline Coleman
Mindy Morrell

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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Waiver for Children with Serious Emotional Disturbances

C. Waiver Number: MI.0438
Original Base Waiver Number: MI.0438.

D. Amendment Number: MI.0438.R01.03

E. Proposed Effective Date: *(mm/dd/yy)*
10/01/10

Approved Effective Date of Waiver being Amended: 10/01/08

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The amendment is to add 4 counties to serve children referred by the Michigan Department of Human Services (MDHS) under the collaborative agreement described in the previously approved amendment.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	2, 4C, 8
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-3e.
☐ **Appendix C – Participant Services**	
☐ **Appendix D – Participant Centered Service Planning and Delivery**	

Component of the Approved Waiver	Subsection(s)
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☐ **Appendix J – Cost-Neutrality Demonstration**	

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

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

Specify:

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*):
Waiver for Children with Serious Emotional Disturbances

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.0438
Waiver Number: MI.0438.R01.03
Draft ID: MI.04.01.04

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

E.
Proposed Effective Date of Waiver being Amended: 10/01/08
Approved Effective Date of Waiver being Amended: 10/01/08

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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Select one:

- **Not applicable**
- **Applicable**

Check the applicable authority or authorities:

- **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- **Waiver(s) authorized under §1915(b) of the Act.**

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

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - **§1915(b)(1) (mandated enrollment to managed care)**
  - **§1915(b)(2) (central broker)**
  - **§1915(b)(3) (employ cost savings to furnish additional services)**
  - **§1915(b)(4) (selective contracting/limit number of providers)**
- **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- **A program authorized under §1915(i) of the Act.**
- **A program authorized under §1915(j) of the Act.**
- **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual 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.

The Waiver for Children with Serious Emotional Disturbance (SEDW) provides services that are additions to Medicaid State Plan coverage for children with SED who are enrolled in the SEDW, up to the child's 20th birthday. This waiver permits the State to provide an array of community based services to enable children who would otherwise require hospitalization in our State Psychiatric hospital for children (Hawthorn Center) to remain in their home and community. The MDCH operates the SEDW through contracts with local Community Mental Health Services Programs (CMHSPs) who have expressed a desire and have shown a capacity to provide SEDW services. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMHSP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and his/her family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in a Plan of Services (POS).

To be eligible for this waiver, the child must:
• Live in a participating county; OR
• Live in foster care in a non-participating county pursuant to placement by MDHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP; AND
• Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR
• Reside with a legal guardian; OR
• Reside in a foster home with a permanency plan; OR
• Be age 18 or age 19 and live independently with supports; AND
• Meet current MDCH criteria for the State psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual; AND
• Meet Medicaid eligibility criteria and become a Medicaid beneficiary; AND
• Demonstrate serious functional limitations that impair their ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
o CAFAS® score of 90 or greater for children age 7 to 12; OR
o CAFAS® score of 120 or greater or children age 13 to 18; OR
o For children age 3 to 7: elevated PECFAS® subscale scores in at least one of the these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND
• Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria and continues to need waiver services, the child can remain on the waiver up to his/her 20th birthday.

The SEDW is currently limited to eighteen counties and twelve CMHSPs. The counties and CMHSPs currently approved are:

• CMH of Central Michigan (comprised of Clare, Gladwin, Isabella, Mecosta, Midland and Osceola)
• Detroit-Wayne County CMH Agency
• CMH Authority of Clinton-Eaton-Ingham Counties (Ingham County only)
• Kalamazoo CMH Services
• Genesee County CMH Services
• Livingston County CMH Authority
• Macomb County CMH Services
• Network180 (for Kent County)
• Northern Lakes CMH Authority (for Grand Traverse and Leelanau Counties)
• Oakland County CMH Authority
• Saginaw County CMH Authority
• Van Buren CMH Authority

If approved, this Request for Amendment would add an additional two CMHSPs / and two counties. CMHSPs: Muskegon County CMH agency (for Muskegon County) and Washtenaw Community Health Organization (for Washtenaw County) and Counties: Clinton and Eaton (counties within the CMH Authority of Clinton-Eaton-Ingham Counties).

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:
The SEDW is currently limited to eighteen counties and twelve CMHSPs. The counties and CMHSPs currently approved are:

• CMH of Central Michigan (comprised of Clare, Gladwin, Isabella, Mecosta, Midland and Osceola)
• Detroit-Wayne County CMH Agency
• CMH Authority of Clinton-Eaton-Ingham Counties (Ingham County only)
• Kalamazoo CMH Services
• Genesee County CMH Services
• Livingston County CMH Authority
• Macomb County CMH Services
• Network180 (for Kent County)
• Northern Lakes CMH Authority (for Grand Traverse and Leelanau Counties)
• Oakland County CMH Authority
• Saginaw County CMH Authority
• Van Buren CMH Authority

If approved, this Request for Amendment would add an additional two CMHSPs and two counties. CMHSPs: Muskegon County CMH agency (for Muskegon County) and Washtenaw Community Health Organization (for Washtenaw County) and Counties: Clinton and Eaton (counties within the CMH Authority of Clinton-Eaton-Ingham Counties). If approved, the SEDW will be limited to twenty two counties and fourteen participating CMHSPs.

☐ **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/MR.

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The SEDW program is fully described on Michigan's Department of Community Health's (MDCH)Website, including contact numbers and email addresses to request additional information and to provide feedback. Responses to inquiries are frequent and are provided by the SEDW Director. The Michigan Medicaid Provider Manual also details the SEDW and is available on the MDCH website. Elements of the SEDW are covered in trainings, presentations, and conferences, which are conducted throughout the state on a regular basis to a variety of stakeholders including: County Commissions, Department of Human Services Directors, Community Mental Health Directors, Children's Clinical Services Director's, Judges, Probation Officers, Representatives of Special Education, and other service providers, advocacy groups, as well as consumers and their families. Additionally, site reviews by MDCH SEDW staff include home visits which provide a valuable opportunity for families to express their views of the waiver, it's services, and the impact on their lives. Feedback from stakeholds was used in developing this renewal application.

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

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

7. Contact Person(s)

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, Michigan Department of Community Health

Address: 400 South Pine St.

Address 2: P.O. 30479

City: Lansing

State: **Michigan**

Zip: 48909

Phone: (517) 241-7172 **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: Stephen Fitton

State Medicaid Director or Designee

Submission Date: Jul 26, 2011

Last Name: Fitton

First Name: Stephen

Title: Director

Agency: Medical Services Administration

Address: 400 S. Pine Street

Address 2:

City: Lansing

State: **Michigan**

Zip: 48933

Phone: (517) 241-7882

Fax: (517) 335-5007

E-mail: fittons@michigan.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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 Community Health (MDCH)-Mental Health/Substance Abuse Services
   (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) Mental Health and Substance Abuse Services (MH/SA)staff perform the following operational and administrative functions:
Staff perform all administrative functions related to the SEDW including completion of the waiver applications, amendments and renewals, and CMS 372 Annual Reports. In addition to the financial information provided in the 372 reports there is a description of the process for monitoring the safeguards and standards under the waiver. If there are deficiencies detected during the monitoring process there is a summary of the significant areas where deficiencies were detected and an explanation of how these deficiencies have been corrected, or steps being taken to ensure that the deficiencies do not recur. These documents are then submitted to the State Medicaid Director for review and submission. Additionally MH/SA staff 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, which include a review of consumer services plans to ensure waiver requirements and CMS assurance are met; conduct utilization management functions; determine waiver payment amounts or rates; conduct training and technical assistance (including Maintenance of the Medicaid Provider Manual and the SEDW Technical Assistance Manual) concerning waiver requirements and implementation.
b) The Memorandum of Understanding between the State Medicaid agency and Mental Health and Substance Abuse Administration outlines the outlines the responsibilities for administration and oversight of the waiver. The responsibilities of the Mental Health and Substance Abuse includes: Monitoring and managing of CWP annual appropriation; Managing waiver enrollment against approved limits; Perform Prior Authorization of selective services for the CWP; Assuring accountability of local match for the SEDW; Establishing clinical eligibility for waivers; Conducting and monitoring quality assurance at the PIHP/CMHSP level; Providing training and technical assistance concerning waiver requirements; Completing waiver applications, renewals, amendments and 372 reports related to the CWP and SEDW (which are then submitted to MSA for review and approval). The responsibilities-Medical Services Administration include: Establishing Fee Screens; Setting and publishing Medicaid policy, including waiver Policy; Determining Medicaid eligibility; Reviewing, approving and submitting waiver applications, renewals, amendments and 372 reports related to the CWP and SEDW; Processing Medicaid claims and make payments based on established methodology.
If the Medicaid Director has a concern as to how the Mental Health and Substance Abuse (MH/SA) Administration fulfills their responsibility as outlined in the MOU, he would take his concerns to the MH/SA Director.
c) While the administration of the waiver falls within the jurisdiction of the MDCH's Mental Health and Substance Abuse Administration, all reports, amendments, renewals, and applications for waivers are reviewed, approved, and then submitted to CMS by the Medicaid Director, within the Medical Services Administration.

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.:*

MDCH contracts with local/regional non-state public entities known as Community Mental Health Service Programs (CMHSPs)or with other approved community based mental health service providers to conduct operational and administrative functions at the local level. MDCH monitors this through the site review process, financial reviews, and waiver enrollment oversight. The review protocols used by both the QMP and the SEDW staff are organized in a way that addresses many of the functions delegated by MDCH to the participating ommunity based mental health service providers for the SEDW. The delegated functions included in the protocol are: level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; and quality assurance and quality improvement activities. MDCH's manages enrollment against approved limits by reviewing, approving and processing applications submitted by CMHSPs and by processing terminations submitted by CMHSPs. The validation of the required local match for the CMHSPs is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. This assures sufficient local funds to earn federal Medicaid match for approved services.

○ **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:
MDCH-Mental Health/Substance Abuse Services

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:
MDCH houses the Bureaus of Mental Health / Substance Abuse Services, Medical Services Administration (MSA), and the Public Health Administration. MSA is the single State agency. A MOU between MSA and the Bureau of Mental Health / Substance Abuse specifies the functions delegated for administration and operation of the SEDW. The Bureau of Mental Health and Substance Abuse is responsible for: monitoring and managing of CWP annual appropriation; managing waiver enrollment against approved limits; perform Prior Authorization of selective services for the CWP; assuring accountability of local match for the SEDW; establishing clinical eligibility for waivers; conducting and monitoring quality assurance at the PIHP/CMHSP level providing training and technical assistance concerning waiver requirements; and completing waiver applications, renewals, amendments and 372 reports related to the CWP and SEDW.

The MDCH Division of Quality Management and Planning (QMP) conducts annual on-site visits to the PIHP/CMHSPs. During these visits, a detailed site review protocol is used to assure quality of services to consumers, compliance with the Michigan Mental Health Code and Administrative Rules, and conformance with all Medicaid requirements. In addition to site reviews completed by the QMP, the MDCH SEDW staff complete bi-annual site reviews of the CMHSPs. These on-site reviews include home visits of selected Waiver participants and a full clinical review of selected records. The review protocol is specific to assuring compliance with Waiver requirements. During the initial waiver approval period site reviews were completed for each of the 5 CMHSPs. The dates of review were as follows: Livingston County CMH Authority-June 27, 2007; CMH for Central Michigan-August 20-21, 2007; Van Buren Community Mental Health Authority-October 29-30, 2007; CMH Authority of Clinton-Eaton-Ingham County-November 27-28, 2007; and Macomb County CMH Services-December 5 & 6, 2007

The review protocols used by both the QMP and the SEDW staff are organized in a way that addresses many of the functions delegated by MDCH to the participating CMHSPs for the SEDW. The delegated functions included in the protocol are: Level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; and quality assurance and quality improvement activities. MDCH's manages enrollment against approved limits by reviewing, approving and processing applications submitted by CMHSPs and by processing terminations submitted by CMHSPs. The validation of the required local match for the CMHSPs is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. This assures sufficient local funds to earn federal Medicaid match for approved services.

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	☑	☐

Function	Medicaid Agency	Contracted Entity
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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of all policies and procedures governing the SEDW are developed by the operating agency and approved by MSA, and published in the Michigan Medicaid Provider Manual through the established concurrance review process prior to implementation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Michigan Medicaid Provider Manual

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: Medicaid Bulletins and instructional letters are issued continuously and ongoing. The Michigan Medicaid Provider Manual is updated quarterly to incorporate all published policies and procedures.	

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:
Prior to submission to CMS MSA reviews and approves 100% of reports, amendments and applications, which provide trend data and information regarding remediation efforts and system improvements.

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

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

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

Data Aggregation and Analysis:

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

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

The Division of Quality Management and Planning (QMP) within MDCH monitors the implementation at the 18 PIHPs (comprised of all 46 CMHSPs), and sends a qualified site review team to each of the PIHPs/CMHSPs to complete a comprehensive review and a follow-up review on the alternate year. This site visit strategy incorporates for all consumers served by all of Michigan's waivers the rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive reviews include the following components:

Reviews of clinical records to determine that Person- centered planning/Family-centered practice is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meets program requirements that are published in the Medicaid Provider Manual. The MDCH review team draws random samples of clinical records to be drawn from encounter data in the MDCH warehouse. Scope of reviews includes all Medicaid state plan and 1915 (b)(3) services, and waiver programs (including the SEDW, upon approval), all affiliates (if applicable), a sample of providers, and an sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:
o PIHP/CMHSP Compliance with the Medicaid Provider Manual
o Written agreements with providers, community agencies
o The results of the PIHP/CMHSPs' annual monitoring of its provider network.
o Adherence to contractual practice guideline
o Sentinel event management

A report of findings from the on-site reviews with scores will be disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDCH in 30 days. On-site follow-up will be conducted the following year, or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council, and SED staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

The SEDW staff site review teams monitor the following:

o Evaluation of level of care will include: assurance that enrolled participants are reevaluated at least annually (as documented by the completion of the Waiver Certification form and the Child and Adolescent Functional Assessment Scale [CAFAS®] or the Preschool and Early Childhood Functional Assessment Scale [PECFAS®}) by the Wraparound Facilitator or clinician and other members of the child's person-centered planning (PCP) team, and that decisions are appropriate and well documented. When a level of care is not documented or supported the process described in the overview is implemented. Individual Plans are reviewed to ensure that: a PCP process is used to develop comprehensive plans that identify the participant's assessed needs (including health and safety), strengths, goals, and that the plan specifies the type, scope, amount, duration and frequency of service; plans are updated as needed, but at least annually; and that participants are given a choice of service providers, and waiver services over institutional care (documented on the SED Waiver Certification form).
o Provider qualifications are reviewed to verify that the providers meet all required licensing, certification and training requirements.
o Health and welfare is monitored by reviews of recipient rights complaints, sentinel events, behavioral management reviews for potentially seclusion and/or restrictive, reviews of the plans of service and consumer interviews to ensure that the child is receiving the services identified in the plan.
o Financial Accountability involves a review of paid claims against services (type, frequency, duration) identified in the plan, prescriptions, and private insurance coverage.
o Home visits are conducted to assess satisfaction with services and service providers and knowledge of: wraparound plan of service, crisis and safety plans, administrative hearing rights, and freedom of choice issues.

An additional strategy employed by the State to discover problems is the External Quality Review (EQR). 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. Very few clinical record reviews are completed as part of this process. One EQR Component addresses PIHP compliance to BBA

requirements. The other two EQR activities, Performance Improvement Program Validation and Performance Measures Validation, have essentially no direct relationship to SEDW service delivery or quality management.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
A standard site review protocol is used at the time of the site visit. The protocol is used to record and document findings during a site review. The findings are sent to the CMHSPs with the requirement that the CMHSP prepare and submit to MDCH plans of correction within 30 days. The plans of correction are reviewed by staff that completed the site reviews and reviewed and approved by MDCH 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 Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ 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			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
◉ Mental Illness					
	☐	Mental Illness			
	☑	Serious Emotional Disturbance	0	19	

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

To be eligible for this waiver, the child must:
• Live in a participating county; OR
• Live in foster care in a non-participating county* pursuant to placement by MDHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP; AND
• Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR
• Reside with a legal guardian; OR
• Reside in a foster home with a permanency plan; OR
• Be age 18 or age 19 and live independently with supports; AND
• Meet current MDCH criteria for the State psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual; AND
• Meet Medicaid eligibility criteria and become a Medicaid beneficiary; AND
• Demonstrate serious functional limitations that impair their ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
o CAFAS® score of 90 or greater for children age 7 to 12; OR
o CAFAS® score of 120 or greater or children age 13 to 18; OR
o For children age 3 to 7: elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND
• Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria and continues to need waiver services, the child can remain on the waiver up to his/her 20th birthday.

*re: "...non-participating county..." second bullet, above: Many of the children identified for the SEDW Pilot will be transitioning from a residential setting into a community setting. Any child enrolled in the SEDW under this criterion is a permanent resident of a SEDW participating CMHSP/county. While permanency in a community setting is the ultimate goal for these children, frequently the participating county's Department of Human Services or Juvenile Court must place the child in a temporary, community-based residence, such as a foster home, to help stabilize the child's behaviors and to orientate him/her back to the community. The ability to use a foster home in a county other than the child's permanent county of residence, while the participating county continues to be financially and administratively responsible for service delivery and oversight, will remove barriers that could otherwise prohibit us from facilitating the child's successful placement back into the community. However, at any

time that the child's status changes and his/her permanent residence changes to a non-participating county, the child will become ineligible for the SEDW.

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:

Youth that are enrolled in the 1915(c) SEDW may continue to have mental health needs that will require planning on the part of the child and family wraparound team. It is the purpose of the waiver to provide community based services and supports to increase mental health functioning across life domain areas and decrease the need for psychiatric or other mental health institutional placement.

When youth are enrolled in the SEDW, the wraparound team develops measurable outcomes that guide the team toward transition or graduation from wraparound and enrolled waiver status. As stated above, this does not always mean that they no longer need any type of mental health services rather that they typically need less intensive services from intake to graduation.

As a youth approaches his/her early adult years, the child and family team focus on planning for this period of transition. There are many things to consider during this time. Some of the basic issues deal with housing, employment, vocational training or school status, emotional/behavioral health, physical health and safety. During this time it is common to focus on the life domain areas that will impact the youth's success as an adult. The team will focus on enhancing these skills utilizing Medicaid State Plan and waiver services, as well as by helping the youth and family identify and understand what services may be available post waiver. If the youth's disability impacts his/her ability to earn income, the team will work with the youth to apply for this benefit at age 18. The team will also work with the youth to identify other entitlements that would assist the youth post waiver.

This is also the time that the team will explore what mental health needs the youth may have after his/her 20th birthday and start that transition process with adult services. Whenever possible we encourage the adult services staff to become part of the wraparound team to assure a smooth transition to adult services. Some CMHSPs also have programs designated for this target age group, which is optimal in assisting them toward independence.

In summary, when youth are enrolled in the waiver, transition planning starts at intake and continues until the child/youth successfully transitions. Transitions are very different for each individual, but the CMHSP assumes the responsibility that the child's/youth's needs are met post waiver.

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	129
Year 2	357
Year 3	363
Year 4	369
Year 5	374

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

a)The SEDW services are provided through agreements with 12 of the 46 Community Mental Health Services Programs (CMHSPs) that are part of the 18 Pre-paid inpatient health plans (PIHPs) for Medicaid Managed Specialty Services in Michigan. These 12 CMHSPs are comprised of Community Mental Health (CMH) for Central Michigan, CMH Authority of Clinton-Eaton-Ingham Counties, Detroit-Wayne County CMH Agency, Kalamazoo CMH & Substance Abuse Services, Genesee County CMH Services, Livingston County CMH Authority, Macomb County CMH Services, Network180, Van Buren CMH Authority, Northern Lakes CMH Authority, Oakland County CMH Authority, and Saginaw County CMH Authority.

If approved, this Request for Amendment would add an additional two CMHSPs and two counties. CMHSPs: Muskegon County CMH agency (for Muskegon County) and Washtenaw Community Health Organization (for Washtenaw County) and Counties: Clinton and Eaton (counties within the CMH Authority of Clinton-Eaton-

Ingham Counties). Upon approval, the waiver capacity will be allocated to fourteen participating CMHSPs.

b)MDCH established criteria for participation as a SEDW service provider. The criteria include an established Wraparound Program, local interagency collaborative agreements, and the capacity to guarantee local funds as the State match for waiver and Medicaid State Plan mental health services. Based on the criteria, CMHSPs are asked to obtain signed interagency agreements between the CMHSP, the local Department of Human Services, local Circuit Court Family Division, and other agencies as appropriate; and to submit a Letter of Committment to MDCH, specifying the total amount of local match guaranteed and the number of children to be served by the SEDW. Participating CMHSPs must also agree to abide by the provisions of the CMHSP/MDCH general fund contract amendment regarding the SEDW.

c)Unused capacity is addressed through a policy that allows MDCH to approve transfers of waiver slots from one participating CMHSP to another participating CMHSP that has identified eligible consumers and sufficient local match to fund needed services.

When a child and his/her family moves to a county within Michigan that has an enrolled CMHSP provider for the SEDW, the child remains eligible for the waiver. However, if the child and his/her family move to a county where the CMHSP is not an enrolled provider of the SEDW, the child's waiver must be terminated. When a child enrolled in the SEDW moves to another county, the following process should be used:
• If the new CMHSP has waiver slot vacancies, the transferring child receives one of the vacancies.
• If the new CMHSP does not have a waiver vacancy, the waiver slot from the originating CMHSP follows the child to the new CMHSP. When the new CMHSP has a waiver vacancy, that slot is returned to the CMHSP who lost a slot to that CMHSP. This will be facilitated by MDCH through written correspondence.

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

The SEDW uses a Wraparound Service Facilitation and Coordination model. The Wraparound model has an infrastructure which includes the Collaborative Body, Community Team, Wraparound Facilitator, and a Child and Family Team with team members determined by the family. The wraparound plan is developed in partnership with other community agencies. Membership on the Community Team consists of administrators and mid-managers of public agencies providing services, e.g. MDCH, CMHSP, schools, family court; parents and youth who have experienced or received services; and community members including faith-based organizations, local business people, and non-profit administrators.

The Community Team is responsible for accepting, reviewing and approving referrals for Wraparound Services. The criteria used by the Community Team for accepting referrals for Wraparound include one or more of the following: The child is involved in multiple systems; the child is at risk of an out-of-home placement, or is currently in out-of-home placement; the child and family have received other community services and supports with minimal improvement; and numerous providers are serving multiple children in the family, and service outcomes have not been met.

Of those individuals determined by the Community Team to be eligible for Wraparound Services, a further review is conducted to determine if the child meets criteria for the SEDW. If a child appears to meet these criteria, a referral is made to the CMHSP for review, eligibility determination (including family choice of waiver services over hospitalization), and possible application to the SEDW. The CMHSP determines eligibility for the SEDW based on the published eligibility criteria, completes the waiver application for each candidate and submits it to MDCH for review, approval, and enrollment in the waiver.

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)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [x] **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)**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (●) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

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

- **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

The following standard included under the State plan

Select one:

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

(*select one*):

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

  Specify the percentage:
- **A dollar amount which is less than 300%.**

  Specify dollar amount:
- **A percentage of the Federal poverty level**

  Specify percentage:
- **Other standard included under the State Plan**

  Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)
SSI standard
Optional State supplement standard
Medically needy income standard
The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)
AFDC need standard
Medically needy income standard
The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section 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 an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**

Specify:

Level of care evaluations and reevaluations are performed by the participating CMHSPs under contract with MDCH Mental Health/Substance Abuse Services (the operating agency specified in Appendix A).

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:

An individual designated by the CMHSP Director is responsible for determining if a child meets the criteria for and is at risk of hospitalization in a state psychiatric hospital. Determination that the child demonstrates serious functional limitations that impair his/her ability to perform in the community is made by a Wraparound Facilitator or clinician who has completed training and is a reliable rater on the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®). The Wraparound Facilitator or clinician must also be a Child Mental Health Professional as defined in rule 330.2105 (b) of the Michigan Mental Health Code Administrative Health Rule for Children's Diagnostic Treatment Service.

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.

Level of Care (LOC) determinations are based on two things: whether the child meets the criteria for and is at risk of hospitalization in a state psychiatric hospital and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. As appropriate for age, the level of functional limitation is identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®). Waiver eligibility requires that the child age 12 or under must have a CAFAS® score of 90 or higher, while children age 13 to 18 must have a score of 120 or higher. For children age 3 to 7, waiver eligibility requires elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others.

Section 8.5.C of the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual sets forth Inpatient Psychiatric Hospital Admission criteria for persons under the age of 21. It reads as follows:
Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective. Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care. The individual must meet all three criteria outlined below:

1)Severity of Illness (signs, symptoms, functional impairments and risk potential)
At least one of the following manifestations is present:
· Severe Psychiatric Signs and Symptoms
· Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions,

extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
· Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
· Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.
· Disruption of Self-Care and Independent Functioning
· Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
· The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has seen a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.
· Harm to Self
· A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.
· There is a specific plan to harm self with clear intent and/or lethal potential.
· There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.
· There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self -endangering behavior.
· There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
· There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
· Harm to Others
· Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
· There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
· There has been significant destructive behavior toward property that endangers others, such as setting fires.
· The person has experienced severe side effects from using therapeutic psychotropic medications.
· Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care.
· The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization if the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
· There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

2) Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.

3) Intensity of Service: The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

* Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

* Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

* Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

* A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

The CAFAS® is an assessment rating tool that measures functional assessment of school aged children and adolescents. Each of the CMHSPs participating in the SEDW must also participate in the Michigan Level of Functioning Project (LOF Project), and must comply with all requirements of that project, including data collection and reporting. The CAFAS® provides an objective, reliable and valid way to identify behaviors that impair a child's functioning. Within family centered practice, the CAFAS® is best utilized when it is completed and discussed with the child/adolescent and family. In using the CAFAS®, the rater should provide a brief explanation of the CAFAS®

to the family, and then - working with the family - use the CAFAS® to identify needs important to the child/adolescent and family. Additionally, the CAFAS® should help to identify strengths of the child/adolescent and family that can be used to develop a plan that will best meet the child's/adolescent's and family's needs and desires.

The PECFAS® is a standardized, validated, reliable assessment tool that measures the impairment in day-to-day functioning secondary to behavioral, emotional, psychological or psychiatric problems for children 3 to 7 years of age that have a mental health diagnosis.

The PECFAS® contains a "menu" of behaviorally-oriented descriptions, from which the rater chooses those that best describe the child. The items are organized within domains of functioning (i.e. subscales), and within each domain, into levels of impairment (i.e., severe, moderate, mild, none). The domains assessed (subscales) are: school/daycare, home, community (delinquent – like behavior), behavior toward others, mood/emotions, self-harmful behavior, thinking/communication.

The primary uses of the PECFAS® include:

· Identifying need for referral to mental health evaluation or services;
· Assigning cases to appropriate levels of care;
· Generating a strengths-based treatment plan;
· Active case management, using ongoing outcome information;
· Communicating with caregivers and others about child's needs; and
· Maintaining clinical documentation which can withstand audits

The PECFAS® was developed for use with children who are not yet enrolled in a full-day Kindergarten program or in first grade. Depending on the child's emotional and cognitive developmental level, the PECFAS® can be used with children ages 3 to 7 years old.

The PECFAS® was also developed by Dr. Kay Hodges.

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:

The SEDW uses a Wraparound Service Facilitation and Coordination model. The Wraparound model has an infrastructure which includes the Collaborative Body, Community Team, Wraparound Facilitator, and a Child and Family Team with team members determined by the family. The wraparound plan is developed in partnership with other community agencies. Membership on the Community Team consists of administrators and mid-managers of public agencies providing services, e.g. MDCH, CMHSP, schools, family court; parents and youth who have experienced or received services; and community members including faith-based organizations, local business people, and non-profit administrators.

The Community Team is responsible for accepting, reviewing and approving referrals for Wraparound Services. The criteria used by the Community Team for accepting referrals for Wraparound include one or more of the following: The child is involved in multiple systems; the child is at risk of an out-of-home placement, or is currently in out-of-home placement; the child and family have received other community services and supports with minimal improvement; and numerous providers are serving multiple children in the family, and service outcomes have not been met.

Of those individuals determined by the Community Team to be eligible for Wraparound Services, a further review is conducted to determine if the child meets the criteria for the SEDW due to the functional limitations identified by a

CAFAS® or PECFAS and if the child meets criteria for admission to a psychiatric hospital. If a child appears to meet these criteria, a referral is made to the CMHSP for review, eligibility determination (including family choice of waiver services over hospitalization), and possible application to the SEDW. The CMHSP determines eligibility for the SEDW based on the published eligibility criteria, completes the waiver application for each candidate and submits it to MDCH for review, approval, and enrollment in the waiver.

The Wraparound Facilitator is the person responsible for the initial level of care evaluation and for making a recommendation to the individual designated by the CMHSP Director. The Wraparound Facilitator must be a Child Mental Health Professional and be working with the child and family.

A description of the reevaluations process is as follows: The date of the CMHSP designee's signature on the Waiver Certification is considered the reevaluation date. If the child continues to meet SEDW criteria and to require the services of the SEDW the Wraparound facilitator submits a newly executed Waiver Certification form to MDCH. The Waiver Certification must be completed and signed within 12 months of the previous Waiver Certification, and must be submitted to MDCH within 30 days of signature to maintain eligibility. The Wraparound Facilitator also submits an updated CAFAS® summary or PECFAS® to document that the child continues to meet SEDW eligibility criteria; an annual budget, based on services identified in the current Plan of Service (POS); proof of current Medicaid eligibility; and an updated demographic intake data form (if there have been changes). MDCH staff review the renewal application and complete and sign section 2 of the Waiver Certification form. A copy of the signed form is sent to the Wraparound Facilitator for the child's file, and the Medicaid Policy office is notified that the child continues to be eligible for the SEDW.

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):*

SEDW enrollment data is maintained in an Excel spreedsheet and is used to identify children coming up for reevaluation/recertification. The appropriate CMHSP is notified in writing by MDCH 60-90 days prior to the renewal due date. A CMHSP Wraparound Facilitator must submit a reevaluation/recertification packet within 365 days of the previous years certification, as stated above.

If necessary, SEDW staff contact the CMHSP wraparound facilitator and instruct them to provide either a recertification or evidence of termination and notification to the family of Right to Hearing.

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 CMHSP maintains consumer's clinical records that include the SEDW initial and reevaluation/recertications packets, along with supporting documentation. The MDCH maintains copies of the initial and recertification packets and approvals letters. The Medicaid agency maintains a copy of notification of both the initial and continuing eligibility for the SEDW.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Level of Care evaluations are completed for 100% of applicants prior to their enrollment in the waiver.

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

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

	☑ **Other** Specify: At time of application	

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:
100% of initial eligibility determinations are made by MDCH staff within seven (7) working days of submission of the application.

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

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

Specify:		☐ **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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Level of Care determinations are completed for 100% of enrolled participants within twelve (12) months of their last annual level of care evaluation.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: The child's needs are continually accessed and can result in a re-determination of LOC completed anytime within the waiver year, but must be completed within 365 days from previous determination.	

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of level of care determinations are completed by the CMHSP, as a qualified provider.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: at time of application and re-evaluation.	

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:
100% of the level of care determinations are documented on the approved Waiver Certification form.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: at time of application and re-evaluation.	

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.

Level of Care (LOC) determinations are based on two things: whether the child meets the criteria for and is at risk of hospitalization in a State psychiatric hospital, and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. The level of functional limitation is identified using the CAFAS® or PECFAS®. Eligibility for psychiatric hospitalization is documented on the Waiver Certification Form, as is the CAFAS® or the PECFAS® score. The Waiver Certification form and the CAFAS® or PECFAS® summary are submitted by the responsible CMHSP to MDCH for review and approval at the time of the initial application and the annual re-certification. MDCH maintains a database of all enrolled participants by CMHSP. The database identifies the initial date of eligibility for the waiver and is used to determine when re-certifications are due. A sample of the CMHSP's waiver consumer clinical records is reviewed annually via an on-site clinical and administrative record review. At this time all assessments and documentations that underpin the waiver certification is reviewed.

b. Methods for Remediation/Fixing Individual Problems

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

Problems with level of care evaluation/re-evaluation are identified during the annual site review and are documented by MDCH using the Site Review Protocol. The Provider Agency is required to respond to the MDCH within 30 day of receipt of the report with a plan of correct. This plan of correction must be reviewed MDCH staff that completed the site review. MDCH administration reviews and approves staff response to the plan of correction. 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 Waiver Certification Form is a double-sided form with three (3) areas for completion. The third section of the Waiver Certification form is the Family Choice Assurance section, and is to be completed by the child's parent or legal guardian. This section verifies that the Wraparound Facilitator has informed the family of their right to choose between the community based services provided by the SEDW and hospitalization in a state psychiatric hospital. The parent(s) must check one of the three choices listed in this section. This section also confirms that the family has been informed of their choice of qualified service providers. The parent/legal guardian signs and dates the "Family Choice Assurance" section of the form. The Wraparound Facilitator, as witness to the parent or guardian's signature, also signs and dates the form.

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 Waiver Certification form and is maintained by the CMHSP in the consumer's clinical record and by MDCH in the consumer record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Michigan Medicaid Provider Manual, Section 4 - Compliance with Federal Legislation, sub-section 4.2 - Nondiscrimination. 6 of the "General Information" state the following:

"Federal regulations require that all programs receiving federal assistance through Health and Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office of Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)

Additionally, the MCDH/PIHP contract, amended 9/11/2003, section 15.7 States:

Limited English Proficiency
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.

PIHP's contract with Interpreters to provide both verbal and written correspondence for individuals who are unable to understand or read the English language when a significant number or percentage of program beneficiaries requires information in a language other than English.

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	**Respite**		
Other Service	**Child Therapeutic Foster Care**		
Other Service	**Community Living Supports**		
Other Service	**Community Transition**		
Other Service	**Family Home Care Training**		
Other Service	**Family Support and Training**		
Other Service	**Therapeutic Activities**		
Other Service	**Therapeutic Overnight Camping**		
Other Service	**Wraparound**		

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):

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following locations: Individual's home or place of residence; family friend's home in the community; Foster home.

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

This service can be billed up to a maximum of 1248 units per month.

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	Other approved community based mental health and developmental disability services providers
Agency	CMHSP

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Other approved community based mental health and developmental disability services providers
Provider Qualifications

License *(specify):*
Foster Care providers are licensed under MCL 222.122.
Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
Direct care, aide level staff employed by the agency must be a responsible adult at least 18 years of age and be:
· Trained in the child's Plan of Care
. Free from communicable disease
· Able to read and follow written plans of service/supports as well as participant-specific emergency procedures
· Able to write legible progress and/or status notes
· In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien)
· Successfully completed Recipient Rights Training
· Able to perform basic first aid and emergency procedures

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.
Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
CMHSP
Provider Qualifications

License *(specify):*
Foster Care providers are licensed under MCL 222.122.

Certificate *(specify):*
The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
Direct care, aide level staff employed by the CMHSP must be a responsible adult at least 18 years of age and be:
· Trained in the child's Plan of Care
. Free from communicable disease
· Able to read and follow written plans of service/supports as well as participant-specific emergency procedures
· Able to write legible progress and/or status notes
· In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien)
· Successfully completed Recipient Rights Training
· Able to perform basic first aid and emergency procedures

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.
Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three 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:
Child Therapeutic Foster Care
Service Definition *(Scope):*
Child Therapeutic Foster Care (CTFC) provides an intensive therapeutic living environment for a child with a behavior disorder. Important components of Child Therapeutic foster care include: intensive parental supervision, positive adult –youth relationship, reduced contact with other behaviorally disorder children and family behavior management skills. CTFC seeks to change the negative trajectory of a child's behavior by improving their social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior and increase appropriate behavior and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. They all contribute to the treatment of the child and the preparation of his/her family for returning home. Foster parents are specially recruited, behaviorally trained and supervised. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed 1. In addition to being licensed all therapeutic foster care programs under this waiver will be pre-enrolled by MDCH to ensure they meet the requirements set forth in this document. Separate payment will not be made for homemaker or chore services, or for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving Therapeutic Foster Care services, since these services are integral to and inherent in the provision of Child Therapeutic Foster Care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
CTFC must be billed as a 'per diem' service, up to a maximum of 365 days per year.

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	Other approved community based mental health and developmental disability services providers
Agency	CMHSP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Therapeutic Foster Care

Provider Category:
Agency
Provider Type:
Other approved community based mental health and developmental disability services providers
Provider Qualifications
License *(specify):*
Child Therapeutic Foster Care (CTFC)providers are licensed by the Michigan Department of Human Services under MCL 722.122
Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

CTFC providers must also be certified by MDCH.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all CTFC providers meet service provider qualifications.
Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Therapeutic Foster Care

Provider Category:
Agency
Provider Type:

CMHSP

Provider Qualifications

License *(specify):*

Child Therapeutic Foster Care (CTFC)providers are licensed by the Michigan Department of Human Services under MCL 722.122

Certificate *(specify):*

The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

CTFC providers must also be certified by MDCH.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.

Frequency of Verification:

MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three 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:

Community Living Supports

Service Definition *(Scope):*

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals of community inclusion and remaining in their home. The supports may be provided in the participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.).

Community Living Services provides assistance to the family in the care of their child, while facilitating the child's independence and integration into the community. The supports, as identified in the POS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included. It may also promote communication, and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

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

Up to 744 units (15 minutes) per month.

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	CMHSP
Agency	Other approved community based mental health and developmental disability services providers

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:
CMHSP
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
Direct care, aide level staff employed by the CMHSP must be a responsible adult at least 18 years of age and be:
• Trained in the child's Plan of Care
. Free from communicable disease
• Able to read and follow written plans of service/supports as well as participant- specific emergency procedures
• Able to write legible progress and/or status notes
• In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien)
• Successfully completed Recipient Rights Training
• Able to perform basic first aid and emergency procedures

Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.
Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three years.

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:

Other approved community based mental health and developmental disability services providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*

Direct care, aide level staff employed by the community based mental health service provider must be a responsible adult at least 18 years of age and be:

- Trained in the child's Plan of Care
- Free from communicable disease
- Able to read and follow written plans of service/supports as well as participant- specific emergency procedures
- Able to write legible progress and/or status notes
- In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien)
- Successfully completed Recipient Rights Training
- Able to perform basic first aid and emergency procedures

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.

Frequency of Verification:

MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three 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:

Community Transition

Service Definition *(Scope):*

Community Transition service is a one-time-only expense to assist beneficiaries returning to their home and community while the family is in the process of securing other benefits (e.g. SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional services:

- The beneficiary must have in his/her family-centered plan of services a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits, such as SSI,

or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available, they will assume these obligations and provide the needed assistance.
Coverage includes:
• Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home
• Interim assistance with utilities, insurance, or living expenses when the beneficiary's family already living in an independent setting experiences a temporary reduction or termination of their own or other community resources
• Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.
All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements exclusively required to meet local building codes. The home maintenance 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.
Coverage excludes those adaptations or improvements to the home that are
• of general utility or are cosmetic,
• are considered to be standard housing obligations of the beneficiary's family
• are not of direct medical or remedial benefit to the child,
• are for on-going housing costs
• costs for room and board that are not directly associated with transition arrangements while securing other benefits.
Requests for transitional services must be prior authorized by the CMHSP following denial by all other applicable resources (e.g., private insurance, Medicaid). All services shall be provided in accordance with applicable state or local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This is a one time only service that can be used while a child is enrolled in the waiver program.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Other approved community based mental health and developmental disability services providers
Agency	CMHSP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
Other approved community based mental health and developmental disability services providers

Provider Qualifications

License *(specify):*

As appropriate to the service): a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company.

Certificate *(specify):*

Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.

Frequency of Verification:

MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

CMHSP

Provider Qualifications

License *(specify):*

When appropriate to the service must be a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company.

Certificate *(specify):*

The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.

Frequency of Verification:

MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three 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:

Family Home Care Training

Service Definition *(Scope):*

This training and counseling service is a clinical/professional service provided by a Master's level Social Worker, psychologist or QMHP to families of individuals served on this waiver. For purposes of this service, "family" is defined as the person(s) who live with or provide care to a person served on the waiver, and may include a parent and/or siblings or the foster parent(s) for a child in Therapeutic Child Foster Care. Training includes instruction about treatment regimens and behavioral plans specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home.

It is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and help the child remain at home. All family training must be included in the child's individual plan of care and must be provided on a face -to-face basis.

This service will not be duplicative of other services provided.

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

This service must be billed per session, up to a maximum of four sessions per month.

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	Other approved community based mental health and developmental disability services providers
Agency	CMHSP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Home Care Training

Provider Category:

Agency

Provider Type:

Other approved community based mental health and developmental disability services providers

Provider Qualifications

License *(specify):*

Individual providers of this service must have a current license under part 18 of Michigan PA 368 of 1978, as amended.

Certificate *(specify):*

Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*

Service providers for Family Home Care Training must be a Psychologist, Masters level Social Worker, or a Qualified Mental Health Professional (QMHP), and have current certification of registration under Michigan PA 352 of 1972, as amended.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.

Frequency of Verification:

MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Home Care Training

Provider Category:

Agency

Provider Type:

CMHSP

Provider Qualifications

License *(specify):*

Service Providers must have a current license under part 18 of Michigan PA 368 of 1978, as amended.

Certificate *(specify):*

The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*

Service providers for Family Home Care Training must be a Psychologist, Masters level Social Worker, or a Qualified Mental Health Professional (QMHP), and have current certification of registration under Michigan PA 352 of 1972, as amended.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.

Frequency of Verification:

MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three 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:

Family Support and Training

Service Definition *(Scope):*

This service is provided by a parent who has completed specialized training. It is a family-focused service provided to families (birth or adoptive parents,siblings, relatives, foster family, and other unpaid caregivers) of children serious emotional disturbance (SED) for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in his ability to achieve goals of: performing activities of daily living; Improving functioning across life domain areas; perceiving, controlling, or communicating with the environment in which he lives; or improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

Coverage includes: Education and training, including instructions about treatment regimens to safely maintain the child at home as specified in the POS; peer support provided by a trained peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with a SED.

Parent-to-Parent Support is designed to support parents/family of children with SED as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals. This service will require a completion of a MDCH approved Curriculum.

This service will not be duplicative of other services provided.

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

The frequency and duration of the training must be identified in the child's POS, along with the child's goal(s) that are being facilitated by this service.

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

- [ ] **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	CMHSP
Agency	Other approved community based mental health and developmental disability services providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support and Training

Provider Category:

Agency

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

Certificate *(specify):*
The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
The Parent Support partner must complete the MDCH statewide training Curriculum and be provided regular supervision and team consultation by the treating professionals.
Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications
Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support and Training

Provider Category:
Agency
Provider Type:
Other approved community based mental health and developmental disability services providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
The Parent Support partner must complete the MDCH statewide training Curriculum and be provided regular supervision and team consultation by the treating professionals.
Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.
Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three 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:

Therapeutic Activities

Service Definition *(Scope):*

Therapeutic activities is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the POS. The POS ensures the child's health, safety and skill development and maintains the child in the family home. Services must be directly related to an identified goal in the POS. Providers are identified through the wraparound planning process and participate in the development of an POS based on strengths, needs and preferences of the child and family. Therapeutic activities may include the following activities: Child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes in the POS. Services provided under Therapeutic Activities include: Music Therapies, Recreation Therapies, and Art Therapies.

The training, coaching, supervision and monitoring activities provided under this service are specific to music, art and recreation therapy, and must be provided by qualified providers of the therapies. This service is not duplicative of any other service provided.

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

This service may be billed for a maximum of 4 times per month.

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	CMHSP
Agency	Other approved community based mental health and developmental disability services providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Activities

Provider Category:

Agency

Provider Type:

CMHSP

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC)
Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR)
Art Therapist must be Board Certified (ATR-BC) Credentials Bard, Inc. (ATCB)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications

Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Activities

Provider Category:
Agency

Provider Type:
Other approved community based mental health and developmental disability services providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

A Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); a Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); an Art Therapist must be Board Certified (ATR-BC) Credentials Bard, Inc. (ATCB)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.

Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three 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:

Therapeutic Overnight Camping

Service Definition *(Scope):*

A group recreational and skill building service in a camp setting aimed at meeting a goal(s) detailed in the child's individualized plan of care. A session can be one or more days and nights of camp. Room and Board will also be excluded from the cost of this service.

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

Three sessions per year. Each session can encompass several days and nights.

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	CMHSP
Agency	Other approved community based mental health and developmental disability services providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Overnight Camping

Provider Category:

Agency

Provider Type:

CMHSP

Provider Qualifications

License *(specify):*

Camps are licensed by the Department of Human Services (DHS)

Certificate *(specify):*

The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*
The staff of the camp must be trained in working with children with serious emotional disturbance.

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.

Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Overnight Camping

Provider Category:
Agency

Provider Type:
Other approved community based mental health and developmental disability services providers

Provider Qualifications

License *(specify):*
Camps are licensed by the Department of Human Services (DHS)

Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*
The staff of the camp must be trained in working with children with serious emotional disturbance.

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.

Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three 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:
Wraparound

Service Definition *(Scope):*

Wraparound Service Facilitation and Coordination for Children and Adolescents is a highly individualized planning process performed by specialized wraparound facilitators employed by the CMHSP, or other approved community-based mental health and developmental disability services provider, or its provider network who, using the Wraparound model, coordinate the planning for, and delivery of, services and supports that are medically necessary for the child. The planning process identifies the child's strengths, needs, strategies and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports. The Child and Family Team create a highly individualized plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health State plan or the waiver. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound.

The focus of Wraparound is to ensure the POS gets implemented; it is a process of enabling and facilitating. The Wrapaound Facilitator provides case management, overall service coordination, communication with the community team, and implementing the POS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Billable Wraparound services include all collateral contacts and ancillary tasks/activities, as well as direct consumer contact - as described above. The maximum number of billable days per month is 4; and only dates-of-service for which there is a documented face-to-face encounter / event with the consumer can be billed. Therefore a "billable day" includes both direct consumer contact that occurred on the billed date-of-service, as well as all collateral/ancillary contacts that occurred on days on which there was not a face-to-face encounter with the consumer. During SEDW Site Reviews, documentation of all facets of Wraparound services is audited, including documentation of the face-to-face service provided on the date-of-service billed to Medicaid.

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	CMHSP
Agency	Other approved community based mental health and developmental disability services providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wraparound

Provider Category:
Agency
Provider Type:
CMHSP
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The CMHSP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
Wraparound facilitators must:
 Complete MDCH wraparound training;
 Possess a bachelor's degree in human services or a related field, or other Agency approved work/personal experience in providing direct services or linking of services for children with SED;
 Have a criminal history screen, including state and local child protection agency registries; and
 Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDCH required training.

Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of CMHSPs. CMHSPs are responsible for verifying staff and contract service providers qualifications.
Frequency of Verification:
MDCH verifies CMHSPs on an annual basis. CMHSP's verify provider qualifications every one to three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wraparound

Provider Category:
Agency
Provider Type:
Other approved community based mental health and developmental disability services providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Community based mental health and developmental disability services providers must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, as amended, and the Administrative Rules applicable thereto.
Other Standard *(specify):*
Wraparound facilitators must:
 Complete MDCH wraparound training;
 Possess a bachelor's degree in human services or a related field, or other Agency approved work/personal experience in providing direct services or linking of services for children with SED;
 Have a criminal history screen, including state and local child protection agency registries; and
 Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDCH required training.

Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH is responsible for verifying certifications of community based mental health and developmental disability services providers; these providers are responsible for verifying that all staff meet service provider qualifications.
Frequency of Verification:
MDCH verifies certification of community based mental health and developmental disability services providers annually. Individual agencies verify provider qualifications every one to three years.

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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ( ) **No. Criminal history and/or background investigations are not required.**
- (●) **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) all direct care aide-level staff, all clinicians, and other CMHSP employees
(b) The CMHSP or it's contracted provider agency is responsible for completing the criminal history/background investigation by checking statewide databases and for providing documentation in the employee's personnel file. The QMP and SEDW site reviews are the mechanisms for ensuring the background checks are completed.
(c) requirements, are set forth in the Michigan Medicaid Provider Manual, state that staff must "be in good standing with the law (ie., not a fugitive from justice, a convicted felon, or illegal alien)."

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.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

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

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

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

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

Michigan does not allow payment to legal guardians or to relatives who are legally responsible for providing services to the child. Subject to this qualification relatives may be paid if they meet all provider qualifications.

Services provided by relatives meeting these criteria are subject to the same claim processing edits (including quantity parameters) as services provided by non-relatives.

○ **Other policy.**

Specify:

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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:

Approved community-based mental health and developmental disability services provider, such as a CMHSP, must meet certification requirements as specified in Section 232a of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto. They must also be able to provide either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.

In order to provide a comprehensive array of services each CMHSP establishes a procurement schedule for enrolling providers. In addition the CMHSP may open enrollment at any time that additional providers are needed. Any provider may enroll directly with Medicaid if they meet the certification requirements specified in the Michigan Mental Health Code, as cited above.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
100% of the CMHSPs are certified by MDCH as a qualified community mental health services provider, both initially and on an ongoing basis.

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:
	☐ **Other** Specify:	

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

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

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

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:
100% of CMHSP contractual providers that are not subject to other governmental regulatory authority are certified by the responsible CMHSP.

Data Source (Select one):

Record reviews, off-site
If 'Other' is selected, specify:

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

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:
	☐ **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 State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of non-licensed and non-certified service providers (limited to Community Living Support and Respite Staff) meet provider qualifications as identified in the Michigan Medicaid Provider Manual, both initially and on an ongoing basis.

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: MDCH reviews 100% of the providers for the sample selected for the site review.
	☐ **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:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
DCH reviews 100% of CMHSPs' documentation of waiver services' provider training.

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:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Section 6.4 of the contract between the MDCH and the PIHPs/CMHSPs specifies provider network requirements. Michigan's Mental Health Code requires that each CMHSP be certified by the MDCH in order to receive funding by the MDCH. Certification can be granted for up to a three-year period. The MDCH ensures that the PIHPs/CMHSPs meet state certification standards using a combination of site review and certification activities. The MDCH grants deemed status to CMHSPs who have achieved a recognized accreditation. Certification application materials from each CMHSP are reviewed to ensure that recognized accreditation processes cover the CMHSP and its provider network. The CMHSPs are required to register all mental health service providers with the MDCH on an ongoing basis. To be certified by the MDCH, a CMHSP must be in compliance with the Recipient Rights Protection standards. Compliance with rights protection requirements is determined during an onsite visit conducted by the Office of Recipient Rights (ORR) within the MDCH.

The annual 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.

The SEDW site review staff will verify that the CMHSPs have documentation of training by reviewing both individual personnel records of staff providing waiver services for selected consumer, and a review of provider training data, aggregated by the CMHSP.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Any findings noted during the site review process are included in a formal report issued by the MDCH to the PIHP/CMHSP. The PIHP/CMHSP 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 Teams review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP/CMHSP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Plan of Service (POS)

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:

The Wraparound Facilitator, who leads the Child and Family Team in the development of the POS, must complete MDCH required training. Also required is a bachelor's degree in human services or a related field; or other approved work/personal experience in providing direct services or linking of services for children with SED. Wraparound facilitators must have a criminal history screen, a screen with state and local Child Protection Agency registries. They must be supervised by an individual who meets criteria as a qualified mental health professional (QMHP), who has also completed MDCH required training.

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:*

Michigan uses a Person-Centered Planning / Family Centered Practice approach that encompasses the belief that the family is at the center of the planning process and the service providers are collaborators. The family is the constant throughout the life of their children, while fluctuations occur at the service system level due to personnel changes and turnover. The wraparound process is an individualized, needs-driven, strengths based process for children and families with multiple needs. The Child and Family Team include those persons most familiar with the child and family, plus service providers and community members. The majority of team members are the parents plus family members, friends and neighbors selected by the family. This is known as the Child and Family Team. The functions of the Child and Family Team include: Participating in the Strengths and Culture Discovery; Developing a wraparound plan that is family-centered; Developing crisis and safety plans; Works to support the implementation of the wraparound plan; Accessing informal and formal supports/resources; Monitoring services/supports for effectiveness; Evaluating on a regular basis the individual/family outcomes identified by the wraparound plan; Pledging unconditional commitment; Revising the wraparound plan based on changing needs, newly identified or developed strengths and/or on the result of an outcomes' review; and Making provisions for long term support of the family after formal services are completed.

The core concepts of planning are the Strengths and Culture Discovery process, completed by the Child and Family Team, which identifies the assets of the family, assists the members of the Child and Family Team to obtain a balanced picture of the family and of other team members, and begins the joining process between the family and the team. The strengths and culture discovery process is built on the identified strengths and culture of the child and family. It is the role of the Wraparound Facilitator to ensure this is completed.

The Strengths and Culture Discovery process sets the stage for a holistic planning process and should: Consider cultural differences in approaching families; Identify the personal assets (values/attitudes, preferences, traditions/daily rituals, skills/abilities, interests, attributes/features) and resources of the individual, family and team member; and Focus on the child, other family members and the family as a whole across all life

domains.

Each Child and Family Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including; emotional/psychological/behavioral, health, education/vocational, financial/resources, cultural/spiritual, crisis, safety, housing/home, relationships/attachments, legal, daily living, family, social/recreational, and other life domains, as determined by the Child and Family Team.

Life Domain planning is always a blend of formal and informal resources. It uses strategies based on strengths, focused on need, and which are individualized, and community-based. It includes a Crisis Plan that is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child and Family Team define the "crisis". The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include a safety plan that is intended to insure the safety of the children or family members in the home.

The Child and Family Team develops a Plan of Service and a budget is completed that outlines use of community funds, family contributions, community donations and Medicaid funds. The Community Team approves all budget expenditures as recommended by the Child and Family Team.

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.

See above.

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):

Michigan uses a Person-Centered Planning / Family Centered Practice approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The family is the constant throughout the life of their children, while fluctuations occur at the service system level due to personnel changes and turnover. The wraparound process is an individualized, needs-driven, strengths based process for children and families with multiple needs. The wraparound planning process begins prior to the application for the SEDW. Once needs are prioritized, the family is informed of available services and choice of qualified providers responsive to identified needs. The Plan of Service is a dynamic document that is revised based on changing needs, newly identified or developed strengths and/or the result of an outcomes' review update. The Child and Family Team include those persons most familiar with the child and family, plus service providers and community members. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the Child and Family Team include: Participating in the Strengths and Culture Discovery; Developing a wraparound plan that is family-centered; Developing crisis and safety plans; Working to support the implementation of the wraparound plan; Accessing informal and formal supports/resources; Monitoring services/supports for effectiveness; Evaluating on a regular basis the individual/family outcomes identified by the wraparound plan; Pledging unconditional commitment; and Making provisions for long term support of the family after formal services are completed. Wraparound team meetings are held at least weekly initially and subsequently no less than twice per month while enrolled in the SEDW unless otherwise documented in a transition plan. An

essential component to engaging the family is the willingness to meet with the family wherever they want, and at a time that ensures their participation and the participation of those important to them.

Two of the core concepts of planning are the Strengths and Culture Discovery and Life Domain Planning. The Strengths and Culture Discovery process, completed by the Child and Family Team, identifies the assets of the family, assists the members of the Child and Family Team to obtain a balanced picture of the family and of other team members, and begins the joining process between the family and the team. The strengths and culture discovery process is built on the identified strengths and culture of the child and family. It is the role of the Wraparound Facilitator to ensure this is completed. The Strengths and Culture Discovery process sets the stage for a holistic planning process and should: Consider cultural differences in approaching families; Identify the personal assets (values/attitudes, preferences, traditions/daily rituals, skills/abilities, interests, attributes/features) and resources of the individual, family and team member; and Focus on the child, other family members and the family as a whole across all life domains.

Each Child and Family Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including; emotional/ psychological/behavioral, health, education/vocational, financial/resources, cultural/spiritual, crisis, safety, housing/home, relationships/attachments, legal, daily living, family, social/recreational, and other life domains, as determined by the Child and Family Team. The Plan of Service must address the coordination and oversight of any identified medical care needs to ensure health and safety. This includes areas of concern such as drug / medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or coexisting general medical condition requiring care.

Life Domain planning is always a blend of formal and informal resources. It uses strategies based on strengths, focused on need, and which are individualized, and community-based. Although a child or youth participates in planning for services, as minors, they can not direct services or service providers. As noted above all individual plans of care include crisis and safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child and Family Team define the “crisis”. The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include a safety plan that is intended to insure the safety of the children or family members in the home.

The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills.

The Child and Family Team develop a Plan of Service and provide on-going oversight, with the Wraparound facilitator taking the lead responsibility. The Child and Family Team must review the Plan of Service at least monthly and revisions must be reflected in the Plan of Service, and Child and Family Team minutes. The outcomes are reviewed and progress measured by the Child and Family Team at least monthly and changes are made if needed. The Community Team formally reviews the Plan of Service every six months. The supervisor will review the Plan of service at least every three months; and the Child and Family Team, supervisor and the Community Team review crisis and safety plans. A budget is completed that outlines use of community funds, family contributions, community donations and Medicaid funds. The Community Team approves all budget expenditures as recommended by the Child and Family Team.

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.

Although a child or youth participates in planning for services, as minors, they can not direct services or service providers. As noted above all individual plans of care include crisis and safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child and Family Team define the “crisis”. The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include a safety plan that is intended to insure the safety of the children or family

members in the home.

The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills.

The crisis plan is based on a careful review of the child's history to identify triggers of crisis. For example, is crisis brought on by new situations, a new route, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the child and family by community agencies, fears or worries expressed by the family, etc. For each identified crisis and safety concern both preventive and reactive strategies are identified and written into the Plan of Service. However, as with all aspects of the Plan of Service strategies are strength based and grounded in the family's strengths and culture.

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.

Michigan assures that each individual found eligible for the waiver will be given free choice of all qualified providers for each service included in his or her written POS. At a practical level once a child and family's needs are identified and prioritized a POS is created. The POS is grounded in the strength and culture discovery and is based on brainstorming options and strategies to meet the identified needs. Options and strategies include but are not limited to waiver services. Where waiver or state plan services are the appropriate service response, the Child and Family Team, lead by the Wraparound Facilitor, identifies qualified providers from which the family may chose. The child and family choice drives the POS. This includes the child and family choice of qualified service providers from the CMHSP provider network. The family choice of waiver services over institutional care is documented on the Waiver Certification form, "Parent Choice Assurance" section, and in minutes of Child and Family Team meetings, and the families signature on the POS.

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 MDCH Division of Quality Management and Planning (QMP) currently conduct annual on-site visits to the PIHP/CMHSPs or other approved community-based mental health and developmental disability services providers. Because the SED waiver is a fee-for-service program, day to day operations are performed by the approved community-based mental health and developmental disability services providers and are not the responsibility of the PIHPs. The MDCH SED Waiver staff complete site reviews of the approved community-based mental health and developmental disability services providers every three years at which time the Plans of Service are reviewed. On alternate years the QMP completes on-site visits, which includes reviews of POSs.

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:

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.

Each child must have a Wraparound Facilitator who is responsible for monitoring the provision of services and supports, as identified in the Plan of Service (POS) and crisis and safety plans. The Wraparound Facilitator provides data (e.g. Child and Family Team minutes, data on goal achievement) to the Community Team to monitor outcomes of Plans of Service and expenditures. The Wraparound Supervisor is responsible for assuring that community safety is planned for and risk has been reduced. The Child and Family Team will review the POS at least monthly and revisions will be reflected in the POS, and Child and Family Team minutes. Child and Family Team minutes are part of the clinical records. Participant access to non-waiver services identified in the POS, including health care, is part of the Life domain portion of the POS, and therefore monitored along with all other domains. Outcomes will be reviewed and progress measured by the Child and Family Team at least monthly and changes will be made if needed. Parents are the essential component of the Child and Family Team, are integral to every decision, and must approve the POS prior to implementation or changes to the POS, as evidenced by their signature on the POS. The Community Team formally reviews the POS at least every six months. The Wraparound Supervisor reviews the POS at least every three months. The Wraparound Facilitator, the Child and Family Team, Wraparound Supervisor, and the Community Team continually monitor participant health and welfare through their review of the crisis and safety plans.

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:*

While the Wraparound Facilitator provides direct services, the child and family team and the community team do not, and they ensure that monitoring is conducted in the best interest of the waiver participant.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of all POSs address participant's assessed needs and identify strategies for meeting those needs.

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:
	☐ **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: At least every six months by the Community Team.

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
All POSs are developed in accordance with MDCH established policies and procedures.

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:
	☐ **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: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of POSs are updated when the child's needs change or, if no changes have occurred, at least annually.

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:
	☐ **Other** Specify:	

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: miminum of 10% of the CMHSP's SEDW enrolled consumer records
	☐ **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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of POSs are reviewed by the CMHSP to ensure that the identified services are provided in the amount, frequency and duration specified.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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: at least every six months	

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: miminum of 10% of the CMHSP SEDW enrolled consumer records
	☐ **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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
100% of SEDW waiver consumers' parents or legal guardians are offered the choice between SEDW services and services in the state psychiatric hospital.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: at the time of initial application and annual re-certifications.	

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:
100% of SEDW consumers are informed of their right to chose among enrolled qualified service providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: mimimum of 10% of the CMHSP SEDW enrolled consumer records
	☐ **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.
The Child and Family Team is charged with developing a POS for each child and family. The Wraparound Facilitator works with the team through the steps of the wraparound process to identify the child's and family's needs and create an action plan that is outcome driven. The team determines the type, amount, duration and frequency of services that will be provided, with the family having the lead voice on what makes sense to meet the outcomes. The Team also ensures that the POS incorporates strengths and is culturally relevant. The Child and Family Team review the POS at least monthly and changes are made as needed. Outcomes are reviewed and progress is measured by the Child and Family Team at least monthly. The Community Team also reviews and approves the plan initially and at least every six months and tracks service utilization.

The Wraparound supervisor reviews the POS at least every three months and the Community Team formally reviews the POS every six months. The Child and Family Team, supervisor and the Community Team also review the crisis and safety plans.

When the MDCH SEDW site review team reviews a consumer record they look for the following things specific to the POS:
the individual POS addresses the consumer's assessed needs and identifies the services by type, amount, frequency and duration; the POS was developed in accordance with the Wraparound principals; and services were delivered in accordance with the POS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Any findings noted during the site review process are included in a formal report issued by the MDCH to the PIHP/CMHSP. The PIHP/CMHSP 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 Teams review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP/CMHSP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

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 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)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

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.

When an individual represents themselves for intake at a CMHSP they are provided basic information regarding available services, recipient rights, local dispute resolution and administrative hearings. At the time of POS development, the consumer is again notified of these rights.

The MDCH Administrative Tribunal provides an hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or CMHSP. The Administrative Tribunal issues timely and legally accurate hearing decisions and orders. Consumers can access the Administrative Tribunal Policy and Procedures manual on the MDCH website.

The parent or guardian must be sent a written notice of actions affecting eligibility or amounts of Medicaid benefits or Medicaid covered services for their child. This may include a termination, suspension or reduction of Medicaid eligibility or covered services. There are two types of written notice: 1) Adequate Action Notice, which is a written notice sent to the parent or guardian at the same time an action takes effect. Adequate notice is provided in the following circumstances: Denial of new services not currently being provided; Approval or denial of an application; Completion of a Plan of Service; Increase in service benefits. 2) Advance Action Notice is required when an action is being taken to reduce, suspend or terminate a benefit or service the child is currently receiving. The notice must be mailed at least 12 days before the intended action takes effect. The action is pended to provide the parent or guardian an opportunity to react to the proposed action. If the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the ALJ or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

The Request for Hearing form (DCH-0092) or its equivalent is sent to the parent or guardian with all adequate or advance notices. It is the responsibility of the CMHSP to designate a hearings coordinator who will serve as the liaison between the agency and the Administrative Tribunal. The purpose of the hearings coordinator is to serve as the single contact point for the Administrative Tribunal in order to communicate procedural aspects of any case. The hearings coordinator may also represent the CMHSP at a hearing.

If a parent or guardian wants to appeal an action, the request for a hearing must be in writing and sent to the State Office of Administrative Hearings and Rules (often referred to as the Administrative Tribunal).

The parent/guardian or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The State Office of Administrative Hearings and Rules must receive the written hearing request within that 90-day period. If a Medicaid covered service is being reduced, suspended or terminated, a written notice must be mailed to the child or authorized representative at least 12 days before the intended action takes effect. The letter sent to the parent/guardian also indicates that if the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the ALJ, or the parent or guardian withdraws the request for hearing, or the parent or guardian does not
appear at a scheduled hearing.

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules assigns a docket number and faxes a copy of the Request for Hearing to the CMHSP that took the action being appealed. The hearings coordinator is responsible for receiving hearing requests, identifying the responsible staff and forwarding a completed Hearing Summary to the State Office of Administrative Hearings and Rules and the appellant within 14 days of receipt of the hearing request, but no later than seven (7) days prior to a scheduled hearing date.

The CMHSP staff prepares the DCH-0367 Hearing Summary form and presents the case at the hearing. The Hearing Summary must be completed in its entirety. The narrative must include all of the following: A clear statement of the action or decision being appealed, including all programs involved in the action; Facts which led to the action or decision; Policy which supported the action or decision; Correct address of the appellant or authorized hearing representative; Copy of the documents the CMHSP intends to offer as exhibits at the hearing; Appellants and authorized hearing representatives (AHR) have the right to review the case record and obtain copies of all documents and materials to be used or relied upon at the hearing. (A copy of the hearing summary, and all supporting documents to be used at the hearing, is sent to the appellant and AHR. All parties should receive copies of the Hearing Summary and all documents at least seven days before the scheduled hearing.) A copy of the documents is also sent to the Children's Home and Community Based Waiver Director.

Hearings are routinely scheduled for telephone conference calls. The ALJ conducts the hearing from his/her office. The appellant or AHR is directed to the local CMHSP or other location as indicated on the notice. The appellant or AHR may

request permission of the Administrative Tribunal to appear by phone from an alternative location. The request must be made to the State Office of Administrative Hearings and Rules at least one full business day before the hearing. The appellant or AHR may request the ALJ appear in person at the hearing. The ALJ will travel to the local office or facility.

The parties present their positions to the ALJ who determines whether the actions taken are correct according to fact, law, policy and procedure. Following opening statement(s), if any, the ALJ directs the CMHSP representative to explain the agency's position. The Hearing Summary, or highlights of it, may be read into the record. The Hearing Summary may be used as a guide in presenting evidence.

Both parties must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses and cross-examine the author of a document offered in evidence. The ALJ must ensure the record is complete and may take an active role in the questioning of witnesses and parties. The ALJ will assist either side to ensure all necessary information is presented on the record, or refuse to accept evidence the ALJ believes is unduly repetitious, immaterial, irrelevant or incompetent. Either party may state on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement and object to evidence the party believes should not be part of the hearing record. When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and the reason it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides.

An appellant or AHR may agree to withdraw their Request for Hearing at any time during the hearing process. The appellant or AHR should complete the DCH-0093 – Request for Withdrawal of Appeal or its equivalent and return it immediately in the postage paid envelope to the State Office of Administrative Hearings and Rules. The Request for Withdrawal of Appeal can be ordered via the Administrative Tribunal Forms Requisition.

When an issue is still in dispute, the appellant or AHR is not to be asked to withdraw their Request for Hearing or to be mailed a withdrawal form unless asked to do so by the appellant.

When all issues have been resolved, the appellant or AHR may wish to withdraw the Request for Hearing. A Request for Withdrawal of Appeal form can be submitted, or the appellant or AHR can submit a signed, written statement. The withdrawal must clearly state why the appellant or AHR has decided to withdraw the Request for Hearing. All identifying case information is entered on the withdrawal form, and the original copy is attached to the request and forwarded to the State Office of Administrative Hearings and Rules. A copy of the withdrawal is maintained in the child's record.

The ALJ's Decision and Order is the final determination of MDCH. Rehearing or reconsiderations may be requested within 30 days of the Decision and Order. The State Office of Administrative Hearings and Rules will send the Decision and Order to the appellant or the AHR for the CMHSP. The State Office of Administrative Hearings and Rules will send a DCH-0829 - Order Certification with the Decision and Order to the AHR if the Decision and Order requires implementation by CMHSP. Since the Order Certification confirms the status of the Decision and Order's implementation (e.g., when the Decision and Order has or will be acted upon), it must be completed in a timely manner and returned to the State Office of Administrative Hearings and Rules. It is the AHR's responsibility to ensure that the decision is implemented within 10 calendar days of the Decision and Order mailing date.

All documentation is maintained in the waiver participant's file.

In addition to the Fair Hearing Process described above the MDCH/PIHP contract requires each PIHP/CMHSP to develop and publish a local dispute resolution process. The MDCH/CMHSP Managed Mental Health Supports and Services Contract, FY 06-07 Attachment C6.3.2.1 details the CMHSP local Dispute Resolution process.
"All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental heath services many access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDCH/CMHSP contract. Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment Pl6l3l2l1 of the MDCH contracts with the Pre-paid Inpatient Health Plans (PIHPs). It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

Chapters 7, 7a, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. For the purposes of this requirement, the focus will be on those complaints related to the denial, reduction, suspension or termination of services

and supports. Each CMHSP must have a written description of its local dispute resolution process available for review by MDCH. The description must reflect all of the requirements below and indicate if the CMHSP ORR system is to be used, and if so, any modification or additions to the CMHSP ORR system to be implemented…"

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**

a. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Per the Michigan Mental Health Code the PIHP/CMHSP (not the State) administers a local dispute resolution process. This process can be used by any consumer to bring a complaint, allegation of rights violation or request mediation to resolve their concern. When the consumer is a Medicaid recipient they also have a right to an administrative hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

b. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Michigan Mental Health Code establishes an Office of Recipient Rights (ORR) within the MDCH, each CMHSP and licensed hospitals. Each CMHSP must complete a recipient rights data report at semi-annual and annual interval. Information from these reports are feed into a database which produces a rolled up report by waiver programs.
The following allegations are report: Abuse Class I, Abuse Class II, Abuse Class III, Abuse I-sexual abuse, Neglect Class I, Neglect Class II, Neglect Class III, Access to Rights System, Retaliation and Harassment, Complaint investigation process, Failure to Report, Denial of Services, Civil Rights, Religious Practice, Family Dignity and Respect, Visitation, Access to Telephone, Written/Posted Limitations, Uncensored Mail, Access to entertainment materials, Disclosure of Confidential Information, Withholding of Information (includes recipient access), Correction of Record, Safe Treatment Environment, Sanitary Treatment Environment, Humane Treatment Environment, Dignity and Respect, Nutrition, Restrictions/limitations, Restraint, Seclusion, Safeguarding Money, Facility Account, Easy Access to Account, Ability to Spend or Use as Desired, Delivery of Money Upon Release, Labor and Compensation, Property Possession and Use, Property Search/Seizure, Property Limitations, Protection of Person Property, Treatment suited to Condition, Treatment by Spiritual Means, Physical and Mental Exams, Choice of Mental Health Professional, Notice of Clinical Progress, Services of Mental Health Professional, Informed Consent, Psychotropic Drugs, Notice of Medication Side Effects, Person-Centered Process, PCP-Timely Development, Request for Review, Assessment of Needs, Prior Consent. The revised Department of Community Health Administrative Rules, effective 12/5/07 included Exploitation as a Abuse II offense.

It is required that anyone who witnesses or becomes aware of a critical event or incident must fill out an incident report. The person witnessing the incident must respond to the needs of the consumer immediately. The timeframes for completing and submitting an incident report vary with the CMHSP. If the incident rises to the level of a sentinel evident (potential for loss of life, limb or function)then there is a 90 clock for investigation and reporting to MDCH.

In addition to the recipient rights reporting, MDCH requires each CMHSP serving SEDW enrollees to electronically report aggregated sentinel event data to MDCH every six months. Sentinel events are defined as an “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998) Sentinel events include recipient death, injuries requiring emergency room visits or hospital admission, physical illness requiring hospital admission, arrest or conviction, serious challenging behaviors, and medication errors.

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

The MDCH Office of Recipient Rights assures that providers of mental health services maintain a rights system consistent with standards established in the Michigan Mental Health Code (PA 258 of 1974, as amended).Office of Recipients Rights (ORR) staff are housed at MDCH in Lansing. Each of the state hospitals and centers also house ORR staff. Finally, each CMHSP has an Office of Recipient Rights.

Each CMHSP is assessed yearly through review and follow-up on semi-annual and annual reports produced jointly by the CMHSP’s Executive Director and their Rights Office. On-site assessments are conducted of approximately

one-third of CMHSPs each year. This review includes interviews with the Executive Director, rights staff, consumers, and staff of contractual providers; compliance reviews of case files and logs; training requirements; and compliance with all 22 rights-related policies required by the Mental Health Code. Site visits are also made to LPH/Us under contract with the CMHSPs.

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.

Charpter 7 of the Michigan Mental Health Code is dedicated to Recipient Rights , including, but not limited to:

330.1706 Notice of rights

Section 706:
Except as provided in section 707, 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.

330.1706a Pamphlet; preparation; distribution; contents.
Section. 706a.
(1) The department shall prepare and distribute to each community mental health services program copies of a pamphlet containing information regarding resources available to individuals with serious mental illness and their families. The information shall include a description of advocacy and support groups, and other information of interest to recipients and their families. The pamphlet shall include the name, address, and telephone number of the organization designated by the governor under section 931 to provide protection and advocacy for individuals with developmental disability or mental illness.
(2) A community mental health services program shall distribute the pamphlet described in subsection (1) to each recipient receiving services through the community mental health services program and, if applicable, to the recipient's guardian or the parent of a minor recipient.
330.1722 Protection of recipient from abuse or neglect.
Sec. 722.
(1) A recipient of mental health services shall not be subjected to abuse or neglect.
(2) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, community mental health services program, or licensed hospital shall ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect.
(3) A recipient of mental health services who is abused or neglected has a right to pursue injunctive and other appropriate civil relief.

330.1755 Office of recipient rights; establishment by community mental health services program and hospital.
Sec. 755.
(5) Each office of recipient rights established under this section shall do all of the following:
(a) Provide or coordinate the protection of recipient rights for all directly operated or contracted services.
(b) Ensure that recipients, parents of minor recipients, and guardians or other legal representatives have access to summaries of the rights guaranteed by this chapter and chapter 7a and are notified of those rights in an understandable manner, both at the time services are initiated and periodically during the time services are provided to the recipient.
(c) Ensure that the telephone number and address of the office of recipient rights and the names of rights officers are conspicuously posted in all service sites.

MDCH Rights offices at facilities are required to do consumer training per the ORR Field manager. At this point in time, the Code only requires staff training, however many CMHSP rights offices do consumer training on recipient rights. Additionally,The MDCH holds both an annual Recipient Rights Conference and an annual Consumer Conference, and an annual Home and Community Based Waiver Conference, all of which include participants and/or their families. Both conferences provided Recipient Rights training that describe the rights consumers have 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.

Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP/CMHSP for the following persons: those receiving Targeted Case Management, enrolled in the Habilitation Supports Waiver, Children's Waiver and the SED waiver , those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services. Sentinel events are reviewed, investigated and acted upon at the local level by each CMHSP and reported to MDCH directly. A sentinel evident (potential for loss of life, limb or function)must be nvestigated and reported to MDCH within 90 days. This information is reported in the aggregate to the MDCH semi-annually.

Michigan law and rules require the mandatory reporting of recipient rights complaints within 48 hours to the CMHSPs' Office of Recipient Rights (ORR) for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to CMHSPs. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Recipient Rights: Semi-annually, local CMHSP ORRs report 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, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state ORR and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC, and waiver staff.

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.

Each CMHSP must complete a recipient rights data report to MDCH at semi-annual and annual interval. Information from these reports are feed into a database which produces a rolled up report by waiver programs. MDCH also requires each CMHSP serving SEDW enrollees to electronically report aggregated sentinel event data to MDCH every six months. Follow-up actions by MDCH include data confirmation, consultation, and on-site follow-up. Post CMHSP sentinel event data submission, MDCH staff contacts the CMHSPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required. On-site follow-up on reported sentinel events takes place during MDCH biennial site reviews. During these site reviews, MDCH staff review the CMHSP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of sentinel event would re-occur. Any noted shortcomings in the CMHSP'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 CMHSP and additional follow-up by MDCH.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

At the local (CMHSP) level, the Child and Family Team, the Community Team and the Wraparound supervisor are responsible for regular review of the Plan of Service and the Crisis and Safety plans. This oversight provides opportunity for early detection of unauthorized use of restraints and/or seclusion. If/when a questionable practice is identified, the Plan of Service is reviewed by the Behavioral Management Committee does not include the unauthorized use of restraint or seclusion.

The previously described ORR reporting system provides the mechanism for reporting, investigating and following-up on allegations or unauthorized use of restraints or seclusion.

At the state level, site reviews conducted by the QMP and SEDW staff provide the mechanism for assuring the health and safety of waiver participants.

ORR annual site reviews include a review policies regarding restraints or seclusion policy.

○ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

At the local (CMHSP) level, the Child and Family Team, the Community Team and the Wraparound supervisor are responsible for regular review of the Plan of Service and the Crisis and Safety plans. This oversight provides opportunity for early detection of unauthorized use of restrictive interventions. If/when a questionable practice is identified, the Plan of Service is reviewed by the Behavioral Management Committee does not include the unauthorized use of restrictive interventions.

The previously described sentinel event reporting system provides the mechanism for reporting, investigating and following-up on allegations or unauthorized use of restrictive interventions.

At the state level, site reviews conducted by the QMP and SEDW staff provide the mechanism for assuring the health and safety of waiver participants.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

a. Medication Management and Follow-Up

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

The SEDW services to which this appendix applies are: Respite provided in a foster home, therapeutic foster care, and therapeutic overnight camp. Foster Care licensing rules require that incident reports be completed when a medication error occurs. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs (wrong person, wrong medication, wrong dosage, wrong time, and wrong route). 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.

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.

At the local level the child and family team is responsible for monitoring the health and safety of the child (including Medication administration) as identified in the child's POS, while in any community setting. Communication is therefore between the provider and the child and family team, not between the provider and the Medicaid State agency. Please see Appendix G-1: response to Critical Events or Incidents.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

i. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The SEDW services to which this appendix applies are: Respite provided in a foster home, therapeutic foster care, and therapeutic overnight camp. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these setting the waiver service provider would administer medications as prescribed by the physician.

The following rule applies to licensed family foster homes for children.
Rule 400.9411 Medical and dental care.
Rule 411. (1) A foster parent shall follow and carry out the health plan for a foster child as prescribed by a physician, health authority, or the agency.
(2) A foster parent shall follow agency approved protocols for medical care of a foster child who is injured or ill.
(3) A foster parent shall ensure that medications are inaccessible to children unless medically necessary.
(4) A foster parent shall ensure that prescription medication is given or applied as directed by a licensed physician.

The following rule applies to licensed camps for children.
R 400.11119 Health service policy.
Rule 119. (1) A camp shall have and follow a written health service policy that is appropriate to the population served and the environment of the campsite.
(2) A camp shall establish the health service policy in consultation with, and reviewed annually by, a licensed physician. (3) A camp's health service policy shall cover all of the following subjects:.....(f) The storage and administration of prescription and nonprescription drugs and medications.

ii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reviewed, investigated and acted upon at the local level by each CMHSP and reported to MDCH directly when the error is considered a sentinel evident . This information is reported in the aggregate to the MDCH semi-annually.

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

Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors a-d to the Department, but only when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs (wrong person, wrong medication, wrong dosage, wrong time, wrong route). 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.

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

"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. It does not include instances in which consumers have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDCH, when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

On-site follow-up on reported sentinel events regarding medication errors take place during MDCH biennial site reviews. During these site reviews, MDCH staff review the CMHSP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that this type of sentinel event would re-occur. Any noted shortcomings in the CMHSP'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 CMHSP and additional follow-up by MDCH. Post CMHSP sentinel event data submission, MDCH staff contacts the CMHSPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required. On-site follow-up on reported sentinel events takes place during MDCH biennial site reviews. During these site reviews, MDCH staff review the CMHSP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of sentinel event would re-occur. Any noted shortcomings in the CMHSP'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 CMHSP and additional follow-up by MDCH.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
All CMHSPs review, investigate, and act upon all sentinel events and report to MDCH.

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: semi-annually

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 CMHSP's submit semiannually aggregate data by event category
for number of sentinel events and plans of action or interventions which occurred during the 6-month period. MDCH analyzes the data and prepares a report on the # of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance indicators, MDCH reviews performance, with potential follow-up by contract managers to determine what quality improvement action is taking place;

and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

In the Final Report CMS requested information regarding effectiveness of the prevention policies and procedures for this waiver. As indicated elsewhere in this application each consumer has an individualized POS developed based on the child's assessed needs and strengths. The POS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each consumer. The Crisis and Safety Plans are proactive in that they identify strategies that seek to prevent crisis and maintain safety for the consumer, the family and the community. Required staff training includes training in the individual POS, as well as in Recipient Rights. The POS is overseen by the Child and Family Team, as well as the Community Team.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All incidents should be reviewed to determine if the incidents meet the criteria and definitions for sentinel events and if they are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events. 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 (JCAHO) or investigation (per CMS approval and MDCH contractual requirement) 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." (JCAHO, 1998)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 MDCH 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.

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: semi-annually

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

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.

Michigan's Quality Management Program (QMP)incorporates all of the programs operated in the public mental health system, including the HCBS waivers B/C Control # MI-14.R04, Habilitation Support Waiver (HSW)Control # 0167.90.R3,Children's Waiver Control #4119.90.R3.01, and the SEDW Control # 0438.01. The PIHPs/CMHSPs adhere to the same standards of care for each individual served and the same data is collected for all consumers regardless of fund source. Each PIHP/CMHSP meets the standards for certification as specified in the Mental Health Code and Medicaid Provider Manual. The MDCH QMP staff is responsible for implementing the QMP at the 18 PIHPs (comprised of all CMHSPs), and sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews. 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 covers all consumers served by all of Michigan's waivers with rigorous standards for assuring the health and welfare of the 1915(c) waiver consumers' homes. The comprehensive reviews include the clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews.

Clinical record review are completed to determine that person-centered/family-centered planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meets program requirements that are published in the Medicaid Provider Manual. The MDCH QMP staff draws random samples of clinical records from encounter data in the MDCH warehouse. Scope of reviews includes all Medicaid State Plan and 1915(b)(3) services, and waiver programs (including the SEDW with renewal approval), all affiliates (if applicable), a sample of providers, and a sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:
o PIHP/CMHSP Compliance with the Medicaid Provider Manual
o Written agreements with providers, community agencies
o The results of the PIHP/CMHSPs' annual monitoring of its provider network
o Adherence to contractual practice guidelines
o Sentinel event management

Consumer/Stakeholder Meetings are completed during the biennial comprehensive review. The QMP staff meet with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered/family-centered planning, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the Quality Assessment and Performance Improvement Programs (QAPIP) and customer services; and the provider's responsiveness to the group's concerns and suggestions.

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 where consumers reside in group homes or living independently with intense and continuous in-home staff or in the homes of families served by the waivers. Interviews of other consumers may be conducted in the provider's office or over the telephone.

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 MDCH in 30 days. On-site follow-up will be conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council, and SED staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QMP has been developed with the input of consumers and the Mental Health Quality Improvement Council (QIC) that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Service Boards. Michigan's QMP reflects the activities, concerns, input or recommendations from the Michigan Mental Health

Commission, MDCHs Encounter Data Integrity Team, MDCHs Administrative Simplification Process Improvement Team, the 2007 External Quality Review (EQR), and the terms and conditions from CMS' previous waiver approvals.

The existing infrastructure in Michigan includes 1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State plan through a managed care delivery system. The combined 1915(b) with the 1915(c) HSW enables Michigan to use typical Medicaid managed care program features such as quality improvement performance plans and external quality reviews to effectively monitor waiver programs. These same quality improvement performance plans and external quality reviews are used to monitor the CMHSPs in their provision of SEDW services. Because the SEDW is a fee-for-service program and is not covered under Michigan's managed care delivery system, the CMHSPs are the sub-state entity responsible for the day to day implementation of the SEDW.

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 MDCH/CMHSP contracts; and they are reviewed by MDCH staff and/or the external quality review process. While a review of the following three areas is not specific to the SEDW, 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. Very few clinical record reviews are completed as part of this process. One EQR Component addresses PIHP compliance to BBA requirements. The other two EQR activities, Performance Improvement Program Validation and Performance Measures Validation, have essentially no direct relationship to SEDW service delivery or quality management.

The following minimum standards for customer services are covered by the MDCH QMP on-site visit or the External Quality Review (EQR):

a. Customer services operation is clearly defined.
b. Customer service staff is knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT).
c. 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.
d. Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP.
e. The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice.
f. Customer services is managed in a way that 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.
g. The relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined organizationally and managerially 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 on-site 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 MDCH. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify CMHSPs that have particularly high volumes of appeals.

Quality Assessment and Performance Improvement Programs: The MDCH contracts with PIHP/CMHSPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors, on-site, the PIHP/CMHSPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: sentinel Events and credentialing of providers. MDCH collects data for performance indicators and performance improvement projects as described in b.i. below.

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the External Quality Reviews

(EQR). The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both. The scope of the review for Years One, Two and Three were: Validation of Performance improvement projects; Validation of performance indicators; and Compliance with Michigan's Quality Standards and BBA requirements.

In addition to the QMP strategies listed above that are implemented for all consumers, the SEDW staff conduct both state level reviews of all applications and re-certifications, and on-site reviews of clinical and administrative records. The on-site reviews use a SEDW quality management protocol to ensure that federal requirements and assurances of quality are met. The SEDW staff includes a Psychiatrist, limited licensed psychologist, two masters' level social workers, and an individual with a master's degree in public health. On -site reviews of the CMHSPs are conducted bi-annually by the SEDW staff with follow-up reviews in the alternate years by the QMP staff. A report of the findings is provided to the CMHSP, along with a copy to the MDCH Manager of the QMP, and the MDCH Contract Manager. A plan of correction must be submitted to MDCH within 30 days if the review staff identifies areas of needed improvement or noncompliance. Information shared with the MDCH contract managers is used by MDCH to take contract action as needed for system improvements.

As the SEDW is new the site reviews have yielded insufficient data from which to trend patterns of effectiveness or to develop strategies for improvement. However, data from site reviews and consultations has been used for more informal systems improvement activities. Examples include: refining the performance indicators and measures for assessing fidelity to the model used in the site review process; developing workshops for the Annual Statewide Waiver conference, developing materials to assist agencies and communities in assessing their readiness for participation in the SEDW; and identifying topics for technical assistance workshops at both state and local levels to address affective systems of care for this population.

Michigan is discussing a strategy for stratifying audit data by each waiver population, to be available at the time of the next CMS Quality Review.

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:

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.

MDCH collects data for performance indicators and performance improvement projects for each of there areas:Medicaid performance indicators measure the performance of the PIHP/CMHSPs. The QIC performance indicators are categorized by the following domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP/CMHSP issues that need to be addressed immediately; to identify trends to be watched; 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 and QI data located in MDCH's data warehouse. Any data that is submitted in

the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDCH 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 MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and SEDW staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Participant level encounter data is reported electronically in HIPAA-compliant format each month for services provided in the previous month and for which claims have been adjudicated. Demographic data are also reported monthly for each individual. Aggregate data from the encounter data system are shared with the MDCH Mental Health and Substance Abuse Management Team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. The SEDW staff review data for those individuals enrolled in the SEDW and whose records will be reviewed as part of an on-site review. This review process is used to ensure that services billed to and paid by the SEDW were included in the approved POS. This review process is also used to assure the participant receives services in the amount and frequency, as identified in the POS. At the time that SEDW claims are processed through CHAMPS (the new Medicaid Management Information System) data will be pulled from the data warehouse, as it is for all other programs. It is expected to occur sometime in 2009.

PHIPs are required by contract to submit Medicaid sub-element cost reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PHIP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PHIP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP for the following persons: those receiving Targeted Case Management, enrolled in the HSW, 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 MDCH semi-annually. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and SEDW staff. Information is used by MDCH to take contract action as needed, becomes the focus of on-site reviews conducted by MDCH, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP ORRs 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: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. 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 MDCH Mental Health and Substance Abuse Management team, the QIC, and SEDW staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years with interim updates as necessary (e.g., changes/additions of new providers: termination of contracts, change in accreditation status, change of address). This information is kept in a database and is used by the Mental Health and Substance Abuse Administration to verify the capacity of the service network.

The MDCH staff collaborates 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 MDCH; 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 MDCH performance improvement project reports are shared with MDCH Mental Health and Substance Abuse Management team, the QIC and SEDW staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDCH staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team, with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

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

The SEDW is just finishing its initial approval period, which included an initial site review at each participating CMHSP. These have yielded insufficient data to formally evaluate the quality improvement strategy. However, it was reviewed for effectiveness and we have determined that no change is needed at this time.

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 validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted by each participating CMHSP. SEDW revenue and expenditures are uniquely identified on these FSRs, which also break out SEDW expenses by federal, local, and state funding sources. During the contract reconciliation and cash settlement process, MDCH staff reconciles the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with federal SEDW revenues. Documentation for the contract reconciliation, cash settlement and the SEDW local match analysis is maintained in the Bureau of Finance.

Beginning with the 1998-2000 contract extension with MDCH, the CMHSPs were obligated to implement the Federal Guidelines for Quality Assessment and Performance Improvement Programs (QAPIP). These guidelines were subsequently replaced with the administrative regulations promulgated as part of the Balanced Budget Act (BBA) of 1997. Among the 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 MDCH's Division of QMP annually.

The PIHP/CMHSP monitors 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 follow

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 MDCH 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.

Beginning fiscal year 2007 the PIHP/CMHSPs are required by contract to secure an independent audit conducted by a CPA external to the organization. This audit tests for compliance with the provisions of the PIHP/CMHSP contracts with MDCH. Specifically it tests to confirm that the FSRs are reconciled to the PIHP/CMHSPs internal financial reports. These compliance exams are submitted to the MDCH Office of Audit.

PIHPs/CMHSPs are also required to contract annually for an independent audit of financial policies, practices and statements. This Financial Statement Audit tests for conformance with generally accepted accounting principles (GAAP), and is performed in accordance with Government Auditing Standards. The audit is submitted to the PIHP/CMHSP and a copy is sent to the MDCH Office of Audit.

The requirments for a Compliance Exam and the Financial Statement Audit do not replace or remove any other audit requirements that may exist, such as a Single Audit. If a PIHP or CMHSP expends $500,000 or more in federal awards, they must obtain a Single Audit. Of the SEDW participating CMHSPs all but Livingston and Van Buren meet this requirement. In general, if a SEDW participating CMHSP is exempt from the Single Audit the SEDW must be tested as part of the CMHSP's Compliance Exam. In addition, if the Single Audit does not cover the SEDW then the SEDW may be tested as part of the Compliance Exam.

(b) As the Medicaid enrolled mental health services provider, participating CMHSPs bill MDCH-MSA for SEDW services. Claims submitted for SEDW services currently are processed manually, as they cannot be processed through the Medicaid Management Information System (MMIS) without substantial programming changes. Michigan is mid-stream in design and implementation of the Community Health Automated Medicaid Processing System (CHAMPS) that will be used to process and pay all Medicaid claims, including fee-for-service payments for services provided to SEDW consumers. The target date for implementation of CHAMPS is early 2009. Systems' requirements to enable processing SEDW claims through CHAMPS have been included in all aspects of design for the new system, and SEDW claims will be paid through that system when it is operational.

The manual payment process has been designed to replicate the essential claims processing functions associated with the MMIS, including the edits that assure accountability. After validation of each claim line, which includes verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service and that the quantity billed does not exceed the parameter for the service, the MSA staff enters gross billing information into an Oracle database. The approved reimbursement amount is the actual cost of the service or the fee screen whichever is less. From this data, a payment voucher and supporting documentation is created and forwarded to the Bureau of Finance. The supporting documentation serves as a remittance advice. Finance staff then calculates and processes payment to the CMHSP. Match for the federal share is provided in one of three ways: State General Fund dollars redirected by MDHS, State General Fund dollars allocated to CMHSPs by MDCH, and local funds allocated or approved by the CMHSP and their local partners.

The SEDW Site Review Team reviews Medicaid billing invoices, budgets and POS's. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were recommended by the Child and Family Team, and were approved by the Community Team.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
SEDW claims are included in the annual Medicaid Services Verification audit completed by all participating CMHSPs and reported to MDCH.

Data Source (Select one):
Financial audits
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: Sampling methodologies are used to conduct the Medicaid Services Verification reviews, which cover all Medicaid-reimbursed services.
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDCH review of the Medicaid Billing Verification Audit 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** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
All SEDW claims are manually reviewed to ensure that: the code is billable; the submitted quantity and frequency is within the established parameters for quantity and frequency; and is paid at the lesser of the charge or the Medicaid fee screen.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Claims submitted by the CMHSPs to Medicaid

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:

All required local match for SEDW services is validated by MDCH during the contract reconciliation and cash settlement process.

Data Source (Select one):
Financial records (including expenditures)
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**

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The PIHP/CMHSP monitors claims through the services verification review process described in I-1 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 follow 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 MDCH 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.

The SEDW Site Review Team reviews Medicaid billing invoices, budgets and POS's. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were recommended by the Child and Family Team, and were approved by the Community Team. If a problem is identified in the course of the site review, the CMHSP is required to address the problem in their plan of correction.

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).

Service Review – Pilot Programs:

For the initial SEDW Application, the services provided in the pilot projects / programs identified below were reviewed for relevance / conformance with the services to be provided under this waiver. The Healthcare Common Procedure Coding System (HCPCS) was then reviewed to identify applicable national codes, service descriptions, units of service and Relative Value Units (RVUs). (For the initial SEDW Application, data from these sources was also used to estimate service utilization and the length of time children received the various types of services to be provided under this waiver.)

Services Which Have an RVU:

For all codes which have an RVU, Medicaid uses the RVU to price the procedure code. The National Physician Fee Schedule Relative Value File is downloaded from CMS. At the beginning of each year it is determined which conversion factor Medicaid will use when determining the fee screen for that year. The RVUs and conversion factors can change from year to year – sometimes quarterly. Currently Medicaid is using the formula of (RVU x $21.53) to determine the fee schedule for RVU codes. This formula is not inclusive of the legislatively mandated 4% decrease applied across-the-board with few exceptions in 2005.

Services Which Do Not Have an RVU:

For SEDW services for which there is no RVU, rates were set based on data from pilot projects/programs, and from SEDW participating CMHSPs providing similar services. Data was used from the following programs:

1. A federally funded (SAMHSA-CMHS) pilot project in Wayne County (Southwest Detroit). The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N=169)

2. A Livingston County CMHSP pilot program providing case rate wraparound services to 19 Medicaid eligible individuals. The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N=19) Additional data from several partial fiscal years was used to estimate the average amount of time a child remained in wraparound services provided by the Livingston County CMHSP.

3. Data from wraparound services provided to 466 children served by 20 Community Mental Health Service Programs (CMHSPs).

4. Encounter data reported by the CMHSPs for selected services (e.g., Community Living Services).

Detail re: Specific SEDW Services:

1. COMMUNITY-BASED WRAP-AROUND SERVICES (H2022 - $340.00 per day; maximum of 4 billable days per month); This service is a highly individualized planning process using the Wraparound model to coordinate the planning for, and delivery of, services and supports that are medically necessary for the consumer. It is an "all inclusive" service that includes developing an individualized plan of service; linking to, coordinating with, follow-up of, advocacy with, and monitoring of waiver services, other state plan services, and other community services and supports; brokering of providers of services; assistance with access to other entitlements; and coordination with the Medicaid health plan or other health care providers. This service includes both direct (i.e., face-to-face) and collateral activity, and can be billed to Medicaid up to 4 times per month. The billable date-of-service is one on which there was a face-to-face encounter with the consumer. The range of costs from the pilot programs was $875.68 - $1360.00 per month, depending on the Wraparound service model used and the number of contact hours for consumers across the length of the pilot program.

2. RESPITE CARE SERVICES; UP TO 15 MIN (T1005 - $6.40 per 15 minutes; maximum of 1248 billable units per month): The range of costs for this service was $3.60 - $8.00 per 15 minutes, with the variance dependent on whether the service was provided by CMHSP employees, by an employee of a contracted agency, and the setting in which the respite was provided (i.e., in the consumer's own home/place of residence, in the home of a family friend or in a licensed foster home).

3. THERAPEUTIC CAMPING, OVERNIGHT (T2023 - $1400.00 per session; maximum of 3 billable sessions per year): This is a group recreational and skill building service in a camp setting aimed at meeting a goal(s) detailed in the consumer's individualized plan of service. A session can be one or more days and nights of camp. Payment includes camp fees (including enrollment and other fees), transportation to and from camp, additional costs for staff with specialized training with this population. Payment for room and board is excluded from the charge billable to Medicaid for this service. Separate charges for staff cannot be billed to Medicaid. The range of costs for this service was $777.00 - $2100.00, with the variance dependent on the staff to camper ratio, the number of days/nights comprising a "session", and the fees associated with the camp session.

4. THERAPEUTIC FOSTER CARE (S5145 - $110.00 per day): This service provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include: intensive parental supervision, positive adult-youth relationships, a foster home serving only 1 youth at a time, and family behavior management skills. Separate payment is not made for homemaker or chore services, or for community living services provided by the foster parents, or for respite care furnished for the foster care parents of a child receiving CTFC services, since these services are integral to and inherent in the provision of CTFC. The rate is based on cost information submitted by the CMHSPs and a survey of other therapeutic foster care programs around the country, including Arizona's Therapeutic Foster Care Program.

The daily rate covers $75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment -oriented appointments for the youth and family, data collection required as part of implementing the Individual Plan of Service (including a daily/weekly log and 24 hour supervision).

The daily rate also includes $35.00 per day to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.

The community team must find a resource to pay the room and board rate (established by the Department of Human Services) to the foster parent, as this must be paid separate from the enhanced therapeutic foster care rate and from a different funding source. Room and board cannot be billed to Medicaid. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials, and is based on the child's age. The rate for consumers age birth – 12 is $14.24 a day; and for consumers age 13-18 is $17.59 a day.

5. TRANSITION SERVICES (T2038 – requires prior authorization by the CMHSP; payment as approved by the CMHSP; maximum billable is one time only per consumer): This is a one-time only expense to assist consumers returning their home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to meet these obligations on an on-going basis. Coverage includes assistance with utilities, insurance and moving expenses where such expenses would pose a barrier to a successful transition to the consumer's family home; interim assistance with utilities, insurance or living expenses when the consumer's family is already living in an independent setting and experiences a temporary reduction or termination of their own or other community resources; home maintenance when, without a repair to the home or replacement of a necessary appliance, the

individual would be unable to move there, or – if already living there – would be forced to leave for health and safety reasons.

Coverage excludes adaptations or improvements to the home that are of general utility or are cosmetic; are considered to be standard housing obligations of the consumer's family; are not of direct medical or remedial benefit to the consumer; are for on-going housing costs; or are expenses for room and board that are not directly associated with transition arrangements while securing other benefits.

Requests for transition services must be prior authorized by the CMHSP following denial by all other applicable resources and in conformance with the agency's purchasing policies. Standards of value purchasing must be followed. All services must be in accordance with applicable state or local building codes.

Process:

Following established Medicaid policy and procedures, proposed rates, with supporting documentation, were submitted to the Medical Services Administrative (MSA) for review and approval. The policy includes a formal promulgation process following a chain of command which requires Medicaid's sign-off before non-standard rates are implemented. Upon approval of the rates, a SEDW fee screen database was developed and published on the Medicaid Provider website. This website, and therefore published rates, is available to consumers, as well as to providers and other parties of interest. When rates are also part of policy implementation or if there is a change in existing rates, a Medicaid Bulletin is used to notify all parties of interest. The bulletins go out for review and approval to both internal Medicaid staff and to interested parties who have said they would like to review proposed bulletins. After this approval and revision process, a final Medicaid Bulletin is sent to all parties who are impacted by the policy/rate change. All Medicaid Bulletins – both "final" and those that are out for review – are fully accessible to both consumers and providers on the MDCH/MSA website.

Payment:

The manual payment process has been designed to replicate the essential claims processing functions associated with the MMIS, including the edits that assure accountability. After validation of each claim line, which includes verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service and that the quantity billed does not exceed the parameter for the service, the MSA staff enters gross billing information into an Oracle database. The approved reimbursement amount is the actual cost of the service or the fee screen whichever is less. From this data, a payment voucher and supporting documentation is created and forwarded to the Bureau of Finance. The supporting documentation serves as a remittance advice. Finance staff then calculates and processes payment to the CMHSP for the federal portion only. Although the CMHSP contracts with MDCH, the CMHSP must provide the match to the federal share either through the State General Fund or local funds. This process is called a Certified Public Expenditure (CPE) and happens when local dollars are used to match a federal share. For all services billed to Medicaid, the CMHSP is paid the lesser of their cost/charge or the Medicaid fee screen established for the service.

State-wide Rate Setting Methodology:

Prior to submitting the Renewal Application for the Children's Waiver Program (for renewal effective October 1, 2010), Michigan will develop a state-wide methodology for review of established rates and for setting rates - applicable to both the CWP and the SEDW. Michigan will complete the required SEDW request for amendment of Appendix I-2 at that time.

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:

Participating CMHSPs and other qualified/approved community-based mental health and developmental disability services providers bill Medicaid directly for services to SEDW enrollees. The Provider sends a zipped, encrypted file to MDCH – Automated Billing (this is the manual payment unit within Medicaid). Claims must be submitted in the electronic ANSI X12N 837 4010A1 professional format. The file produces a data stream that includes the Medicaid Recipient Identification number, date of service, billable services (procedure codes), number of units of services provided, and charge/cost of service. Claims are completed in accordance with the Billing & Reimbursement for Professionals chapter of the Michigan Medicaid Provider Manual and the 837P Implementation Guide.

The manual payment process has been designed to replicate the essential claims processing functions associated with the MMIS, including the edits that assure accountability. After validation of each claim line, which includes verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service and that the quantity billed does not exceed the parameter for the service, the MSA staff enters gross billing information into an Oracle database. The approved reimbursement amount is the actual cost of the service or the fee screen whichever is less. From this data, a payment voucher and supporting documentation is created and forwarded to the Bureau of Finance. The supporting documentation serves as a remittance advice. Finance staff then calculates and processes payment to the CMHSP for the federal portion only. Although the CMHSP contracts with MDCH, the CMHSP must provide the match to the federal share either through the State General Fund or local funds. This process is called a Certified Public Expenditure (CPE) and happens when local dollars are used to match a federal share.

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)Participating CMHSPs
(b) & (c) Several vehicles are used to assure that the CPE is based on total computable costs for SEDW services: The Compliance Exam; Verification of fee-for- service billings by Medicaid staff and SEDW Site Review staff; and the contract reconciliation and cash settlement process. As described previously, the validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted from each of the participating CMHSPs. The SEDW revenue and expenditures are uniquely identified on the FSRs of the participating CMHSPs. SEDW expenses are broken out by federal, local, and state funding. During the contract reconciliation and cash settlement process, MDCH staff will reconcile the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with federal SEDW revenues. The contract reconciliation and cash settlement documentation and SEDW local match analysis is maintained in the Bureau of Finance.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) Pre-payment validation assures that claims are paid only for dates-of-service when the consumer was both eligible for Medicaid and enrolled in the SEDW. Currently, this pre-payment validation is done by Medicaid staff processing manual payments by consulting the list of SEDW enrollees, their MA Recipient ID#s and SEDW enrollment dates. When CHAMPS is operational, pre-payment validation will be accomplished by edits set by the weekly SEDW enrollment list sent by the SEDW Program to CHAMPS.

(b) and (c) Post-payment validation that billed services are included in the consumer's approved service plan and that billed services were provided is done at the time of the annual SEDW on-site review. It may also be done as part of the annual Medicaid Services Verification audit (as described in Appendix I-1 above).

The SEDW Site Review Team reviews Medicaid billing invoices, budgets, POSs, case notes, assessments and reports. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were recommended by the Child and Family Team, approved by the Community Team, and that the services were provided.

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:

As discussed in detail in I-1 above, as the Medicaid enrolled mental health services provider, participating CMHSPs bill MDCH-MSA for SEDW services. Claims submitted for SEDW services currently are processed manually, as they cannot be processed through the Medicaid Management Information System (MMIS) without substantial programming changes. Michigan is mid-stream in design and implementation of the Community Health Automated Medicaid Processing System (CHAMPS) that will be used to process and pay all Medicaid claims, including fee-for-service payments for services provided to SEDW consumers. The target date for implementation of CHAMPS is early 2009. Systems' requirements to enable processing SEDW claims through

CHAMPS have been included in all aspects of design for the new system, and SEDW claims will be paid through that system when it is operational.

The manual payment process has been designed to replicate the essential claims processing functions associated with the MMIS, including the edits that assure accountability. After validation of each claim line, which includes verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service and that the quantity billed does not exceed the parameter for the service, the MSA staff enters gross billing information into an Oracle database. The approved reimbursement amount is the actual cost of the service or the fee screen whichever is less. From this data, a payment voucher and supporting documentation is created and forwarded to the Bureau of Finance. The supporting documentation serves as a remittance advice. Finance staff then calculates and processes payment to the CMHSP for the federal portion only. Although the CMHSP contracts with MDCH, the CMHSP must provide the match to the federal share either through the State General Fund or local funds. This process is called a Certified Public Expenditure (CPE) and happens when local dollars are used to match a federal share.

MDCH utilizes a coding reduction technique where a Program Cost Account (PCA) is required on all payments / accounting entries. The PCA identifies various characteristics of the payments, including but not limited to the appropriation and funding source, grant number and grant phase and an agency code #1. These elements identify everything needed to properly identify on the CMS-64. At quarter end, MDCH – Grants Management staff prepares and submits the CMS-64 utilizing standardized reports based on the elements defined on the PCA. In addition, the Mental Health and CSHCS Support Section within the Bureau of Finance, prepares a confirmation memo, which details the SEDW costs and anticipated federal reimbursement. The Grants Management staff reconciles what is reflected in the standardized reports to what is reflected in the confirmation memo prior to submission of the CMS-64.

Through the CMHSP contract with MDCH, the CMHSP must provide the match to the federal share (i.e., the CPE) either through the State General Fund or local funds. The validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted from each of the participating CMHSPs. The SEDW revenue and expenditures are uniquely identified on the FSRs of the participating CMHSPs. SEDW expenses are broken out by federal, local, and state funding. During the contract reconciliation and cash settlement process, MDCH staff will reconcile the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with federal SEDW revenues. The contract reconciliation and cash settlement documentation and SEDW local match analysis is maintained in the Bureau of Finance.

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **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.

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: *Complete item I-3-e.*

The providers of SEDW services include participating CMHSPs and other qualified/approved community-based mental health and developmental disability services providers. The waiver services they provide are identified in Appendix C.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

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:

CMHSPs are considered Organized Health Care Delivery Systems (OHCDS). In a participating geographical area other mental health service providers may enroll with Medicaid and provide SEDW services if they meet the requirements of the Michigan Mental Health Code as an approved community based mental health and developmental disability services provider.

All direct service providers (e.g., CLS, respite) must: 1) be employed by the CMHSP or other approved community based mental health and developmental disability services provider; or 2) be part of the CMHSP's or other approved community based mental health and developmental disability services provider's network; or 3) have a current contract with the CMHSP or other approved community based mental health and developmental disability services provider. All direct service providers (e.g., CLS, respite) must meet qualifications as detailed in the SEDW renewal application and the Michigan Medicaid Provider Manual. SEDW enrollees have freedom to choose among qualified service providers.

When clinical and administrative records for SEDW enrollees are selected for an on-site review, records are sampled from each participating CMHSP or other approved community based mental health and developmental disability services provider. As detailed elsewhere in this renewal application, the on-site review of clinical and administrative records includes a detailed review of provider qualifications and agency contracts – including whether the contract contains clear performance expectations.

The process for financial accountability is the same whether the provider is a CMHSP or other approved community based mental health and developmental disability services provider. All participating CMHSPs and other approved community based mental health and developmental disability service providers are required to submit the same annual Financial Status Reports (FSRs) to MDCH and are subject to the same auditing requirements.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

The source of the non-federal share to MDCH Administration is funded through an appropriation of tax revenue paid to the CMHSPs as General Fund-formula funds. Should the CMHSP not have adequate local funds to provide local match they may use their General Fund dollars.

☑ **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:

As noted in I-1 the match for the federal share is provided in one of three ways: State General Fund dollars allocated to CMHSPs by MDCH, and local funds allocated or approved by the CMHSP and their local partners (as noted above), and State General Fund dollars redirected by MDHS.

MDCH will report Medicaid expenditures on a quarterly basis to MDHS and MDHS will transfer State General Fund dollars to MDCH using an interagency journal voucher process. The redirected State funds will be used as State match for waiver services provided to children identified by MDCH and referred to the Community Team in accordance with the purpose of this amendment.

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:

(a)& (b) County Boards of Commission have the authority to levy taxes and allocate a portion of general county funds (including property tax revenue) to CMHSPs to be used as local match. Cities and townships also have authority to appropriate funds to CMHSPs.

(c) Funds are directly expended by participating CMHSPs as specified in Item I-2-c.

☑ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

(a) & (b) As long as the source of revenue is not federal or state funds, revenues from other county departments and funds (such as child care funds) and from public or private school districts can be received by CMHSPs to use as local match for services.

(c) Funds are directly expended by participating CMHSPs as specified in Item I-2-c.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a.

Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The following waiver services can be provided to SEDW consumers in residential settings other than the individual's private residence: child therapeutic foster care (can be provided in a Department of Human Services (DHS) licensed

foster home), and therapeutic overnight camp (can be provided in a DHS licensed camp).

DHS, Michigan's child welfare organization, licenses and regulates children's foster care. The current approved rate for room and board is based on age and is as follows, and is not billable to Medicaid:

Age Group | Room & Board

0-12 $14.24
13-18 $17.59

The Therapeutic Foster Care rate for the SEDW is comprised of 3 components, 2 of which are billable to Medicaid; 1 which is not.

1. The daily rate covers $75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment-oriented appointments for the youth and family, data collection required as part of implementing the POS (including a daily/weekly log and 24 hour supervision).

2. The daily rate also includes $35.00 per day to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.

3. Room and Board rate paid to Foster Parents: This must be paid separate from the enhanced therapeutic foster care rate and from a different funding source (e.g., Title IV-E); Medicaid cannot be used to pay this component. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials. The Room and Board rate is based on the child's age:
a.) Age birth - 12: $14.24 a day
b.) Age 13 - 18: $17.59 a day

Therapeutic Overnight Camping (per session): CMHSPs and other approved community-based mental health and developmental disability services providers must contract with DHS licensed camps for this service. Contracts for all providers must specify performance expectations. In the case of licensed camps, performance expectations include the length of the session and detail of all costs (e.g., cost of staff with specialized training with this population, enrollment and other camp fees, transportation to and from the camp) included in the charge for the session. The contracted rate must exclude the cost of room and board. This is accomplished in 1 of 2 ways: subtracting the applicable room & board rate (see table above) for each day of the camp session from the total charge for the session; or subtracting the cost attributed to room and board in the detailed cost of the session.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a.

Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Hospital

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	11397.98	6763.00	18160.98	35886.00	861.00	36747.00	18586.02
2	13867.85	9884.00	23751.85	36378.00	933.00	37311.00	13559.15
3	15876.33	10712.00	26588.33	36876.00	1011.00	37887.00	11298.67
4	16145.49	11610.00	27755.49	37382.00	1096.00	38478.00	10722.51
5	16424.16	12583.00	29007.16	37894.00	1188.00	39082.00	10074.84

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	129	129	
Year 2	357	357	
Year 3	363	363	
Year 4	369	369	
Year 5	374	374	

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 SEDW maintains a database for each enrolled consumer. The database includes the date of enrollment and the termination date, when applicable. The first consumer was enrolled effective October 1, 2006 (year 2 of the initial application). The dates of enrollment were reviewed for all consumers who were on the SEDW during the second year of the waiver. We then reviewed dates of enrollment for year 3 using actual enrollment and terminations dates (when applicable). The number of days enrolled on the waiver was calculated for each consumer. The number of days was then totaled across all consumers and divided by the unduplicated count for each year. The rate of growth between year 2 and year 3 o the initial waiver was calculated at a 13% increase. This rate of increase was trended forward through 2010 (year 2 of the renewal). Starting with year 3 of the renewal we project the average lengh of stay will level off and therefore no further increase in the average lenght of stay was projected for 2012-2013.

The requested effective date of this amendment is May 1, 2009. The ALOS for year 1 of the renewal was recalculated estimating that the additional 50 children would only be on the waiver for an average of 4 months. For years 2 through 5 of the renewal period, the ALOS was not recalculated as it remains the same as projected in the renewal application.

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 for these estimates is as follows:

(a) The estimated number of service users was determined in 4 ways: 1) actual data for Waiver year 2 was analyzed to determine the unduplicated number of SEDW enrollees who used each service. This data was expressed as a percent and applied to the number of enrollees for which we are requesting approval for each

year of the renewal; 2) For services that were not used during year 2 (i.e.. Therapeutic Foster Care, Community Transition) the expected number of users was carried forward from the amendment in Waiver year 3; 3) For the new services called Therapeutic Activities the number of users was estimated based on the most recent Children's Waiver 373 Report; and 4) the new service called Family Support and Training estimates were based on experience from service use in other areas of Michigan's Mental Health system.
(b) The estimated number of units per user was based on the same data source as used for (a) above. In this case it was used to project the estimated average number of units of each service per enrollee.
(c) The average cost per unit of service was determined by applying a 2.2 percent cost increase to the current Medicaid fee screens for each service, beginning year 2 of the Waiver renewal. No rate increase was applied to Waiver year 1, as no change in the fee screen has been or will be approved.

For all years of the waiver renewal, the estimated number of users was recalculated maintaining the same estimated percent of enrollees using each service as projected in the renewal application. For year one only the average units per user was recalculated for the revised ALOS.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was calculated based on the estimated annual average per capita Medicaid cost for all services that were furnished to the waiver enrollee, in addition to waiver services while the child was in the waiver. There were two sources of data: 1) expenditures for waiver services and other mental health state plan services billed by the CMHSPs maintained in Michigan's Manual Payment System combined with 2) expenditures for all other Medicaid covered services for SEDW enrollees maintained in Michigan's Data Warehouse (MMIS). Using data from 2003-2007 we arrived at an average annual rate of growth for Medicaid expenditures for all other services. This rate of growth is 8.38 percent and was used to trend the actual D' data for Waiver year 2 (2007) forward through Waiver Year 5 of the renewal.

Factor D' was recalculated only for year 1 to include estimated expenditures for increased waiver partipants, adjusted for ALOS.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was determined by averaging the annual rate of growth of Medicaid costs for inpatient state institutional care for years 2003 through 2006, which as 1.37 percent. This percent was used to trend Factor G though year 5 of the Waiver renewal.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was determined based on the estimated annual average per capita of Medicaid cost for all other services provided to individuals while the individual was in a psychiatric hospital. Using data from 2003-2007 we arrived at an average annual rate of growth for Medicaid expenditures for all other services. This rate of growth is 8.38 percent and was used to trend the actual G' data for 2005 forward through Waiver Year 5 of the renewal.

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	
Respite	
Child Therapeutic Foster Care	
Community Living Supports	
Community Transition	
Family Home Care Training	
Family Support and Training	
Therapeutic Activities	

Waiver Services	
Therapeutic Overnight Camping	
Wraparound	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**144038.40**
Respite	15 minutes	66	341.00	6.40	**144038.40**	
Child Therapeutic Foster Care Total:						**283360.00**
Child Therapeutic Foster Care	day	8	322.00	110.00	**283360.00**	
Community Living Supports Total:						**178848.00**
Community Living Supports	15 minutes	45	621.00	6.40	**178848.00**	
Community Transition Total:						**5720.00**
Community Transition	one time only	8	1.00	715.00	**5720.00**	
Family Home Care Training Total:						**10800.00**
Family Home Care Training	session	18	4.00	150.00	**10800.00**	
Family Support and Training Total:						**51053.04**
Family Support and Training	15 minutes	86	153.00	3.88	**51053.04**	
Therapeutic Activities Total:						**17300.40**
Music Therapy	session	8	10.00	66.54	**5323.20**	
Art Therapy	session	10	10.00	66.54	**6654.00**	
Recreation Therapy	session	8	10.00	66.54	**5323.20**	
Therapeutic Overnight Camping Total:						**33600.00**
Therapeutic Overnight Camping	session	8	3.00	1400.00	**33600.00**	
Wraparound Total:						**745620.00**

GRAND TOTAL:	**1470339.84**
Total Estimated Unduplicated Participants:	**129**
Factor D (Divide total by number of participants):	**11397.98**
Average Length of Stay on the Waiver:	206

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Wraparound	day	129	17.00	340.00	**745620.00**	
				GRAND TOTAL:		**1470339.84**
				Total Estimated Unduplicated Participants:		**129**
				Factor D (Divide total by number of participants):		**11397.98**
				Average Length of Stay on the Waiver:		206

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**810529.72**
Respite	15 minutes	182	682.00	6.53	**810529.72**	
Child Therapeutic Foster Care Total:						**857809.68**
Child Therapeutic Foster Care	day	21	364.00	112.22	**857809.68**	
Community Living Supports Total:						**572191.25**
Community Living Supports	15 minutes	125	701.00	6.53	**572191.25**	
Community Transition Total:						**15318.24**
Community Transition	one time only	21	1.00	729.44	**15318.24**	
Family Home Care Training Total:						**30606.00**
Family Home Care Training	session	50	4.00	153.03	**30606.00**	
Family Support and Training Total:						**163734.12**
Family Support and Training	15 minutes	239	173.00	3.96	**163734.12**	
Therapeutic Activities Total:						**57833.76**
Music Therapy	session	21	12.00	67.88	**17105.76**	
Art Therapy	session	29	12.00	67.88	**23622.24**	
Recreation Therapy	session	21	12.00	67.88	**17105.76**	
Therapeutic Overnight Camping Total:						**89981.64**
				GRAND TOTAL:		**4950823.62**
				Total Estimated Unduplicated Participants:		**357**
				Factor D (Divide total by number of participants):		**13867.85**
				Average Length of Stay on the Waiver:		294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Overnight Camping	session	21	3.00	1428.28	**89981.64**	
Wraparound Total:						**2352819.21**
Wraparound	day	357	19.00	346.87	**2352819.21**	
				GRAND TOTAL:		**4950823.62**
				Total Estimated Unduplicated Participants:		**357**
				Factor D (Divide total by number of participants):		**13867.85**
				Average Length of Stay on the Waiver:		294

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**949949.10**
Respite	15 minutes	185	771.00	6.66	**949949.10**	
Child Therapeutic Foster Care Total:						**1035218.58**
Child Therapeutic Foster Care	day	22	411.00	114.49	**1035218.58**	
Community Living Supports Total:						**669889.44**
Community Living Supports	15 minutes	127	792.00	6.66	**669889.44**	
Community Transition Total:						**16371.96**
Community Transition	one time only	22	1.00	744.18	**16371.96**	
Family Home Care Training Total:						**39810.60**
Family Home Care Training	session	51	5.00	156.12	**39810.60**	
Family Support and Training Total:						**192417.12**
Family Support and Training	15 minutes	243	196.00	4.04	**192417.12**	
Therapeutic Activities Total:						**65727.74**
Music Therapy	session	22	13.00	69.26	**19808.36**	
Art Therapy	session	29	13.00	69.26	**26111.02**	
				GRAND TOTAL:		**5763106.13**
				Total Estimated Unduplicated Participants:		**363**
				Factor D (Divide total by number of participants):		**15876.33**
				Average Length of Stay on the Waiver:		332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreation Therapy	session	22	13.00	69.26	**19808.36**	
Therapeutic Overnight Camping Total:						**96170.58**
Therapeutic Overnight Camping	session	22	3.00	1457.13	**96170.58**	
Wraparound Total:						**2697551.01**
Wraparound	day	363	21.00	353.87	**2697551.01**	
				GRAND TOTAL:		**5763106.13**
				Total Estimated Unduplicated Participants:		**363**
				Factor D (Divide total by number of participants):		**15876.33**
				Average Length of Stay on the Waiver:		332

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**985646.40**
Respite	15 minutes	188	771.00	6.80	**985646.40**	
Child Therapeutic Foster Care Total:						**1056105.60**
Child Therapeutic Foster Care	day	22	411.00	116.80	**1056105.60**	
Community Living Supports Total:						**694742.40**
Community Living Supports	15 minutes	129	792.00	6.80	**694742.40**	
Community Transition Total:						**16702.62**
Community Transition	one time only	22	1.00	759.21	**16702.62**	
Family Home Care Training Total:						**41410.20**
Family Home Care Training	session	52	5.00	159.27	**41410.20**	
Family Support and Training Total:						**199457.44**
Family Support and Training	15 minutes	247	196.00	4.12	**199457.44**	
				GRAND TOTAL:		**5957687.56**
				Total Estimated Unduplicated Participants:		**369**
				Factor D (Divide total by number of participants):		**16145.49**
				Average Length of Stay on the Waiver:		332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Activities Total:						**67965.30**
Music Therapy	session	22	13.00	70.65	**20205.90**	
Art Therapy	session	30	13.00	70.65	**27553.50**	
Recreation Therapy	session	22	13.00	70.65	**20205.90**	
Therapeutic Overnight Camping Total:						**98113.62**
Therapeutic Overnight Camping	session	22	3.00	1486.57	**98113.62**	
Wraparound Total:						**2797543.98**
Wraparound	day	369	21.00	361.02	**2797543.98**	
				GRAND TOTAL:		**5957687.56**
				Total Estimated Unduplicated Participants:		**369**
				Factor D (Divide total by number of participants):		**16145.49**
				Average Length of Stay on the Waiver:		332

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**1020518.73**
Respite	15 minutes	191	771.00	6.93	**1020518.73**	
Child Therapeutic Foster Care Total:						**1077444.72**
Child Therapeutic Foster Care	day	22	411.00	119.16	**1077444.72**	
Community Living Supports Total:						**719001.36**
Community Living Supports	15 minutes	131	792.00	6.93	**719001.36**	
Community Transition Total:						**17040.10**
Community Transition	one time only	22	1.00	774.55	**17040.10**	
Family Home Care Training Total:						**39787.80**
Family Home Care Training	session	52	5.00	153.03	**39787.80**	
				GRAND TOTAL:		**6142637.09**
				Total Estimated Unduplicated Participants:		**374**
				Factor D (Divide total by number of participants):		**16424.16**
				Average Length of Stay on the Waiver:		332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support and Training Total:						**206623.20**
Family Support and Training	15 minutes	251	196.00	4.20	**206623.20**	
Therapeutic Activities Total:						**69340.96**
Music Therapy	session	22	13.00	72.08	**20614.88**	
Art Therapy	session	30	13.00	72.08	**28111.20**	
Recreation Therapy	session	22	13.00	72.08	**20614.88**	
Therapeutic Overnight Camping Total:						**100094.94**
Therapeutic Overnight Camping	session	22	3.00	1516.59	**100094.94**	
Wraparound Total:						**2892785.28**
Wraparound	day	374	21.00	368.32	**2892785.28**	

GRAND TOTAL:	**6142637.09**
Total Estimated Unduplicated Participants:	**374**
Factor D (Divide total by number of participants):	**16424.16**
Average Length of Stay on the Waiver:	332